MINUTES

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

July 18-19, 1985
Room 514-S — Statehouse

Members Present

Representative Joe Knopp, Chairman
Senator Jack Walker, Vice-Chairman
Senator Roy M. Ehrlich
Senator Paul Feleciano
Senator Frank D. Gaines
Senator Nancy Parrish
Senator Robert Talkington
Senator Wint Winter, Jr.
Senator Eric Yost
Representative Marvin Barkis
Representative William Brady
Representative J. Frank Buehler
Representative Rex Hoy
Representative Ruth Luzzati
Representative Michael O'Neal
Representative Vincent Snowbarger
Representative John Solbach
Representative Dale Sprague
Representative Thomas Walker

Staff Present

Mike Heim, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Melinda Hanson, Kansas Legislative Research Department
Mary Ann Torrence, Revisor of Statutes Office
Mary Hack, Revisor of Statutes Office
Bob Coldsnow, Legislative Counsel
Mary Jane Holt, Secretary

Others Present

Mike Mullen, Medical Protective Company, Ft. Wayne, Indiana
Ralph Gundelfinger, Providers Insurance Company, Kansas City, Missouri
Bob Trunzo, St. Paul Fire and Marine Insurance Company, St. Paul, Minnesota
Ron Todd, Kansas Insurance Department
Ted Fay, Kansas Insurance Department
Derenda J. Mitchell, Kansas Insurance Department
Bob Hayes, Kansas Insurance Department
Homer Cowan, Western Insurance Companies, Ft. Scott
Wayne Stratton, Topeka Attorney
Jerry Slaughter, Kansas Medical Society
Ron Smith, Kansas Bar Association
Lynn Johnson, Kansas Trial Lawyers Association
Betty Arnold, HSASEK, Wichita
Kathern Forest, American Association of Retired Persons, Wichita
Suellen Weber, Kansas Department of Administration
Elaine Spencer, Independent Insurance Agents of Kansas
Richard Harmon, Domestic Insurance Companies
Denise Everhart, Governor's Office
Martin Kennedy, Kansas Division of the Budget
Walter Darling, Kansas Division of the Budget
Pat Davis, Kansas Division of the Budget
Tom Bell, Kansas Hospital Association

Others Present (continued)

Patricia Henshall, Office of Judicial Administrator
Marsha J. Hutchison, Kansas Medical Society
Paul E. Fleenor, Kansas Farm Bureau, Manhattan
Mary Greenborg
David Litwin, Kansas Chamber of Commerce and Industry
Sherman A. Parks, Jr., Kansas Chiropractic Association
Ron Cobb, American Insurance Association, Houston, Texas
Stacie Hedges, Office of Judicial Administrator
Karen McClain, Kansas Association of Realtors
Don Strole, Kansas Board of Healing Arts
Harold Riehm, Kansas Association of Osteopathic Medicine
Mark Bennett, American Insurance Association
Ruby DePriest, Governor's Policy Office
Dotson Bradbury, Greenwood County Hospital, Eureka
Michele Hinds, Kansas State Nurses Association
Verna Roberts, United Way of Topeka
Jim Oliver, Professional Insurance Agents of Kansas
Gary Robbins, Kansas Optometric Association

July 18, 1984
Morning Session

The meeting was called to order at 10:00 a.m. by the Chairman, Representative Joe Knopp.

Mike Heim brought to the attention of the Committee the following materials: copies of the minutes of the last meeting; an updated Glossary of Terms (Attachment I); an AMA three-part report on Professional Liability in the 1980s (Attachment II); summary and addendum of a medical malpractice insurance study that was done in Pennsylvania by a consulting firm (Attachment III); and a memorandum dated July 8 from Don Strole, General Counsel for the Board of Healing Arts (Attachment IV).

The Chairman announced the Committee would be hearing testimony from insurance companies and introduced Mike Mullen, Executive Vice-President of the Medical Protective Company, Ft. Wayne, Indiana.

Mr. Mullen testified in response to a letter from Mike Heim dated July 5, 1985. He stated the underwriting gains and losses over the past ten years were in 1975, a loss of $111,555; in 1976, a gain of $34,811; in 1977, a gain of $281,323; in 1978, a loss of $155,347; in 1979, a loss of $459,119; in 1980, a loss of $178,854; in 1981, a loss of $511,529; in 1982, a loss of $158,114; and in 1983, a loss of $1,724,424. A 30 percent rate increase was put into effect for 1984 and there was an underwriting gain of $947,037 (Attachment V). In Kansas, investment income, he said, was not as significant a factor due to claims-made type policies that must be issued. The premiums cover the claims filed in that period and then the books are closed so there is less time for investment earnings. On the other hand, it could be six or seven years under an occurrence policy before the payment of a claim, so a reserve is set up and investment income is received from the reserves until the claim is paid. He said premium rates do not vary much between occurrence policies and claims made policies. They do not rely on investment income for rate making purposes. They use it as a buffer against adverse underwriting losses. The National Insurance Commissioner's Task Force, that dealt specifically with investment income in the ratemaking process, recently adopted a report that rate making should not be tied to the investment ability of an insurance company. Rates would go up and down depending on the interest rate or rate of investment return as well as market experience, he said.

In answer to Committee questions, Mr. Mullen explained, under a claims-made policy, if a physician changes his insurance company, all services rendered in the past go with the physician to the new insurance company. If the physician ceased to practice, then the Fund would cover any claims made. Since the state of Kansas has the Health Care Stabilization Fund, insurance companies do not sell tail insurance coverage in Kansas. He further explained under a claims made policy, a reserve is set up based on historical claims developed. The money is invested in municipal bonds on which interest is collected. However, as claims are reported, the money is drawn down from the incurred but not reported into the reported column of the insurer's books. This is a bookkeeping function. When the claim is paid, the money comes out of reserve and it becomes a paid loss. Under the claims made policy, the money is taken out of reserve to pay claims made that year so that the initial formulated reserve only encompasses one year.

Mr. Mullen stated in response to a question by a Committee member that the Fund was on an occurrence basis and insurance companies operate on a claims-made basis. Since the Fund has been operating for ten years, he did not know if it would be possible to switch the Fund over to a claims-made basis, nor what affect it would have on the rates.

An exhibit was presented in answer to questions pertaining to the number of Kansas doctors insured by Medical Protective, the number who have had malpractice claims, the number of claims paid, whether the claims resulted in settlements or jury awards, and amounts of each, all of which were for the last ten years (Attachment VI).

In regard to the average legal costs for defense associated with a claim being filed against a health care provider, Mr. Mullens said it is roughly 30 percent and he had some charts to support the figures.

He stated it was impossible until after the close of their calendar year to project future premium rate increases. In Kansas, they file their rates in the spring, which become effective on July 1. He said there would likely be premium increases in the future.

In answer to the question concerning Medical Protective Company's underwriting standards for doctors, Mr. Mullen stated their standards encompass the length of time in the community, place and degree of graduation, specialty of practice, nature of procedures performed, and losses occurring. They screen whether the doctor is doing any procedures they would not insure. They also visit with the doctor at his office to judge his personality and communication skills. The second part of their underwriting process is "post loss" underwriting. After the doctor has his first claim and loss, the insurance company has a meeting with the defense counsel and the insurance agents and ask if the doctor was defensible, did he present himself on the witness stand appropriately, and should they continue to defend the doctor. If he is a defensible risk, they will renew his policy.

Mr. Mullen said his company does not use a surcharge for experienced doctors who have claims filed against them, rather they elect to decide whether to renew or not to renew the insurance policies. In a professional liability situation, a relationship must be developed between the insured and insurer. Doubling the rate or surcharging builds a fence between the insured and insurer and the insured feels no allegiance to the insurer, which makes the insured difficult to defend. He further stated a general practitioner in a small town who delivers a small amount of babies pays a class III premium, and an obstetrician in a large city who delivers a lot of babies pays a class VIII premium. The reason is due to the risk involved. This is not a territorial rate, rather a rate based on the type of practice.

Mr. Mullen explained to the Committee his company writes only medical malpractice insurance. He stated insurance companies should report incidents of medical malpractice they are aware of to the Board of Healing Arts or other appropriate state agencies, if immunity is provided to the insurance companies.

In regard to "trip insurance," Mr. Mullen said they felt this concept was not workable and would be too costly.

Staff questioned what would happen if the state required all of the insurance companies to charge the same rate and permit deviations from that rate based on actual experience of malpractice. Mr. Mullen replied, in his opinion, it would be disastrous. He cited the so-called Nye Report for the state of Pennsylvania (Attachment III). He recommended contacting the Medical Society and plaintiff's attorneys in Pennsylvania to see what their opinion of the Nye Report was.

He said Kansas does not have enough doctors for a bureau to promulgate a rate based on Kansas experience only and listed the experience of the different insurance companies and how they vary widely by the methods they use in underwriting, claims handling, and overhead expenses.

Mr. Mullen used a flip chart to assist in explaining the comparison of Kansas' experiences with the Indiana Plan for the years 1980-84 and explained a model act based on Indiana law (Attachment VII). He stated 30 percent of the payout in malpractice cases is for the defense of the claim and another 35 percent to 50 percent of the payout goes to the plaintiff's attorney. All figures referred to were averages. The average Kansas attorney fee paid was $6,500 for each case. The insurance company's cost of malpractice insurance has increased 30 to 40 percent and much of this cost is passed on to the general public for health care. He stated Indiana has declined in the amount of the average paid claim, while Kansas' average has soared. The Indiana suit ratio is much higher than Kansas, because Indiana did not cut off access to the courts, therefore, the frequency of claims is higher in Indiana. When asked if the frequency of claims in Indiana indicated a failure in their system to deter malpractice, Mr. Mullen said he did not think that was the case. He said that possibly more claims were filed in Indiana since the screening panel process was risk free, since the winner paid the costs. He said there was a lottery atmosphere in Kansas with the unlimited coverage by the Health Care Stabilization Fund until last year and the $3 million cap that now exists.

He noted his company does not operate a formal risk management program. When asked if his reaction to the Nye Report assertion that a 40 percent savings could be realized through more effective risk management, he said he did not agree.

Mr. Mullen said doctor owned insurance companies who had discounted malpractice rates 15 to 20 percent were now going out of business.

When asked if he agreed with a proposal to limit experts to local areas, Mr. Mullen said this would not be necessary if the Indiana Plan were adopted.

He said the answer to the differences between the charts for Indiana and Kansas is an absolute cap on awards, and a mandatory screening panel. The winner pays when a screening panel is convened.

In answer to a question, Mr. Mullen replied they do not like to insure new procedures. He noted the cap on awards in Nebraska is $1 million.

A Committee member asked if it was true that Pennsylvania would experience a 40 percent savings in medical malpractice premiums if measures were taken in response to the study that was done. Mr. Mullen answered absolutely not. He said some of the recommendations had been tried in other states.

Mr. Mullen recommended a $500,000 cap be placed on all pecuniary and nonpecuniary loss awards and no limitation on the first $200,000 for plaintiff's attorney fees, but a 15 percent cap on attorney fees thereafter. Structured settlements would take care of the multimillion dollar suits, he said. The $500,000 cap would not include future medical expenses. In response to a question, Mr. Mullen said the $500,000 cap would not have an immediate effect on primary insurer premium rates since their liability limit was now $200,000 per occurrence but would eventually have a stabilizing effect on rates.

The Committee recessed for lunch.

Afternoon Session

Ralph Gundelfinger testified representing Providers Insurance Company of Jefferson City, Missouri. He explained Providers Insurance Company was organized in 1981 and is a wholly-owned subsidiary of Missouri Professional Liability Insurance Company of Missouri. In 1981 the Kansas Hospital Association asked Providers Insurance Company to write malpractice insurance for hospitals in Kansas since there were not many companies writing malpractice insurance for hospitals in Kansas. He distributed a sheet (Attachment VIII) which shows a projected loss from 1984 until 1987, on all lines of insurance, not just medical malpractice insurance. He also distributed a list of reinsurers and their losses (Attachment IX).

He said the reasons so few insurance companies are writing medical malpractice insurance in Kansas, both for hospitals and physicians, is the relatively low dollar income and a relatively high claims exposure. He said the Health Care Stabilization Fund has narrowed the base in Kansas by taking away the market for excess insurance. Mr. Gundelfinger said his company does write insurance for doctors, but only if they are employed by a hospital.

Mr. Gundelfinger handed out a sheet (Attachment X) which shows his company's profit and loss statement for the state of Kansas. After 18 months of writing medical malpractice insurance in Kansas, they sell to 28 hospitals, including the University of Kansas Medical Center. Their underwriting losses were 194.95 percent for the year ending December 31, 1983; 190.58 percent for the year ending December 31, 1984; and 165.98 percent as of March 31, 1985. They have received a rate increase to stay in business in Kansas. The parent company is a nonprofit organization owned by hospitals in Missouri and is run by a board of hospital administrators. He recommended good hospital management, good risk management, and an incident reporting system as a way to control medical malpractice insurance costs. He said these things were working in Missouri and were needed for doctors as well. He said medical advancement is going on faster than hospital administration can cope with. He said risk management procedures had been revised at the Kansas University Medical Center and this has begun paying off by a downturn in the number of claims and a better relationship between physicians and the hospitals. He said for four years in a row, his company has returned premiums to hospitals.

In answer to a question by the Chairman, Mr. Gundelfinger replied the screening panel theory was very good, but was found to be unconstitutional in Missouri. The screening panel was working very well in Missouri and had reduced the average cost of legal fees per malpractice case from $15,000 to $1,200. The panel consisted of a hospital administrator, a doctor, a lawyer, and a layman and was presided over by a judge. Anyone who had a claim against a hospital or a doctor first had to go before the screening panel. If the screening panel felt a claim was justified then a suit was filed in court. As soon as the screening panel was ruled unconstitutional costs soared again in Missouri. Other states have declared screening panels constitutional. The Supreme Court ruled the screening panel was unfair because it discriminated against one group.

Staff was asked by Committee members to provide them with information about screening panels from the states that have screening panels, especially those that have been challenged and found constitutional, and also information from the states that have structured settlements.

Mr. Gundelfinger recommended Kansas not consider legislating structured settlements, but to let private industry handle structured settlements themselves.

Bob Trunzo, St. Paul Fire and Marine Insurance Company stated that he did not have any prepared testimony and had not, as yet, prepared written answers to the questions submitted to him by the Committee staff. He stated his company writes 15 percent of the medical malpractice insurance nationwide, and the medical division comprises one-third of their total business. They market through independent agents. He explained when considering a doctor for insurance they take into consideration education, speciality, and loss history. His company's rate making procedure in Kansas does take into consideration national experience. The Kansas physician population and the number of claims are not a credible (large enough) amount actuarially to permit only Kansas experience to be used to compute rates. Out of the 43 states where they write medical malpractice insurance, Virginia is the only state where they do not use national experience. The data base in Virginia is 4,600 physicians and 640 claims in 1984 whereas in Kansas the data base is 2,000 physicians and 229 claims in 1984.

Mr. Trunzo said his company was a pioneer in risk management in hospitals. Now risk management programs are being developed and are being used by doctors. He noted St. Paul's rates are higher than Medical Protective rates. Rates are based on their experience and take into consideration the frequency and severity of claims in classes 1 through 8. About 6 percent of the cost is for using independent agents.

Mr. Trunzo recommended consideration of a $100,000 cap on pain and suffering awards. He did not recommend limiting wage loss or medical expenses. In regard to territorial pricing, his company does do some of this in Florida and Illinois. They have done claim analysis in those states and can specifically identify the problems which are coming from certain counties. However, in Kansas the problems are coming from all over the state, from large cities as well as rural communities, he said, so they could not use territorial pricing here.

Mr. Trunzo said the St. Paul Fire and Marine Insurance Company is opposed to a loss surcharge on premiums or experience rating physicians as it destroys the relationship and confidence between the doctor and the insurer.

In answer to a Committee question, Mr. Trunzo stated under a claims-made policy, the first year's rate is lower since there will be no claims to pay that year. The premium rates increase each year until they reach the five-year level.

He noted his company does not endorse the so-called Indiana Plan. His company does not believe medical expenses and disability payments should be capped. He further replied his company recommends using a noneconomic cap and the option of making structured settlements, along with the suggested two-year statute of limitations which Kansas now has. He suggested risk management and peer review practices be looked at also. The reasons his company will not renew a physician's policy are loss history, underwriting decisions, and company guidelines. The physician is notified by letter by St. Paul of the nonrenewal and the reasons why. The seven states where they do not write malpractice insurance, he said, have regulations they do not want to become involved in. They use trending factors based on national frequency and severity along with the number of Kansas physicians, the number of cliams, and the number of years in Kansas, for determining premium rates in Kansas.

In response to a Committee member, Mr. Trunzo replied he would request their actuaries to furnish information to the Committee about procedures and formulas used in different states to set premium rates. Mr. Trunzo agreed to ask his actuaries what the impact on rates would be if only Kansas experience were utilized. In regard to screening panels, he said screening panels can add a double layer of costs. Currently, there are problems in Wisconsin and Louisiana with screening panels. He also stated if screening panels are made binding, then there is a constitutional problem in some states.

The Committee discussed the underwriters bringing their actuaries to a future meeting or hiring an independent actuary and what questions the Committee would ask. Mr. Trunzo stated he would be willing to bring his actuary. He also stated an independent actuary would be very expensive. A study in Virginia on the statute of limitations by an independent actuary cost $10,000. It was also suggested the Committee consider just requiring primary insurance coverage for health care providers, and no secondary coverage.

The Committee adjourned until 9:00 a.m., Friday, July 19, 1985.

July 19, 1985
Morning Session

The Chairman introduced Ron Todd, Assistant Insurance Commissioner, Kansas Insurance Department. Mr. Todd distributed to the Committee a list of members and minutes of the Board of Governors of the Kansas Health Care Stabilization Fund (Attachment XI) and a list of members and minutes of the Board of Governors of the Kansas Health Care Providers Insurance Availability Plan (Attachment XII). He explained the Board of Governors of the Kansas Health Care Stabilization Fund was created by 1984 S.B. 507 and became effective July 1, 1984. This board consists of 13 persoes appointed by the Commissioner of Insurance, as specified by S.B. 507 and in addition to other duties, is directed to study and evlauate the operation of the Fund and make such recommendations to the Legislature as may be appropriate to ensure the viability of the Fund. He further stated the board was empowered to remove a health care provider from the coverage provided by the Health Care Stabilization Fund if, after a hearing, it was determined the health care provider presented a significant future hazard to the Fund. He also distributed (Attachment XIII) Health Care Stablization Fund defense costs from July 1, 1976 to June 1, 1985. He explained attorneys are hired by the Fund and represent the provider in the Fund's interest if it is determined the Fund is going to become involved in a claim. From July, 1976 to July, 1980, $97,947.21 was paid out for defense of the Fund and $1,641,247.70 was paid out for defense of the Fund during July, 1980 to June, 1985. The number of cases and amounts paid have increased dramatically, he said.

Mr. Todd handed out a sheet explaining the defense of the Health Care Stabilization Fund. The sheet explains when outside legal counsel is employed to defend the Fund and how it is determined when the Fund is going to be involved in malpractice litigation (Attachment XIV). He noted there has been $1.7 million in defense costs for defending $35 million in awards. When asked why they can operate so efficiently, Mr. Todd said it was not because they were not minding the store.

Mr. Todd distributed to the Committee (Attachment XV), Alternative Health Care Stabilization Fund Surcharge Strategies, as requested by the Citizens Advisory Committee, which lists surcharge revenue under the surcharge procedure in accordance with K.S.A. 40-3401 for FY 1977 to FY 1984 as $17,282,016; at 45 percent for the same period as $36,521,683; and accrual funding for FY 1977 to FY 1984 as $45,736,478.

In answer to a question by a Committee member, Mr. Todd stated it was considered at the time the Fund was enacted to put the Fund on an actuarial basis but the decision was made to cap the Fund at $10 million.

A spreadsheet showing the basic professional liability insurance rates, Health Care Stabilization Fund information for FY 1977-1984 showing surcharge levied, number and amounts of settlements, number and amounts of judgements, number of claims and suits filed and legal defense costs, and a sheet showing Kansas Closed Claims information for calendar years 1977 to 1984, were distributed (Attachment XVI). A Committee member noted that it did not appear from the spreadsheet that Kansas juries were awarding high amounts, since jury verdicts were similar in size to settlement amounts.

Ms. Derenda Mitchell of the Insurance Department said the statement that cases are going to trial and hitting it big is not borne out by the facts, since the Fund has only paid 12 jury awards so far and has won two-thirds of the time it is involved in a trial. She noted the Department sends hammer letters to insurers all the time encouraging settlements. She said in one case the Fund threatened to sue St. Paul and they finally agreed to settle. Mr. Todd noted that there have been cases where the Fund has settled a case and the primary carrier has not.

A question was asked about how many cases in which the Fund was involved went to trial and were won or the case was dismissed and how many cases are settled by St. Paul and by Medical Protective. The Insurance Department agreed to provide this information.

The Insurance Department stated they could provide the Committee with a display on a closed claims reporting mechanism furnished by the industry that gives distribution of the claims by size and loss.

In answer to a Committee member, the Insurance Department replied they have 380 case files open in their office and feel they are capable of handling their responsibilities. They have requested additional clerical help.

It was noted that the Insurance Department hires independent counsel to review case files to determine potential Fund liability in cases and whether a conflict will exist between the Fund and the private insurer. It was noted that a claims review position was requested by the Fund to monitor the paperwork and to insure accurate reserves are kept on a claim.

Homer Cowan, Western Insurance Companies, testified his insurance company is the servicing carrier of the joint underwriting association (JUA) or Plan. They have returned to the Fund about $325,000 out of the servicing carrier fee, however, they are not breaking even now. He stated none of Western Insurance money is involved, just the doctors' money, both at the lower layer and the higher layer, so there is no conflict of interest involved. If the Plan makes a profit, the profit is transferred to the Fund, and if the Plan has a loss, then the Fund transfers money to the Plan. He stated there are 250 doctors in the JUA now and if there were more companies in the private market, doctors would not have a problem getting malpractice insurance. He said the surcharge in the JUA is designed to get doctors to look elsewhere for coverage.

In answer to Committee questions, Mr. Cowan replied a loss surcharge by the industry would not work, as it would cause bad relationships between the insurance company and the physician. If the JUA did not exist, Mr. Cowan felt this would encourage other insurance companies to come into the state. He agreed the JUA is keeping some health care providers afloat who otherwise would be uninsurable risks. He noted more providers may seek coverage from the JUA if St. Paul and Medical Protective begin retreating from this market. He noted that if the JUA did not exist then Aetna might come in, since this company now will not compete with a state-run insurance company. He also stated the Plan has some risk management services, but not to the extent St. Paul does. He further replied that he believes the Insurance Department does need additional help.

A Committee member asked that Mr. Cowan furnish a list of the doctors in the JUA by class of city.

A request was made by a Committee member to ask Brad Smoot, a member of the Fund Board of Governor's, to testify before the Committee.

Mr. Cowan replied to a Committee member that by law, doctors have to be accepted by the JUA. He further replied that if the Plan needed money and the Fund did not have any, the law provided that the insurance industry, not just companies selling malpractice insurance, but all companies selling all kinds of insurance, would be assessed; and this was done for startup money for the Fund. He stated there should be some kind of a cap on the percent of surcharges for the Plan. He noted an underwriting board recommends the surcharge to the JUA Board of Governors for review and approval. The Board of Governors then submit it to the Insurance Department for their review and approval.

A Committee member questioned whether conditions continue to exist which require the existence of the Fund and the JUA.

The Committee recessed for lunch.

Afternoon Session

Ron Todd passed out a sheet (Attachment XVII) which compares the total amount of money paid out for automobile liablity settlements and awards to medical malpractice settlements and awards for the years 1979 through 1983. He explained company expenses are not included in the direct losses paid and the overhead expenses of the insurance companies are estimated at 30 to 35 percent. He stated by law there is a grievance procedure for the insured under the Joint Underwriting Association Plan. The insured can take his grievance to the Board of Governors, with the right of appeal to the Insurance Commissioner.

In reply to staff, Mr. Todd agreed that the Plan only provides basic coverage and if the provider was removed by the Board of Governors from the Fund, the insured would have to go to the market to find coverage above the basic coverage. Mr. Todd said for the physician to retain his license, basic coverage is all of the insurance that is required. After Committee discussion, a Committee member suggested a legal opinion might be necesary to determine the status of a physician who was removed from the Fund.

In answer to Committee questions, Mr. Todd stated the Board of Governors, as yet, had not held any hearings concerning doctors who are high risks, but they have a subcommittee working on particular problems to see what they can or cannot do. The Board of Governors had a meeting July 9 and plan to meet more often. He stated it was the Medical Society's idea to set up the Board of Governors. The Board is composed of health care providers, since the money paid out of the Fund is provided by health care providers. Before a physician can be removed from the Fund, material significant risk to future liability of the Fund has to be established as a result of a hearing. The Fund was established to provide the availability of coverage for higher limits of liability.

Staff asked Mr. Todd if the statement made at the last meeting that the Fund was functionally broke was correct? Mr. Todd said the Fund was in the same position as a bank if the depositors withdrew all of their money at the same time. He explained a portion of the surcharges goes to building up the reserves.

A Committee member asked if the Insurance Department participated in peer review or risk management. Mr. Todd replied the Insurance Department would not have a reason to become involved with peer review, however, in regard to risk management in the defense of the Fund, seminars might be helpful.

The Chairman introduced Wayne Stratton, a defense attorney who represents health care providers and the Fund. He said he is often asked to report to the insurance company the status of the litigation and what the jury verdict might be and amount of the verdict. He also stated he keeps the Health Care Stabilization Fund informed with the same information he gives the insurance company. If the Fund believes there is a case where the liability will involve the Fund, they call the insurance company involved and suggest the insurance company offer their limits and the Fund will try to settle the case. He said the potential conflict of the attorney representing both an insurer and the Fund has been misrepresented to the Legislature. He also stated in certain instances, it is appropriate for the Fund to hire additional counsel.

In answer to a question by a Committee member, Mr. Stratton said the defense attorney defends one client, the doctor, or the hospital. If the insurance company asks the Fund to assume any additional costs in the defense, the insurance company is billed for their part by the defense attorney and then the Fund can either agree to continue with the same attorney or hire someone else. He noted in some cases a plaintiff will seek punitive damages and agree to drop this aspect of the suit if the insurer will pay the policy limits. This amount then is used to finance the case against the Fund. He said this seems to be happening, especially in the Wichita area.

The Chairman invited interested parties to make comments.

Ron Smith, Kansas Bar Association, suggested a merit or experience rating system for physicians be implemented, noting insurers now merit or experience rate attorneys.

Jerry Slaughter, Kansas Medical Society, stated the Fund is not popular with physicians and hospitals, but there is no other company that offers excess coverage in Kansas. He stated there are tools available to the Board of Healing Arts with added disciplinary staff and the Board of Governors of the Fund to weed out negligent doctors. In regard to risk management, the Medical Society with the hospitals are involved in a joint study of this issue.

Lynn Johnson, representing the Trial Lawyers Association, recommended mandatory risk management and good peer review. He stated the Insurance Department is improving in defending the Fund. He suggested screening panels should be designed by the people that are going to be using them. The reason lawyers use doctors from Denver, St. Louis, Boston, or Dallas, is because doctors will not testify against their local fellow doctors. He said perhaps the Fund's exposure should be reduced.

The Chairman asked what information relating to insurance the Committee would like to have for future meetings. The Chairman also requested position papers from the various interest groups be submitted to the Committee within the next two weeks concerning their suggestions.

A Committee member recommended the Committee investigate whether the state should continue to be in the insurance business. Another Committee member requested a legal opinion from Bob Coldsnow, Arden Ensley, or the Attorney General on whether a doctor could continue to practice without Health Care Stablization

Fund coverage, and what are the due process rights, if any, that the Board of Governors must exercise when making its decisions. A Committee member requested information about Virginia and how they arrive at rates using only Virginia data. Mr. Slaughter noted that the Medical Society had spent a lot of time and money looking at the possibility of establishing a doctor-owned insurance company and it was determined there were too few doctors in Kansas to make this work. He noted many such companies were going bankrupt now nationwide.

During Committee discussion, Ted Fay, Kansas Insurance Department, informed the Committee for the Insurance Department to be able to respond to the Committee on what the impact on Fund surcharges and JUA Plan rates would be if certain statutory changes were made, their actuaries estimate it would cost $5,000 to $10,000 and would take four to five weeks. The money would come from the Fund from moneys set aside for actuarial services. After Committee discussion, it was decided to ask the interested parties to submit questions they think should be studied by the Insurance Department.

A motion to approve the July 1-2 minutes was made by Representative Thomas Walker, and was seocnded by Representative John Solbach. The motion passed.

It was noted the Insurance Commissioner's Committee for Tort Reform would be having its subcommittee report in September.

The Committee adjourned.

Prepared by Mike Heim

Approved by Committee on:

September 13, 1985
(date)

Attachment I

MEMORANDUM

July 15, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: Glossary of Terms

This Glossary contains simplified definitions of many of the basic terms commonly used during Committee hearings and discussion. It is intended to be a quick resource aid for members and should not be considered as comprehensive or authoritative.

Health Care

HMO — health maintenance organization.

Health Care Provider — The definition found in K.S.A. 1984 Supp. 40-3401(f) is the one pertinent to Committee discussion. Note that the definition does not include some professionals colloquially considered to be providers (e.g., registered nurses).

Medical Care Facility — General or special hospital, recuperation center, or ambulatory surgical center.

Nonresident Health Care Provider — A provider whose usual place of practice is out of state.

Peer Review — Review of the practice of a provider by his peers, i.e., individuals who are licensed in the same practice, usually through a private agency such as hospital medical staff or a professional association.

Persons licensed to practice medicine and surgery — MDs (Doctors of Medicine) and DOs (Doctors of Osteopathy).

Persons licensed to practice the healing arts — MDs, DOs, and Chiropractors.

Provider Regulatory Agencies:

for MDs, DOs, and Chiropractors — Board of Healing Arts

for medical care facilities — Secretary of Health and Environment

for HMOs — Commissioner of Insurance

for optometrists — Board of Optometric Examiners

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for podiatrists — Board of Healing Arts

for pharmacists — Board of Pharmacy

for licensed professional nurses — Board of Nursing

for certain dentists practicing anesthesia in a medical setting — Board of Healing Arts

for physical therapists — Board of Healing Arts

Resident Health Care Provider — A provider whose usual place of practice is in Kansas.

Insurance

Actuarial Principles — Rules by which probability and statistical theories are applied to the practical problems of insurance. The operation of these laws underlies premium and reserve calculation and other forecasting functions within the insurance field.

Basic Coverage — Policy of professional liability insurance required to be maintained by each health care provider. Current limit is not less than $200,000 per occurrence (subject to $600,000 annual aggregate for claims made during the policy period). See K.S.A. 1984 Supp. 40-3402, as amended by 1985 S.B. 362.

Claim — A demand made against an insured for damages covered by a policy he or she holds. A claim is generally referred to the insurer for handling on behalf of the insured in accordance with the contract terms.

Claims File Opened — Status at time when a potential claim is reported, and the Insurance Commissioner begins a file on that claim.

Claims Made Policy — Policy under which coverage purchased at the beginning of the year protects only against claims made during that year. (See "occurrence policy.")

Earned Premium — The part of an insurance premium that pays for the protection the insurer has already given on a policy.

Expense Ratio — Percentage of the premium used to pay the costs of acquiring, writing, and servicing business.

Fund — Health Care Stabilization Fund established pursuant to K.S.A. 1984 Supp. 40-3403(a); sometimes called Patient Compensation Fund.

HCPIA — Health Care Provider Insurance Availability Act (K.S.A. 40-3401 et seq.).

HCSF — Health Care Stabilization Fund.

Indemnity — Restoration of the victim of a loss, in whole or in part, by payment, repair, or replacement.

ISO — Insurance Services Office. This organization assists property and liability insurance companies by establishing underwriting rules and rates and by analyzing statistics.

JUA — Joint Underwriting Association or Authority (also called an assigned-risk pool) — a device for making insurance available to high-risk physicians by mandating a subsidy from other policyholders. (See K.S.A. 1984 Supp. 40-3413.)

Loss — The basis for a claim for indemnity or damages under the terms of an insurance policy. The term also is used to refer to payments made in behalf of the insured.

Loss Development — Adjustment to claim reserve as investigation proceeds concerning the claim (initially a certain reserve is set aside; more investigation will lead to another figure and the reserve amount will be charged; then discovery proceeds, with additional ensuing adjustment, etc.).

Loss Ratio — Percentage of losses to premiums.

Loss Reserve — The portion of the assets of an insurer kept readily available to meet probable claims.

Losses Incurred — Total losses, whether paid or unpaid, sustained by an insurer under a policy or policies.

Losses Incurred but not Reported — Losses that have taken place, but which have not yet come to the attention of the insurer or the Insurance Department.

NAIC — National Association of Insurance Commissioners.

Occurrence Policy — Policy under which a physician purchases at the beginning of year one coverage against all claims (whenever they might be made) on incidents occurring during year one. The insurance, thus, would apply to a suit even if it were brought in year two. (See "claims made policy.")

Policy Year Loss Ratio — The figure resulting when every claim that could be made against the one policy year premium has been made and paid. When this figure exists, it is the only circumstance when profit and loss can be accurately determined as an absolute amount.

Rate (also called premium rate) — The price per unit of insurance.

Rate Filing — Submission to the Insurance Commissioner by an insurance company (or rating organization) of the per unit cost of insurance it plans to use as a base for the determination of premiums. The filing must contain supporting documentation adequate to justify the proposed rate.

Reinsurance — An agreement between two or more insurers by which risk of loss is apportioned. The goal is to spread the risk of loss so that a disproportionately large loss under a single policy does not fall on one company. The reinsurer is the one accepting all or part of the risk of loss of another insurer.

Reserves — Funds set aside by an insurer for the purpose of meeting obligations as they become due.

Self-Insurer — Entity that, rather than purchasing insurance coverage from another, makes provisions on its own to set aside funds to cover losses it may suffer; certain health care providers may self-insure pursuant to K.S.A. 1984 Supp. 40-3414.

Surcharge — Assessment levied by the Insurance Commissioner on the annual premium of each health care provider and self-insurer. This assessment is used to fund the Health Care Stabilization Fund and is currently assessed at the rate of 110 percent of premium.

Underwriter — Person (or company) who selects risks for insurance and determines in what amounts and on what terms the insurer will accept the risks.

Unearned Premium — The portion of the original premium not yet earned by the insurance company. If the policy is cancelled, this amount is due the policyholder.

Legal

Additur — Power that the trial court has to increase the amount of a jury award in cases of inadequate compensation.

Collateral Source Rule — Under this rule, compensation received by a plaintiff for injury from sources other than the defendant should not be deducted from a jury award. This general rule was modified in Kansas in 1976 and again in 1985 with S.B. 110 regarding medical malpractice actions.

Compensatory Damages — Awarded to compensate the injured party for the injury sustained, to replace the loss caused by the harm or injury.

Contested Claims — Claims that will be litigated by the insurer.

Contingent Fee — Arrangement between client and attorney, frequently used in personal injury actions, by which the attorney agrees to represent the client with compensation to be a percentage of the amount recovered. Sometimes regulated by court rule or statute.

Nonpecuniary Damages (sometimes called "intangible damages") — Pain and suffering types of damages, as opposed to money damages.

Pattern Instructions for Kansas (PIK) — Model jury instructions given by the judge to the jury to inform them of the law applicable to the case at hand.

Punitive Damages — Damages above and beyond compensatory damages; awarded against a person to punish for outrageous conduct. Sometimes limited by statute.

Remittitur — Procedural process by which a judge may order a plaintiff to remit a portion of the award in cases when money damages awarded by a jury are grossly excessive as a matter of law.

Res Ipsa Loquitur — A rule of evidence that permits negligence of a defendant to be inferred from the mere fact that the injury occurred. The plaintiff must prove that the defendant was in exclusive control of whatever caused the injury and that the injury would not have occurred if reasonable care had been used.

Special Master — Appointed by the court to act as the court's representative in a case to assist with specific judicial duties.

Statute of Limitations — Sets a time limit within which the right to a cause of action exists.

FROM: PROFESSIONAL LIABILITY IN THE '80s, Report #2; American Medical Association Special Task Force on Professional Liability and Insurance, 1984-85.

TORT REFORM GLOSSARY

Ad damnum clauses - The *ad damnum* clause is that part of a plaintiff's initial pleadings which states the amount of monetary damages and other relief requested by the plaintiff in a court action. Most of the legislation on this subject provides for the elimination of the *ad damnum* clause altogether; legislation also often provides that the defendant be apprised of the precise amount sought by the plaintiff through the normal course of pre-trial discovery.

Arbitration - Arbitration statutes relate to voluntary procedures whereby patients and health care providers may enter into written agreements for the submission of any medical liability claims to binding arbitration. This procedure is an alternative to and in lieu of trial by jury. This procedure provides for limited judicial review of the arbitration decision.

Medical liability claims can currently be arbitrated in at least 30 states under the general arbitration statutes in those states. The chart only lists those states with arbitration legislation specifically for medical liability claims.

Most of the medical liability arbitration statutes provide that written arbitration agreements may cover present and future medical injury claims. All of the statutes generally provide that a person's right to treatment shall not be prejudiced in any way by the decision whether or not to enter into an agreement for arbitration of medical liability claims. In other words, the agreement must truly be voluntary to be binding. Also, most statutes which permit arbitration agreements to cover future medical injury claims provide for a certain period of time, either following execution of the contract or provision of the services, in which the patient may reject the arbitration agreement.

Attorney fee regulation - The most common arrangement for payment of plaintiff attorney fees in medical liability cases is the "contingent fee." Under this type of arrangement the attorney receives as his fee an agreed upon percentage (commonly 30% to 50%) of any final award or settlement made to the plaintiff.

Legislation enacted during the last few years regulating attorney fees in medical liability cases has taken several different approaches: a sliding scale for the plaintiff attorney fees in terms of a percentage of the award; court review of the proposed fees and approval of what it considers to be a "reasonable fee"; or limiting attorneys' fees to a certain percentage of the amounts recovered by the plaintiff.

Awarding costs, expenses and fees - A few states have provisions designed to deter the pursuit of frivolous medical injury claims. These statutes generally provide that where one party to the action has been found to have acted frivolously in bringing the suit, the party may be found liable for payment of the other party's reasonable attorney and expert witness fees and court costs. These provisions differ from the usual civil trial situation in which payment for attorney fees and expert witness fees are normally paid by the party who incurs them.

Collateral source provisions - The collateral source rule is a rule of evidence that prohibits the introduction into evidence at trial of any indication that a patient has been compensated or reimbursed for the injury from any source other than the defendant.

Legislation modifying the collateral source rule has taken several approaches: permitting consideration of compensation or payments received from some or all collateral sources; requiring the mandatory offset against any award in the amount of some or all collateral source payments received by the plaintiff; or allowing the defendant to introduce evidence of the plaintiff's compensation from collateral sources. The jury is instructed to make a mandatory reduction of the award for economic loss by a sum equal to the difference between the total benefits received and the total amount paid by the plaintiff to secure such benefits.

Expert witness - Expert witnesses are required to explain many of the complex and difficult issues in a medical negligence case. Legislation affects the qualifications and use of expert witnesses.

Limits on liability - Some states have enacted legislation that limits the liability of defendants in medical liability lawsuits. These statutes limit liability in one of several ways: limiting recovery of a particular type of damages; placing an absolute cap on the amount of damages recoverable; or placing an absolute cap on physician liability under a patient compensation fund.

over, please

Patient compensation fund - A patient compensation fund is a governmentally operated mechanism established to pay that portion of any judgment or settlement against a health care provider in excess of a statutorily designated amount. A fund may pay the remainder of the award or it may have a statutory maximum (e.g. one million dollars).

Patient compensation funds are generally funded through an annual surcharge assessed against health care providers, with such surcharge often being a specified percentage of the provider's annual insurance premium. Patient compensation funds are also known as "excess recovery funds."

Periodic payments - In most states, unless otherwise agreed on by the parties or mandated by the court, judgments can only be lump-sum awards. Under a periodic payments system, the payments are made over the actual lifetime of the plaintiff or for the actual period of disability.

Pre-trial screening panels - Pre-trial screening panels are prerequisites to trial. Procedures for panels usually require a mandatory pre-trial hearing to be conducted by a panel comprised of members as dictated by statute. In some states the pre-trial hearing is voluntary. The composition of the panel and its scope of inquiry vary greatly from state to state.

All statutes establishing pre-trial screening procedures provide that the panel's decision is not binding on the parties and that it does not preclude a plaintiff from initiating a lawsuit. Although some states permit the decision of the panel to be introduced into evidence in a subsequent lawsuit, the panel's decision is not binding upon a judge or jury.

Res ipsa loquitur - *Res ipsa loquitur* ("the thing speaks for itself") is a common law doctrine which applies when a plaintiff can demonstrate that the injury occurred while the instrumentality causing the injury was under the exclusive control of the defendant and which, if operated in a non-negligent fashion, does not normally cause injury. In recent years, a number of state courts have expanded the application of *res ipsa loquitur*, and increased the effect of its applicability from that of a mere inference to that of a presumption, which if not rebutted, will allow the jury to reach no finding other than liability.

Legislation enacted in several states has codified the doctrine in regard to medical liability cases by delineating those circumstances when the doctrine may be applied, such as when a foreign object has been left in a body or the patient has suffered radiation burns. However, these statutes have sought to make it clear that the mere fact of injury is not sufficient to invoke the doctrine.

Standard of care - The standard of care in a medical negligence action is that level of care to which a health care provider is held accountable to a patient, and is based upon the prevailing level of care practiced within locality (community, state, or national).

Statute of limitations - A statute of limitations is a law that bars a cause of action after the expiration of a specified time period. In many states the statute of limitations for medical liability actions begins to run only upon discovery of the injury. Injuries may be discovered several years after the treatment was provided, so the time period for filing an action may be uncertain. Some states have sought to eliminate the "long tail" by placing an absolute maximum time period within which medical liability suits may be brought. An exception to the time period is provided in some of these statutes where foreign objects are left in the body, or where the health care provider has fraudulently concealed the fact of injury.

Most state statutes of limitations provide that if an injury is incurred by a minor, the statute is tolled (i.e., stops running) on the minor's cause of action until he reaches the age of majority. Changes in the statute of limitations for a minor's actions usually provide that the statute will begin running prior to the age of majority.

Attachment II

Professional Liability in the '80s

Reports 1, 2 & 3

American Medical Association
Special Task Force
on Professional Liability
and Insurance
1984-85

7/18-19/85
Attachment II

Inside...

This volume contains three reports commissioned by the AMA's Special Task Force on Professional Liability and Insurance. The reports, entitled "Professional Liability in the '80s", were published separately in *American Medical News* on October 26, 1984; November 23, 1984; and March 22, 1985.

An action plan—the Task Force's recommendations addressing the professional liability problem—is found in Report 3. (Pages 9-16) The recommendations build on information compiled and analyzed in the first two reports and roundtable discussions and incorporate many of the suggestions made there. They are intended as a blueprint for AMA action.

Report 1

This report traces the evolution of the professional liability problem since the mid-'70s and documents with the latest statistical data a developing new "crisis in affordability" for physicians, hospitals and the public. (Pages 3-24)

Report 2

Part one of this two-part report summarizes a roundtable discussion among professional liability insurers who assess the prospects for continued provision of affordable insurance protection. (Pages 3-13) Part two analyzes the strengths and weaknesses of previously enacted tort reform and reports on six widely adopted measures. (Pages 13-24)

Report 3

This two-part report begins with a recap of a roundtable discussion among physicians and lawyers about the roots of the professional liability problem and its possible resolution. (Pages 3-9) Part two is an action plan developed by the Special Task Force on Professional Liability and Insurance. (Pages 9-16)

Action Plan

Eighteen recommendations are made in the action plan. The recommendations are a blueprint for activities designed to create a balanced system in which victims injured for actual negligence are fairly and swiftly compensated and in which physicians can practice without undue exposure to liability. Recommendations are made in four areas: education and community action; legislation, including state and federal tort reform and judicial reform; defense coordination; and risk control and quality review. (Report 3: Pages 9-16)

Special AMA Task Force on Professional Liability and Insurance

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A time for renewed attention ...

The medical professional liability problem again is a serious one, affecting physicians and hospitals, patients, the delivery and cost of health care. This report assesses the current professional liability climate, its impact upon those who provide care and those who receive it and the toll it extracts from the nation.

In recent years the specter of a professional liability action—what some physicians call a "malpractice suit"—has haunted the physician. Increasingly, the physician is acutely aware of the potential for legal liability each time he or she treats a patient. The physician's concern is well founded.

Claims and suits against physicians and hospitals have proliferated. Settlements and awards have broken all records, with million-dollar payouts becoming increasingly common. As a result, physicians' costs for professional liability insurance protection have risen to extraordinary levels in many areas, threatening to divert some physicians out of their major specialties and barring young physicians from practicing in places or specialties where premiums are especially high. The effect of today's professional liability climate is to restrict patients' access to quality medical care.

Apace with the multiplying claims and rising premiums, there is a growing awareness that many physicians are resorting to the practice of "defensive medicine"—ordering additional tests and procedures in diagnosing and treating—to protect against charges of omission and to justify their actions should any subsequent negligence claims be filed. Estimates are that defensive medicine may add anywhere from $15 billion to $40 billion annually to health care costs. These costs, as is the cost of liability insurance, are largely borne by society as a whole, and at a time when there is nationwide pressure to bring down expenditures for health care.

The professional liability problem plainly affects not only physicians, but patients, and the way in which medicine is practiced and its cost to society.

In a Board of Trustees report to the American Medical Association's House of Delegates in June, 1984, Chairman John J. Coury, Jr., MD, Port Huron, Michigan, said: "...it has become obvious that one of the most important issues, if not the most important issue, facing the members of the Association today is professional liability and liability insurance ... it has become readily apparent that the medical profession today needs immediate action on this subject." Dr. Coury's statements reflected the deep concerns of AMA's House of Delegates, and in response a Special Task Force on Professional Liability and Insurance, chaired by James H. Sammons, MD, AMA's executive vice president, was created. The AMA Committee on Professional Liability, chaired by Raymond Scalettar, MD, Washington, DC, has already done, and is continuing to do, valuable work studying the problem and will be aiding the Task Force in its work.

One of the Task Force's immediate objectives is to provide physicians, legislators, and the public in general with a current assessment of the professional liability problem and its ramifications, and to involve all parts of society in a concerted effort to alleviate the developing new crisis. There are no easy solutions, and it is by physicians themselves that the primary action will probably have to be taken.

Documenting the extent and effects of the problem for the public, as well as for physicians, is an essential first step.

This first report will describe the events and data which form the background of the current situation and demonstrate the need for new, more intensified action.

A second report will: (1) identify the changes in laws and in the judicial system which have been, or can be, successful in ameliorating the problem, both at the state and federal level, and (2) offer a better understanding of professional liability insurance and, in particular, how to reduce its cost without reducing the scope to physicians.

The final report will present detailed recommendations and a plan of action. In addition to legislative reforms, the recommendations will address the need to assure that all physicians practice the best medicine possible, explain the necessity of improving communication with patients, identify the most effective risk management techniques, and report on some new approaches to the problem currently being studied.

"The ultimate goal," said James S. Todd, MD, Ridgewood, N.J., an AMA trustee and president of the Physician Insurers Assn. of America, "is improving patient care."

Tracing the history of the liability problem

Not until the 1930s did professional liability suits begin to materialize in any significant numbers—a development that paralleled the birth of modern medicine and its sophisticated technology. There was an upswing in numbers of claims until World War II and then there was a temporary decline.

After World War II, the problem began to surface again, increasing in the 1960s. The rising volume of claims against physicians and hospitals, with their growing impact upon health care costs, health manpower and the delivery of health services—services increasingly paid for by the government—prompted President Richard Nixon in 1971 to direct the Secretary of Health, Education, and Welfare to create a Commission on Medical Malpractice to gather current information on the problem and offer a set of recommendations.

In the introductory chapter of its final report issued in 1973, the Commission said, "The tempo of malpractice litigation again began to increase shortly after World War II. In part, this was due to the simple fact that many more people were able to afford, and received, medical care, automatically increasing the exposure to incidents that could lead to suits.

At the same time, innovations in medical science increased the complexities of the health care system. Some of the new diagnostic and therapeutic procedures brought with them new risks of injury; as the potency of drugs increased, so did the potential hazards of using them. Few would challenge the value of these advances, but they did tend to produce a concomitant number of adverse results, sometimes resulting in severe disability ... (and) thus the number of malpractice claims and suits increased."

The Commission, in one of the first detailed examinations of medical liability claims on a nationwide basis, surveyed claims closed in 1970 taken from a universe representing approximately 90% of the total in the nation. The Commission found that there were 15,000 claim files closed in 1970, representing 12,000 incidents and patients and 22,000 defendants—physicians, hospitals, nurses, drug companies, and equipment manufacturers. An estimated 10.6% more claims were opened in 1970 than were closed in that year, which, the Commission pointed out, "indicates the direction and some of the magnitude of this change."

The claims increase was not surprising. Numbers of claims were growing steadily and the rate of increase was clearly accelerating. Some areas of the country, as is the case today, were affected more than were others. The Commission's 1970 study showed Tennessee leading the list of states in the rate of increase—40.9%—but that was partly due to its small base number of claims. California showed the greatest volume of change—up 26%. Upward blips were beginning to appear in Maryland, Texas and Missouri and in 11 other states, while a few, such as Minnesota, actually showed a downturn.

The Commission's 1970 analysis, however, merely underscored a developing trend.

"Between 1935 and 1975 — in that 40-year period—80% of all medical malpractice lawsuits were filed in the final five years of that period," Elvoy Raines, professional liability expert with the American College of Obstetricians and Gynecologists, told the Senate Committee on Labor and Human Resources on July 10, 1984.

Crisis effect: market for insurance shrinks

As the wave of claims, whose values were expanding daily, began to hit, some professional liability insurers began to seriously reconsider their involvement in what was becoming a highly volatile line of business. In New York, for example, Employers Insurance of Wausau, Wis., which had underwritten the state medical society's professional liability insurance program for 25 years, pulled out of this market in 1973. New York physicians, searching for another carrier, engaged Argonaut Insurance Company to provide coverage. Argonaut agreed but boosted rates 93.5%. Late in 1974 Argonaut requested an additional 200% increase—and shortly thereafter abandoned what it saw as a sinking insurance ship.

On the west coast, in these troubling years, the California Medical Association reported that professional liability insurance rates increased between 400% and 600% between 1965 and 1971. Surgeons experienced a 950% rate increase between 1960 and 1970.

In Maryland, in 1974, where the St. Paul Companies insured about 95% of the practicing physicians, a 46% rate increase was imposed and immediately after that increase, the company asked for another 48% hike. When the request was turned down, St. Paul ceased writing in that state, in effect leaving physicians with few if any alternatives for obtaining coverage.

Meanwhile, numbers of claims were increasing at the rate of between 8% and 10% a year, and awards were similarly increasing, at a rate estimated to be an average 13% to 14% each year, even factoring in inflation. Said an *American Medical News* article in November, 1974, describing the deteriorating medical liability outlook, "In 1970, the average amount awarded either as a settlement or a court judgment, was just under $5,000. In 1973, the average amount was about $8,000."

A similar scenario was being played out—to a greater or lesser degree—all across the U.S. Insurance carriers watched profits from professional liability business decline and losses increase dramatically. Within just a few years—by the mid-'70s—the market for professional

liability had similarly begun to shrink. Where coverage remained available, its price was increasingly prohibitive, so much so that in California, for example, physicians engaged in work slow-downs, and even gave serious thought to striking to publicize their problems.

Raines, who is now a lawyer with the American Society of Law and Medicine, summed up succinctly to the Senate Committee what happened to precipitate the '70s crisis. "There was a sudden blossoming of litigation, a burst of claims which had not been anticipated by insurance carriers. The carriers were unprepared, under-reserved, and the effect of such massive litigation was to drive many carriers out of the medical malpractice market. It simply became impossible to purchase insurance coverage in some states."

The commercial companies who had not already fled the market, put their actuaries to work on projections for the future, given the claims explosion that was taking place. The St. Paul Companies, which in 1975 wrote professional liability insurance for 48,000 physicians in 44 states, looked at their numbers for 1974 and estimated that their claims would run at a rate of 5,000 a year in 1975—a 225% increase over the 1,538 claims logged against the company in 1970. Other companies were making similar calculations and coming up with equally dismal projections.

A handful of carriers remained. St. Paul moved from an occurrence to a claims made policy in the states in which it remained in the market, in order to be able to make quick rate adjustments on a year-to-year basis. Others effected huge premium increases in a number of states.

While plaintiffs' lawyers asserted that insurers were actually profiting substantially from the medical liability business and that their rate increases were unjustified, the carriers pointed to the "long tail" on liability claims—at that time, the big unknown in terms of down-the-road costs.

Said Gene Cudworth of the Hartford Insurance Company in another *American Medical News* story in November, 1974: "In automobile liability, we at least know the total number of accidents that occurred at the end of a given year. But only 10% of malpractice claims are filed the first year." Cudworth emphasized that it was virtually impossible to figure what the influence that inflation and increasingly liberal and generous juries in medical liability cases might be on the other 90% of the cases, many of which would not be resolved for as long as 7 to 10 years.

Steps to solve the availability problem

Two major developments took place in those tumultuous mid-'70s. First, physicians in many states mounted campaigns to enact legislation to ease the crushing liability burden—shortened statutes of limitations, ceilings on amounts of awards, modification of collateral source rules, limits on lawyers' contingency fees, arbitration and pretrial screening panels, and others. The rush to enact such legislation swept the country. (An evaluation of the success and constitutionality of these and other tort reforms will be presented in Report II.)

Second, alternative forms of coverage were developed. Some legislatures created joint underwriting associations to provide professional liability protection to physicians and hospitals in states in which the market had evaporated. And in a few states, physicians, frustrated with the huge premiums charged by most commercial insurers, resistant to a claims made policy, or with no insurance alternative at all, struck upon a new idea, creating physician-owned non-profit companies to provide professional liability protection.

Maryland, New York, and physicians in eight Northern California counties pioneered the movement. In mid-1975 the Medical Mutual Liability Insurance Society of Maryland was organized by the Medical and Chirurgical Faculty of the State of Maryland and the Medical Society of the State of New York launched the Medical Liability Mutual Insurance Company of New York. In California the Medical Insurance Exchange of California led the way, covering the counties of Alameda, Contra Costa, San Francisco, Marin, Solano, Shasta-Trinity and Siskiyou. By fall, 1975, the North Carolina Medical Society had its Medical Liability Mutual Insurance Company of North Carolina in operation.

By the end of 1977 there were 15 medical society created physician-owned companies functioning in the nation, covering some 76,000 physicians, and five others were in the planning stages. That count did not include several other physician-owned companies and programs, such as the California-based Doctors' Company, and Physicians and Surgeons Insurance Exchange and several other trusts in Florida which had no direct ties to medical societies.

To assist the fledgling companies, the American Medical Association took an unprecedented step. The young physician-companies required reinsurance to protect against big losses; with no track record, this essential coverage was difficult to obtain. AMA launched the American Medical Assurance Company (AMACO), a wholly-owned AMA subsidiary, to provide part of the needed reinsurance package to interested physician-companies able to meet AMACO's criteria, one of

which was a link to a medical society.

AMACO was incorporated in Illinois on October 17, 1975, and began transacting business on June 14, 1976, with authorized capital of $2 million and $3 million in subordinated debentures issued to AMA.

At the end of 1983 AMACO's policyholder surplus was $11 million, its assets were $40 million, and its earned premiums were $9.6 million. It writes a portion of the reinsurance for 17 of the 30 physician-owned companies now operating.

Temporary respite ends as new problems arise

By 1978, the crisis in availability with regard to medical liability insurance appeared to have abated. "Generally, most physicians can buy professional liability protection today, although probably not the type of coverage they would prefer and maybe not at a price they consider reasonable," a special *American Medical News* Impact section report published in April, 1978, said.

By that time, about one-third of the physicians in the private practice insurance market, then estimated to be about 150,000, were buying protection through their own companies. Joint underwriting associations (JUAs) were picking up the slack in other states and there were signs that some of the big carriers who shied away from the market were edging back into the business.

Physicians could again buy liability insurance. With support from AMA, state medical associations had effected enactment of some 300 different tort reform measures which were on the books in the states designed to ameliorate the "malpractice crisis." And perhaps because of the flurry of national publicity about the professional liability situation—perhaps for other obscure reasons—by 1978 it appeared that the numbers of claims were tapering off.

The St. Paul Company, which had predicted that the 20% increase in claims annually experienced between 1970 and 1975 would continue, or even rise substantially, experienced a claims frequency drop of nearly 11% between 1975 and 1976. Another major commercial carrier said its analysis showed an 11.8% drop in claims in 1977 from 1976. By 1977, even in California, the state initially hardest hit by the professional liability problem, the numbers of claims decreased by 29.5%.

Success seemed assured for the new physician-owned companies in those early years. Premium dollars accumulated, while high interest rates brought in substantial return on investment, and few claims were filed.

> "The malpractice situation is not good. Washington, D.C. is perhaps the only jurisdiction in the U.S. without tort reform. There's no crisis in availability as there was several years ago. The crisis now is affordability. If the situation deteriorates more, there may be one in availability."
>
> **— Charles H. Epps, Jr., MD**
> **Chairman**
> **Board of Directors**
> **National Capitol Underwriters, Inc.**

For awhile, it appeared that the professional liability problem had been resolved.

"The 'crisis' appeared to subside," Raines told the Senate committee in mid-1984. "... in fact, it did not. Perhaps it was in a period of remission, but it never went away."

Climbing claims costs reveal ominous trend

For though numbers of claims declined in the years from 1976 through 1978, an ominous trend was developing. The average dollar value of claims was steadily moving upward.

Until the mid-'70s, professional liability insurance claims data had not been separated out of the "miscellaneous" category into which it had traditionally been slotted by the property/casualty industry. The National Association of Insurance Commissioners (NAIC) remedied this problem in new reporting requirements for its members and it launched the first study of closed medical claims since the study done by the Secretary's Commission on Medical Malpractice using 1970 data.

The NAIC study began in July, 1975, and was extended through December, 1978. Nearly 72,000 closed claims were analyzed and new solid data on frequency, severity, and spread of claims across specialties was produced.

The full results, made available in 1980, were not encouraging.

The paid indemnity over the 3-1/2 year period of the study totaled $876 million, of which $333 million or 39% was paid during 1978. The average award increased 70% from $26,565 in 1975 to $45,187 in 1978. Even though NAIC adjusted for inflation, the percentage of increase still was 44%.

One of every 1,000 claims in 1975 was for $1 million or more, but by 1978 three out of every 1,000 claims represented a million-plus award. In 1975 there were only five such

Professional liability premiums and losses: 1977-1983

Premiums Written	Losses (Losses and loss expenses incurred)
1977 $1.20 billion	$817 million
1980 1.27 billion	1.5 billion
1982 1.48 billion	1.6 billion
1983 1.57 billion	2.0 billion
(selected years)	

Premiums Written
Losses

Data source: *Best's Insurance Management Reports*, 1983-1984

By the late 1970s losses and loss adjustment expenses exceeded premiums written for professional liability insurance. From 1982 the losses sharply increased compared to the increase in premiums written.

payouts: in 1978 there were 23.

NAIC found that 60% of all liability claims involved physicians and 31%, hospitals, with many claims arising from activities of physicians performed in hospitals. Hospitals were the site of injury in 78% of all accidents resulting in paid claims. But physicians assumed 71% of the total indemnity, with hospitals accounting for only 25%. Often a claim named several defendants.

While hospitals' average indemnity, which rose 59% between 1976 and 1977, decreased 5% between 1977 and 1978, the average indemnity paid for physician defendants increased 37% from 1977 to 1978.

The time from incident to disposition of the claims closed with payments rose from 37 months in 1975 to nearly four years or 46 months in 1978—one more factor tending to increase eventual settlements and awards.

Defense costs, NAIC found, increased 73% in the 3-1/2 year time interval, and significantly, the average indemnity paid for "grave injuries" rose 63%—from $213,777 in 1975 to $349,203 in 1978.

Stated NAIC: "Although 'grave injuries' represented only 2% of all injuries resulting in claims payment in 1975 and 3% in 1978, claims for these injuries accounted for 16% of total indemnity in 1975 and 22% of indemnity in '78." NAIC said "grave injuries" often involved "anesthesia accidents, patient monitoring problems or birth injuries."

Impaired baby cases were beginning to emerge as the most costly. NAIC found that while infants accounted for 13% of all cases where indemnity was paid for "permanent major injuries" (a category just below "grave injuries") in 1975, the percentage rose to 25% in 1978. "Grave injuries" to infants nearly doubled, climbing to 32% in 1978 from 17% in 1975 in terms of claims in which indemnities were paid.

Concluding its analysis, NAIC said, "If 1978 total medical malpractice losses are projected at this 30% (indemnity) growth rate, they approach $1 billion annually in only a few years."

> "The situation is getting worse. The courts are becoming more liberal and the awards are higher."
>
> **— Merlin Otterman, MD**
> **Director**
> **COPIC Trust (Colorado)**

The insurance commissioners' assessment was correct, but their estimates actually proved low. Medical professional liability insurance, along with other miscellaneous liability lines, had "moved into fantasyland," *Best's Review* editors concluded early in 1983. By the end of 1983 medical professional liability losses surged to nearly $2 billion from $817 million in the peak "crisis" year of 1975. The increase was 145%.

About the same time, Fred R. Marcon, president of the Insurance Services Office, pacesetter for industry rate-making, said that when an insurance company's combined ratio (premiums to losses and loss expenses) reaches 114%, "you're past the point where investment income can offset underwriting losses. At 114% broad-based, multi-line insurers as a whole will have reached the precipice."

Insurance experts underscored the critical position into which the professional liability business was being propelled. A year later, on February 20, 1984, Best's Insurance Management Reports said that "since 1980, medical malpractice's losses (including loss expense incurred) have been higher than premiums earned, resulting in a combined ratio of 150.1% in 1982." The situation only slightly improved in 1983, with this line showing a combined ratio of 142.1%.

To contain the slippage, commercial carriers and physician-companies for the most part began to raise rates that had been competitively low in recent years, mainly because high interest rates and substantial investment return offset losses on the underwriting side.

Affordability crisis now troubles physicians

Between 1975 and 1983, medical liability premiums increased by more than 80% in general. But in some areas of the country, harder hit by more and costlier claims, high risk physicians were being forced to pay annual premiums running $20,000, $30,000, and even as high as $70,000.

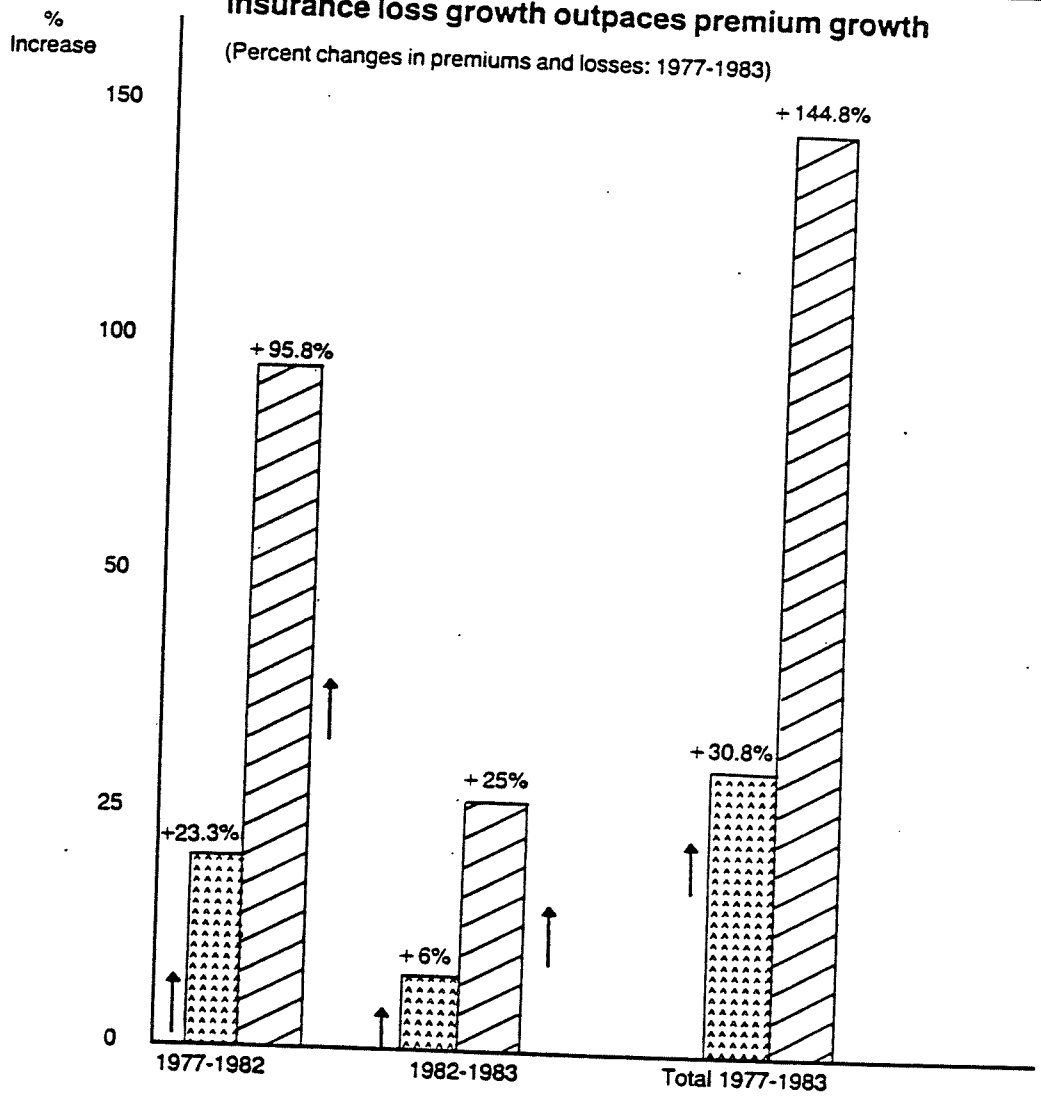
To physicians in general and to some specialists in particular, it was becoming increasingly clear that a new "crisis" was developing, as insurance premiums rose to new levels.

In May, 1982, Ivan Neubauer, MD, Los Gatos, CA, president of the Physician Insurers Assn. of America, and then chairman of the board of NORCAL Mutual Insurance Company, San Francisco, described the situation from physicians' point of view.

Saying that physician-owned companies had been reasonably successful so far, but warning that this doesn't "secure the future", Dr. Neubauer said, "We are facing a 'crisis of affordability'. We need adequate rates of coverage and

Insurance loss growth outpaces premium growth

(Percent changes in premiums and losses: 1977-1983)



Data source:
Best's Insurance Management Reports

While premiums for the total medical professional liability industry increased 30.8% between 1977 and 1983, from $1.20 billion to $1.57 billion, losses soared 144.8%, rising to $2 billion in 1983 from $817 million in 1979. The ratio of total net written premiums to losses and loss adjustment expenses climbed to 133.8 in both 1982 and 1983 from 98.9 in 1979.

Adding the underwriting expense ratio to the loss ratio produces the combined ratio before dividends to premiums—a number indicative of how well or how poorly an industry is doing. In 1979 the combined ratio for professional liability insurance was 112.4. Return on investments at high interest rates still permitted profit-making. In 1982 the combined ratio was 150.9 and in 1983 it was 150.1.

"Medical malpractice is reaching the point of no return in terms of producing investment income from loss reserves that exceeds the underwriting loss," said *Best's Insurance Management Reports* on January 2, 1984.

Losses and Loss Adjustment Expenses

Premiums Written

sometimes are forced to collect obscene premiums that continue to climb. There doesn't seem to be any relief in sight."

A look at what has been happening with regard to numbers and costs of claims reveals that the professional liability problem is again extremely serious—and that actually, in some areas of the nation, from a financial impact standpoint, it is more serious than it was in the mid-'70s.

The temporary respite that followed the mid-'70s upheaval is over.

When the NAIC analyzed claims for the year beginning July 1, 1975 through June 30, 1976—a "crisis" year—there were a total of 14,074 claims against physicians and surgeons. In 1983, modest projections indicated that the total of claims and suits against these professionals would come within range of 40,000.

The increased number of claims means that physicians stand a greater chance of having a claim or suit lodged against them. The St. Paul Companies, with 14.6% of the national medical market, reported 5,870 claims in 1983—2,757 more than in 1979, an increase of 88.6% in numbers. Spokesmen from the company said that from 1979, "the frequency of claims reported ... countrywide on a calendar year basis has increased from 3.3 claims per 100 doctors in 1979 to 5.4 in 1983, or 63%." Actually, the 5.4 figure is for physicians in Class 1. If all classes are considered, St. Paul says that for 1983, it would be realistic to triple that frequency—bringing the number of claims per 100 insured MDs to about 16.2.

Another large commercial carrier reported that the number of claims filed in 1983 increased 64.5% over the number filed in 1979. (3,440 in 1983; 2,091 in 1979). Now 9.5 out of every 100 physicians insured with this company face the likelihood of a claim or suit; in 1979 the number was 5.4.

Twenty-three physician-owned companies tied to medical societies logged a total of 11,189 more claims in 1983 than in 1979. These companies, many now experiencing the lash of the "long tail" on professional liability claims, reported to AMACO that they registered a total of 21,104 claims for a total of 87,715 insureds last year.

In July and August, 1983, data collected through AMA's Socioeconomic Monitoring System revealed that the average incidence of claims per 100 physicians increased from 3.3 claims per 100 prior to 1978 to 8 claims during the years 1978-1983, "a statistically significant (increase) for general and family practitioners, surgeons, physicians in the northeast and north central regions, male physicians and physicians practicing in urban areas."

An AMACO analysis in September, 1984, of reports from 23 physician-owned companies revealed that incidence more than doubled in the last five years, rising from a national average of 12.2 claims per physician (the range by region was from 7.9 claims per 100 to 19.6 claims per 100) to 20.3. Thus, one out of every five physicians now faces the prospect of a claim or suit today. For these companies 91 claims or suits are filed every working day.

For certain specialists, the risks more than doubled, sometimes tripled. In mid-1984 the American College of Obstetricians and Gynecologists told a congressional committee that 60% of all OB-Gyns in the

Claims increases: the national picture

Type of carrier	No. of physician insureds	Total claims filed 1983
Commercial	91,050	9,310
Physician-owned companies linked with medical societies (23 of 30)	87,715	21,104
Independent physician- or hospital-owned companies covering physicians	17,600	1,940
Total (Approximately 77% of physician market)	196,365	32,354
Projected total claims for physicians: 1983		42,018

Frequency or number of professional liability claims has been increasing steadily in recent years, modestly in some areas, but more dramatically in others. The projected number of claims in 1983 is more than double the number in the mid-70s.

From July 1, 1975 through June 30, 1976 the National Assn. of Insurance Commissioners (NAIC) tracked a total of 14,074 claims in the heat of the "crisis" period. In the next 30 months NAIC logged an additional 57,926 closed claims or about 23,169 per year.

The figures above are only approximate; companies differ in the way they define and count "claims." One company may count a single incident with multiple defendants as one claim; another may count as many claims as there are defendants listed. Even with this caveat, the projected claims totals for 1983 are a significant indication of the seriousness of the professional liability problem today.

Data source:
AMACO
American Medical News

nation have been sued, 20% of them three or more times. A Florida Medical Assn. survey indicated that 25% of obstetricians/gynecologists in the state no longer deliver babies and 30% are considering stopping.

AMACO learned in its most recent physician-company survey that obstetricians/gynecologists, and general surgeons, including orthopedic surgeons and neurosurgeons, generated a percentage of claims far out of proportion to their numbers in the insured population. Across the country in 19 of the 30 reporting MD-companies, these physicians generated an average of 34.5% of all claims, even though they comprised only 19% of all policyholders.

> "Malpractice is a difficult situation now and gradually worsening in terms of claims frequency and severity."
>
> **— Fred Z. White, MD**
> **Chairman**
> **Illinois State Medical Inter-Insurance Exchange**

There is no doubt that the numbers of claims have been climbing steadily in the last few years, though more modestly in some areas than in others. Traditionally, professional liability has been considered an "urban" phenomenon. In the Chicago area, for example, *Cook County Jury Verdict Reporter* said that medical malpractice filings increased 13.6% to 1,908 in 1983, breaking the 1982 record of 1,680, and that 1984 was showing a similar increase. Max Sonderby, publisher of *JVR*, said that 1983 "registered a new record in medical malpractice jury awards in the seven Chicago area counties sufficient to make the total of the last three years almost twice that of the combined 11 prior years ..."

Timothy Graham, actuarial services officer in the medical services division of the St. Paul Companies, noted that "the trend is countrywide; we can't say there are any regional hotbeds. There are a few exceptions. Nebraska, for example, was good for a number of years, but then in the last 12 to 24 months it's been extremely bad. The same goes for Massachusetts. They're catching up and taking a big kick. Generally, we're finding that there is no distinction between rural and urban areas anymore. It's fading."

Hospitals also register large claims increases

Hospitals also are subject to increasing numbers of claims and suits. One company that insures 1,550 hospitals in 46 states—the St. Paul Companies—said that since 1979, the frequency of hospital claims reported on a calendar year basis increased more than 76%, from 2,112 claims in 1979 to 3,541 in 1983—a 76% rise. According to St. Paul that translates into 3.0 claims per occupied bed in 1983 as contrasted with 1.7 claims in 1979.

Other companies around the nation also are seeing frequency increase. The Doctors Company, based in California, reports 9,400 insureds. In 1979 it had received only 591 claims, when it was a new company, but by 1983 the total had climbed to 1,212, a 105% increase. Claims per insureds nearly doubled, rising to 16.7 per 100 from 8.9 in 1979.

Fremont Indemnity reported that it was showing 6.76 claims per 100 physicians in 1983 and the Pennsylvania Hospital Insurance Company (PHICO), based in Philadelphia, said that out of each 100 policyholders in 1983, 8.2 faced the prospect of a claim or suit.

Growing costs pose problems for all

While the increase in numbers of suits and claims is unsettling, the real problem lies in the tremendous growth in severity—or cost—of claims.

"The increase in severity is sometimes startling, as is frequency, but severity is the bigger problem," said Michael Mullen, executive vice president of The Medical Protective Company of Fort Wayne, IN. "The demand for increased limits has led to higher judgments and the line has grown very expensive." Medical Protection insures 36,050 physicians.

The St. Paul Companies reported that on a nationwide basis, claims severity including both paid and reserved claims increased nearly 38% during the 1979-1983 period. The average cost per claim rose from $14,333 in 1979 to $19,718 by year-end 1983. (For averaging purposes claims are capped at $100,000. Company spokesmen said the numbers would be higher if the larger awards were averaged in.)

For St. Paul-covered hospitals the severity increased nearly 72% during the same five-year period, with the average cost per primary claim (for the first $100,000 of coverage) rising from $6,918 in 1979 to $11,856 by the end of 1983. The average hospital claim paid in 1979 was $18,450; in 1983 it was $29,241.

The effects of severity varied from region to region when AMACO information from physician-companies with medical society links was analyzed. Companies in the South reflected the greatest increases—from an average of $13,139 per claim in 1979 to $106,712 in 1983—

Percentage increase in claims filed: 1979-1983

Type of carrier	Percent of physician market	Average increase 1979-1983	
Commercial	35.6%	66%	
Physician-owned companies linked with medical societies (23 of 30)	34.4	124.4*	*Northeast 79.6% South 154.8 Midwest 225.3 West 37.8
Independent physician- or hospital-owned companies covering physicians	6.8	152.2	
Total	76.8%	114.2%	

The increases in frequency of claims vary in degree around the nation. The western states, first and hardest hit by the professional liability claims explosion in the last decade, presently register modest increases. The midwest and the south are experiencing significant claims increases.

Physician-owned and hospital-owned companies covering physicians registered the largest percentage increases in recent years.

It should be pointed out, however, that these companies are young companies and some are just beginning to feel the impact of the "long tail" on professional liability claims —a delayed process that can stretch anywhere from seven years or more. The Secretary's Commission on Medical Malpractice reported in 1973 that on average, only half of these claims are closed within 18 months after they are opened; 10% remain open 6½ years later.

Data source: AMACO
American Medical News

a 712.1% increase between 1979 and 1983 and, significantly, a 108.6% increase between 1981 and 1983. National comparisons based on regional averages showed a $20,396 claim cost for these MD-operations in 1979 with a figure of $42,432 in 1981 and $72,243 in 1983. The severity increase factor was 254.2% in the five-year period and 70% between 1981 and 1983.

For 12 physician-companies, the median indemnity paid in 1979 was $9,227. In 1983 17 companies reported that the median had jumped to $49,871, an increase of 500%.

Jury Verdict Research of Solon, Ohio, produces verdict expectancy tables for its *Personal Injury Handbooks.* Some of the midpoint verdicts calculated by JVR shed additional light on the climbing costs of professional liability claims and suits.

The midpoint of a typical verdict against a physician in 1975 was $48,500 and the average was $94,947. By 1981 the mid-point had climbed to $145,000 and the average to $244,607. For 1983-84, JVR reported that the midpoint verdict was $200,637 and the average was $338,463. For verdicts related to surgery, the midpoint number rose from $330,000 in 1981 to $456,621 in 1983. Injuries to newborns revealed a 40% increase, rising to $1,452,211 for a midpoint verdict in 1984 from $1,030,000 in 1981.

The large payouts in verdicts to birth-injured infants reflect a trend toward more and more awards that exceed $1 million and increasingly often run into the many millions of dollars.

In the nation, 42% of all million-dollar verdicts are in products liability and professional liability cases. The latest figures show that there have been 196 million-dollar verdicts in medical cases. There were three in 1975, 10 in 1980, and 45 in 1982. Said former ACOG spokesman Raines to Congress: "Now there are more than four million-dollar verdicts in personal injury cases per week."

An analysis of the verdicts in California Superior Courts professional liability cases in 1983 revealed that while there were fewer verdicts and plaintiffs won fewer cases, total dollar awards doubled in 1983. The Insurance Information Institute (III) said, "The total of awards against physicians and hospitals was $31.8 million in 1983, twice the figure of $15.4 million in 1982. The average award in 1983 was $649,210, more than twice the 1982 figure of $257,222."

Of 49 verdicts for plaintiffs in 1983 —down from 60 the previous year— nearly one out of five resulted in an award of more than $1 million. A total of nine such awards were made, totaling $21.7 million, or more than two-thirds of the overall $31.8 million total.

"Paradoxically, the total of 49 plaintiff verdicts is the smallest number to be reported in the 12-year period from 1972 for which the Institute has records," said III.

Whenever jury verdicts are reported it is important to recognize that these numbers are only the tip of the iceberg. Most lawsuits are settled or dropped before trial.

Impact of claims cost increase on the public

These mammoth awards carry the potential for disaster for larger states as well as smaller states. In Florida, for example, the Patients Compensation Fund was bankrupted last year partly because two or three astronomical awards far exceeded the premiums generated and ate deeply into reserves.

Physician-owned company claims frequency trends: national picture 1979-1983

Year	No. of claims filed	No. of reporting companies	No. insureds
1979	9,915	17	71,310
1980	12,797	19	75,411
1981	15,450	20	79,948
1982	17,895	23	85,760
1983	21,104	23	87,715

In the five years between 1979 and 1983, as physician-owned companies matured and new ones formed, the total number of claims reported was 77,161. The inexorable upward climb in claims totals occurred in every region of the country as shown below.

Regional claims trends of physician-owned companies: 1979-1983

Region	Year	No. of claims filed	No. of reporting companies	No. insureds
Northeast	1979	4,395	5	33,625
	1980	5,364	6	34,697
	1981	6,205	6	36,139
	1982	6,749	6	36,841
	1983	7,895	6	37,150
South	1979	1,489	4	12,457
	1980	2,014	5	13,894
	1981	2,303	5	14,184
	1982	2,968	7	17,108
	1983	3,794	7	17,702
West	1979	1,972	4	10,891
	1980	2,192	4	11,675
	1981	2,489	4	11,697
	1982	2,609	4	12,210
	1983	2,716	4	12,696
Midwest	1979	2,059	4	14,337
	1980	3,227	4	15,145
	1981	4,453	5	17,928
	1982	5,569	6	19,601
	1983	6,699	6	20,167

Data source:
AMACO

More recently, Wisconsin's insurance commissioner said that state is "facing a medical malpractice insurance crisis" today that may be worse than the mid-1970s crisis. Thomas P. Fox said in August, 1984, that the Patients Compensation Fund, a mandatory program that picks up all awards over $200,000 for private physicians who participate, has a projected 1985 deficit of $48 million.

"We face the possibility of funds not available to compensate patients and the possibility of driving doctors out of business because they can't afford insurance," Fox said. One award reached $5 million in 1984, he pointed out.

The state's Wisconsin Health Care Liability Insurance Plan, which provides primary coverage for many physicians, is estimated to be running $8.1 million short.

"This (1984) crisis is being caused by the same components that caused the mid-1970s crisis—only magnified," the insurance commissioner emphasized. Among the causes Fox cited were a "sharp increase" in numbers of claims filed, "a drastic increase in the amount of awards given to individuals filing claims," and "rapidly increasing costs of medical professional liability insurance.

"Ultimately, it is the public who will pay the costs," Fox said, "either through increases in health care costs or by having their access to health care services limited because providers, unable to pay the fees, withdraw from the market."

> "We definitely see an increase in the number of claims and an increase in the amount of awards. Being a rural state, it is not the proportion that other states see... but it's enough to be concerned about."
>
> **— Robert G. Cox**
> **Executive Vice President**
> **Kentucky Medical Association**

Since June, 1982, a specially constituted AMA Committee on Professional Liability has been conducting an in-depth, on-going study of the direct and indirect costs of professional liability, providing annual reports to AMA's House of Delegates. The committee's chairman, Raymond Scalettar, MD, Washington, D.C., said in a report to the House in December, 1983, that "no segment of litigation has had a more rapid growth during the past 15 years than claims emanating from health care in the U.S."

The committee explored both the direct and indirect costs of professional liability borne by society in the U.S. predicting:

—That in 1982 total premiums paid for protection against medical liability claims would range from $1.43 billion to $1.47 billion.

—That in 1983 these premiums would range from $1.645 billion to $1.75 billion.

That is just for the price of buying insurance protection. It doesn't take into consideration the costs of the resolution of claims by the courts. Nor does it reflect any of the many hidden costs associated with the problem.

Regional increases in claims incidence among physician-owned companies

Region	1979 frequency per 100 MDs	1983 frequency per 100 MDs	Difference	% Increase	No. companies
Midwest	10.5	21.9	11.4	108.6%	4(1979)/6(1983)
Northeast	7.9	18.1	10.2	129.1	3(1979)/6(1983)
West	19.6	24.6	5	25.5	4(1979-1983)
South	10.7	16.5	5.8	54.2	4(1979)/7(1983)

Average frequency per 100 physicians for physician-owned companies in 1983 was 20.3. In other words, one out of five physicians could expect a claim to be filed against him/her. For these companies in 1979 the claims frequency on average was 12.17 per 100 physicians.

The National Assn. of Insurance Commissioners found that the average incidence was 3.3 claims per 100 physicians prior to 1978 and rose to 8.0 claims during the late '70s and early '80s.

Data source: AMACO

Average incidence of professional liability claims

	Annual claims per 100 physicians	
	1978-1983	Prior to 1978
All Physicians	8.0	3.3
Specialty		
General/Family Practice	8.2	3.8
Medical	4.5	2.3
Surgical	11.8	4.8
Region		
Northeast	10.8	2.3
North Central	9.5	3.8
South	4.8	3.0
West	8.3	4.1
Location		
Urban	8.0	3.2
Rural	8.2	3.4
Sex		
Male	8.4	3.3
Female	3.6	2.4

AMA's Socioeconomic Monitoring System (SMS) collected data on the incidence of professional liability claims, cost of claims incurred and physician responses to increases in insurance premiums through interviews with 1,240 physicians conducted in July and August, 1983.

Change in the average incidence of claims per 100 physicians is shown in the table above. The increase in the annual rate of claims was found to be statistically significant for general and family practitioners, surgeons, physicians in the northeast and north central regions, male physicians and physicians practicing in urban areas.

The variation in the rate of claims across specialties, regions, locations and sexes within each time period was not statistically significant, SMS said.

Data source:
AMA Socioeconomic Monitoring System

The high cost of defensive medicine

One of the many thrusts of the AMA Committee on Professional Liability was to approximate some of these indirect costs.

"The most important aspect of our report related to the direct and indirect costs of professional liability," said Dr. Scalettar. "Nobody had ever really attempted to categorize and quantify these numerous factors before."

Defensive medicine and defensive administrative costs led the list, estimated to total $15.1 billion annually. The calculations were made after reviewing an earlier AMA Socioeconomic Monitoring System study indicating that 40% of responding physicians said they prescribed additional diagnostic tests and 27.2% said they provided additional treatment procedures as a response to the increased risk of a professional liability action. In other words, they were practicing "defensive medicine."

"Other surveys have estimated that positive defensive medicine constitutes 25% to 50% of the cost of treatment," the committee said, adding that physicians build up additional defensive administrative costs because they must necessarily keep more records and spend more time with patients explaining medical details and acquiring written consents.

"Assuming that the average net income per physician per year in the U.S. is $100,000 and the gross income is $200,000, billings for patient care attributable to defensive medicine would amount to $50,000 per physician engaged in direct patient care. The estimate would be projected to $15.1 billion in total annual costs," the committee said.

"Defensive medicine is also defensible medicine. Nevertheless, we must recognize that it is costly ..." Dr. Scalettar said, accounting for perhaps as much as 10% of total medical care costs.

The committee estimated the cost of the productivity loss because physicians retire early rather than pay large professional liability premiums at approximately $250 million annually.

> "Yes, the situation is getting worse (but)... a recent study by the (Maryland) legislature shows that the situation is not as serious as we think it is."
>
> **— John Sargeant**
> **Executive Director**
> **Medical and Chirurgical Faculty of the State of Maryland**

Ten leading allegations in professional liability claims: 1983

1.	Treatment issue: bad results (negligent post-surgical care, etc.)	224 claims
2.	Patient fall: bed-related	239
3.	Treatment issue: delay/omit treatment	186
4.	Treatment issue: injury to body part adjacent to treatment site	170
5.	Diagnostic issue: wrong diagnosis	158
6.	Treatment issue: other (dental bridge damaged during surgery, etc.)	156
7.	Treatment issue: type of treatment incorrect	147
8.	Treatment issue: infection contamination exposure	140
9.	Patient falls: ambulation-related	125
10.	Patient falls: bathroom-related	119
		1,928 claims

These are the leading allegations in professional liability claims lodged against the St. Paul Companies, one of the major commercial insurers of physicians and hospitals during 1983. Treatment issues with bad results head the list.

Data source:
The St. Paul Companies

National severity trends: physician-owned companies tied to medical societies (Average paid losses and increases)

Average paid losses and percents of increases

1979	1981	1983	% Increase 1981-83	% Increase 1979-83
$20,396	$42,432	$ 72,243	70.2%	254.2%

Region	Av. 1979	Av. 1981	Av. 1983	% Increase 1981-1983	% Increase 1979-83
Northeast	$28,194	$32,075	$ 68,409	113.3%	142.6%
Midwest	20,455	39,101	65,668	67.9%	221.0%
South	13,139	51,140	106,712	108.6%	712.1%
West	19,796	47,415	48,185	1.6%	143.4%

All reporting companies (23)

Average paid losses for reporting physician-owned companies with ties to medical societies increased approximately 254% between 1979 and 1983, from $20,396 to $72,243.

The largest percentage increase in an average claim cost was registered in the south where in 1977 the cost was lowest—$13,139—to $106,712—the largest average claim paid cost for any of these 23 companies reporting.

(Bear in mind that these physician-owned companies have been operating less than 10 years; results in the given year or area sometimes reflect early year experience and a few large payments can skew these results. The trend toward higher payments, however, is clear.)

Data source:
AMACO

The committee further calculated that physicians who had claims filed against them in the last five years spent a total of 3.7 days in depositions and court appearances taking them away from their practices. "The projected total income loss here could be estimated to range from $10 million to $44.7 million," the committee pointed out.

Not only do patients pay additional indirect costs when their physicians retire early because of malpractice pressures, and these patients must establish new relationships with new physicians, but there is the intangible cost of physician dysfunction, once a claim is filed, the committee said.

"The biggest cost is not only one that can be calculated in dollars. It is the emotional injury that a physician experiences ... .Decreases in physician productivity as a result of such dysfunction cannot be estimated," the committee said.

Recently Sara C. Charles, MD, an associate professor of clinical psychiatry at the U. of Illinois, surveyed physicians in the Chicago area who had been sued between 1977 and

"Louisiana has a fairly stable environment. Severity has moderately increased in the last 12 to 18 months, consistent with inflation."

— Gerald R. LaNasa, MD
President
Louisiana Medical Mutual Insurance Company

Median indemnity paid 1979-1983: physician-owned companies

1979		1983	
$1,900		$17,531	
4,132		20,070	
4,161		20,750	
8,000		28,470	
8,300		38,218	
9,227	Median	39,321	
17,035		41,136	
23,392		49,871	Median
23,497		55,585	
25,550		62,855	
42,884		64,039	
45,489		68,000	
		69,233	
		111,118	
		131,754	
		132,783	
		348,903	

The median indemnity paid by 12 physician-owned companies in 1979 was $9,227. By 1983 the median was approximately $49,871 for 17 companies. The percentage increase is 440%.

Data source:
AMACO

Selected midpoint and average verdicts and probability range in professional liability cases

Failure to diagnose or misdiagnosis

	$208,735	**(1984)**
Mid-point verdict	$150,853	(1981)
Probability range	$50,000-203,000	(1981)
Verdict range	$20,000-1,400,000	(1981)
Average	$194,954	(1981)

Improper treatment

	$207,555	**(1984)**
Mid-point verdict	$150,000	(1981)
Probability range	$50,000-400,000	(1981)
Verdict range	$5,000-1,500,000	(1981)
Average	$272,634	(1981)

Surgical error

	$176,422	**(1984)**
Mid-point verdict	$127,500	(1981)
Probability range	$55,000-300,000	(1981)
Verdict range	$2,500-1,236,000	(1981)
Average	$247,305	(1981)

Improper medication

	$207,555	**(1984)**
Mid-point verdict	$150,000	(1981)
Probability range	$30,500-300,000	(1981)
Verdict range	$10,000-950,000	(1981)
Average	$231,021	(1981)

Injury to the mother

	$155,666	(1984)
Mid-point verdict	$112,500	(1981)
Probability range	$77,500-500,000	(1981)
Verdict range	$25,000-2,000,000	(1981)
Average	$407,814	(1981)

Injury to the infant

	$1,452,211	**(1984)**
Mid-point verdict	$1,030,000	(1981)
Probability range	$600,000-1,300,000	1981)
Verdict range	$19,585-2,526,000	(1981)
Average	$1,045,937	(1981)

Data source:
Jury Verdict Research.

1981 to ascertain how physically and mentally devastating the litigation process can be to a physician and his family.

There were 154 physicians in her sample—names randomly selected from *Cook County Jury Verdict Reporter* over a five-year period. Most were men (96.5%), and 40% were surgeons, 20% were in obstetrics-gynecology, and another 25% were in internal medicine.

"The Utah environment is much better than the rest of the country, but we're concerned that we are seeing some of the trends occurring in other parts of the nation headed this way."

— J. Leon Sorenson
Executive Vice President
Utah State Medical Association

The survey showed that most physicians experienced anger, 28% stopped performing certain high risk procedures, and 42% stopped seeing certain kinds of patients.

Twenty-five or 18.8% said they felt a "loss of nerve in some clinical situations" and 14% said that their medical practices had suffered. One-third or 33.6% thought about early retirement after being sued.

More than one-third (39%) admitted to four or five symptoms suggestive of a possible major depressive disorder after the suit and 8% noted the onset of a physical illness during the litigation. Three suffered coronaries during the process.

It isn't the outcome of the suit that is stressful, Dr. Charles emphasized, since 75% of physicians who go to trial in Cook County are vindicated—a percentage replicated to a greater or lesser degree in other parts of the nation. "It is the litigation process itself that is agonizing and stressful," the psychiatrist said. "People have to realize that suing your doctor is not an event that has no repercussions."

Eventually, said Dr. Charles, the public must reflect on its attitudes about compensation and determine whether every misfortune of life, regardless of the reason that it occurred, is compensable.

"Because malpractice is so painful and the issues involved so seemingly elusive, there is a tendency to delegate its management to lawyers and insurers. The end result is increased premiums, increased legal maneuverings, and a system that continues to work, but under enormous stress itself," Dr. Charles concluded.

That "end result", of course, is a system ever more costly financially, and one that undermines physician-patient relationships and, ultimately, drains strength from the entire medical care system in the nation.

No end in sight to insurance rate hikes

In the meantime, premiums are continuing to increase. Late in 1983, AMACO surveyed 29 of the physician-owned companies and learned that 22 had been forced to raise rates, from a low of 6.7% for a California company to approximately 30% for a Florida company.

"The average increase (was) about 17%," said Richard Layton, AMACO's vice president for marketing. "Additionally, eight or nine states already have reported specific rate increases planned for 1984 ... "

These rate increases came on top of rate increases for 20 of the 27 physician-companies during the three billing periods since 1980 that ranged from 20% to 99%. Ten companies had established rate increases in each of the three previous years and six more had increased premiums two out of three years. Average increase over the past three years was 47%, said AMACO.

Commercial companies are raising rates as well. The St. Paul Companies told physicians last July to expect an average increase of 32%, depending on their medical specialty and the state in which they practice. Medical Protective Company of Fort Wayne also expects to put in rate increases.

"In Minnesota the situation is worsening with increases in both severity and frequency of claims. Our big problem has been infants neurologically damaged at birth."

— Robert S. Flom, MD
President and Chairman of the Board
Minnesota Medical Insurance Exchang

Medical Protective's Mullen said, "The price of the product continues to spiral upward ... There's no way of knowing when or by how much because we take it state by state and on a monthly basis. Who knows? Depending on the class and states, rates could increase in the teens range or all the way up to 100%."

The Doctors Company in California, covering physicians in that state and in Nevada, Montana and Wyoming, raised rates an average of 19.5% in July in southern

Fewer verdicts but awards doubled in California Superior Courts in 1983

California Superior Court Verdicts—Medical Malpractice Cases 1973-1983

Year	Total no. verdicts	Defendant verdicts	Plaintiff verdicts	Total amount awarded	Average plaintiff award
1972	137	82 (60%)	55 (40%)	$11,016,305	$200,296
1973	165	115 (70)	50 (30)	10,642,391	212,848
1974	215	142 (66)	73 (34)	9,768,628	133,817
1975	215	156 (73)	59 (27)	9,025,248	152,970
1976	226	168 (74)	58 (26)	9,661,795	166,582
1977	205	146 (71)	59 (29)	16,066,354	272,311
1978	204	147 (72)	57 (28)	11,456,873	200,998
1979	204	133 (65)	71 (35)	24,961,427	351,569
1980	180	110 (61)	70 (39)	21,607,739	308,682
1981	146	94 (64)	52 (36)	20,548,490	395,163
1982	163	103 (63)	60 (37)	15,433,327	257,222
1983	152	103 (68)	49 (32)	31,811,292	649,210

Though the number of verdicts reached in professional liability cases in California Superior Courts dropped from a high of 226 in 1976 to 152 in 1983, the average award to a plaintiff increased 224% from $200,296 to $649,210.

There were 11 fewer verdicts in 1983 than in 1982 but the average award shot up from $257,222 to $649,210—an increase of 152%. The average award was down $137,941 in 1982 from a 1981 figure of $395,163 but the dip was apparently only temporary.

Data source:
The above summary is reprinted with permission from the Insurance Information Institute. The information was compiled by the Institute's Pacific Coast Regional Office in San Francisco and released recently.

California. "It averaged about 10% in northern California," said Joseph Sabella, MD, president and chief executive officer. "It is in Nevada, Wyoming and Montana where we've had adverse experience. In Nevada and Wyoming rates were increased an average of 35% on July 1 while in Montana a 35% increase will take effect in October."

Actuary Myron F. Steves, Jr., Houston, TX, underwriter, predicted earlier this year that the long-term trend in paid claim severities for medical liability will range between 12% and 15% annually throughout the '80s. Even if this severity increase is discounted by insurers by an anticipated rate of return on investments, "a net increase of five to seven percent annually" will have to be absorbed, he said.

The problem is that even with the constant upward march of premiums, the insurers seem to be fighting a losing battle against losses. With loss ratios in the 140s and 150s, as they were in 1982, "this business is no success, claims made or otherwise, professionally-spon-

> "The malpractice situation is at the critical level. The Michigan State Medical Society House of Delegates has been asked to review alternatives and to get AMA involved."
>
> **— William Madigan Staff Managing Director Michigan State Medical Society**

Physician-companies raise rates

Colo.	"We had a 10% increase last year and anticipate one next year." — Merlin Otterman, MD, Colorado
D.C.	"We had a 39% increase last year. If the severity of claims continues to increase and the numbers increase, we'll have to increase our rates for the future. —Charles H. Epps, Jr., MD, Washington, D.C.
Ill.	"This year we had a rate increase of about 11.5%—part of a cumulative increase of 23% over the last three years. I'm sure it will increase in the future—unless something miraculous happens—because reserves have to be put aside and reinsurers have increased their premiums to us." —Fred Z. White, MD, Ill.
Ky.	"In 1984 we raised rates about 10% and I wouldn't be surprised if we had to increase the rate for 1985." —Robert G. Cox, Ky.
La.	"Yes, we've had rate increases—6.4% two years ago, 6.9% last year and 15% in 1984." —Gerald R. LaNasa, MD, La.
Md.	"We've had rate increases across the board. Rates for some classes of physicians went up and others went down. We anticipate future increases on a consistent basis to keep pace with inflation." —John Sargeant, Md.
Mich.	"Our rates are rising—to crisis proportions for OB/GYN—close to $40,000. (Generally) 1984 rates increased about 30% and there was an increase two years ago. Our members accept normal cost of living raises but get perturbed at 25% to 30% increases. At the rate claims are coming in, there will probably have to be an increase in the future." —William Madigan, Mich.

sored insurer or otherwise," *Best's Insurance Management Reports* said candidly earlier in 1984.

On the financial side of the professional liability ledger the red ink is spreading, with the prospects of continued increases in insurance premiums for physicians and upward pressures on health care costs.

It would be easier if there were simple answers. There are none. There are legitimate instances of medical negligence. "The reason for malpractice claims is malpractice," said AMA's Dr. Todd. That undeniable fact, however, cannot fully account for the explosion in numbers and severity of claims. Indeed, the evidence shows that on the whole, physicians are better trained than ever before and practice a higher quality of medicine, a fact reflected in lower mortality rates and longer lifespans for Americans.

> "The malpractice environment is a consistent wave-maker.... We're seeing the same waves all over again... (with) frequency and size of indemnity increasing."
>
> **— Vincent A. Maressa**
> **Executive Director**
> **The Medical Society of New Jersey**

Medicine is more sophisticated and its technology more advanced. As a report published by the Rand Corporation's Institute for Civil Justice concluded in 1982, "the diversity and growth in claims frequency are

Minn.	"In Minnesota we have had to increase our rates every year since the inception of our company in 1980. The average increase over the years is 22%. Hopefully, we won't have an increase in the future—it all depends on the projections. We're hoping to decrease premiums some day." —Robert S. Flom, MD, Minn.
Miss.	"Mississippi has been faced with steadily escalating rates since 1977 when we started our company. There was no general rate increase in 1984. We did raise family practitioners who do OB one class and we also raised OB/GYN one class. However, we are faced with continuing losses with defense costs and anticipate a future increase." —C. G. Sutherland, MD, Miss.
N.J.	"In N.J. between 1977-1984 we had a 32% total rate increase with an average annual increase of 4% which we think is the effect of inflation. In 1980 we had our largest increase of about 15%. Some classes—OB/GYN and orthopedics—have been adjusted upward and others—ophthalmology, pediatrics and urology—have been adjusted downward. We will have to increase our rates (in the future)." —Vincent A. Maressa, N.J.
Okla.	"In Oklahoma we have some of the lowest premiums (in the nation) and can still sell an occurrence policy. In 1984 we had a 15% rate increase—the first in the five years of our existence. It's too early to predict for the future... (perhaps) small increases." —David Bickham, Okla.
Tenn.	"Tennessee has raised rates every year (because) it writes a modified claims made policy. We have rate increases projected for the future." —L. Hadley Williams, Jr., Tenn.

Data source:
AMACO

partly the result of changes in medical services and would therefore not be fully eliminated even if legal environments were uniform."

Some of the problems may lie with the courts; changes in the laws relating to professional liability actions and in some rules of the court could be beneficial.

A multitude of other factors also contribute to the professional liability problem—higher public expectations of what medicine can offer, a more litigious society, a greater number of lawyers willing to file suits that may not have merit and the lure of possible huge awards or settlements.

Future *American Medical News* reports will explore more fully the possible causes of this professional liability claims explosion as well as methods to contain it.

Editor's Note: Information from many sources is contained in this report because many organizations and agencies have gathered information and statistics on medical liability claims over the years. Different data collecting and reporting methods have been used. The definition of what constitutes a "claim" has varied from study to study and many utilized closed claim statistics without specifying when the alleged injury occurred. For that reason, the data and the methodology must be analyzed before making any comparisons, and even then, caution is advisable.

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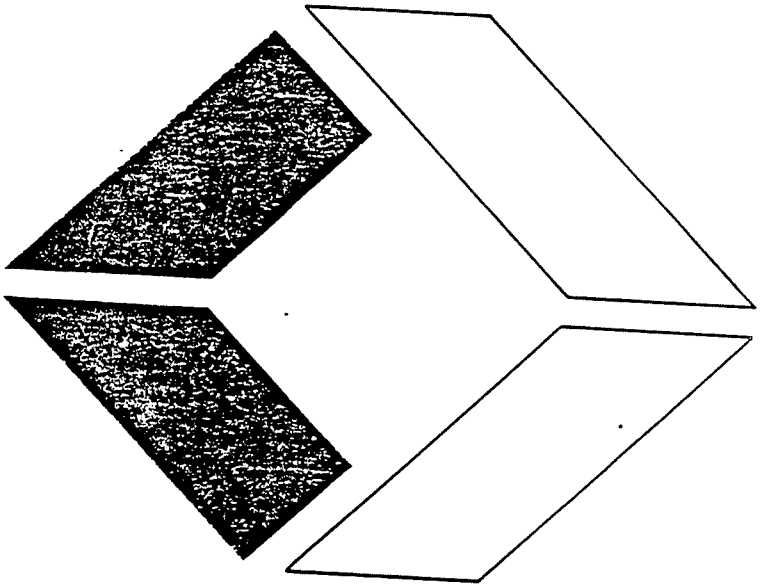
American Medical News thanks the many individual physicians, medical society representatives, physician-company and commercial insurance company spokespersons who contributed valuable information to this special report.

Professional Liability in the '80s

Report 2



American Medical Association
Special Task Force
on Professional Liability
and Insurance
November, 1984

A time for consideration...

Increasing numbers and costs of professional liability claims pose serious problems for physicians and the public. Two unanswered questions arise. First, can a stable insurance market providing protection at a reasonable price to physicians and others in the health care field be maintained? Second, are tort reforms and other changes in the court system an effective way to minimize the professional liability problem? These are the subjects of this two-part report.

Medical Malpractice Roundtable

Ten years ago professional liability insurance protection was difficult and sometimes nearly impossible for physicians to obtain. As claims and costs of claims spiraled, commercial carriers, many of them in the business for years, deserted this line of business, creating a "crisis in availability" for medicine.

Moving into the vacuum was a new phenomenon—the physician-owned professional liability insurance company. Today some 40 of these companies, most linked to medical societies, provide coverage to more than half of the practicing physicians in the nation.

After a temporary respite, numbers of claims are multiplying and costs of claims are rising dramatically, forcing up professional liability insurance rates. Now a new "crisis in affordability" may be developing. This crisis threatens to drive up health care costs and reduce availability of some medical services.

A key question for physicians as well as for health policy-makers is whether the physician-owned companies and the commercial insurers that have been returning to the professional liability market in recent years will be able to hold down prices for protection to affordable levels in today's deteriorating environment.

Five insurance company spokesmen—four from physician-owned companies and one from the largest commercial insurer in the professional liability market—sat down to consider this question recently. Chairing the roundtable discussion was Robert L. Dion, vice president and general manager of the American Medical Assurance Company (AMACO), AMA's wholly owned reinsurance subsidiary, with Richard G. Layton, AMACO's vice president for marketing, sitting in.

Participating in the discussion were: Tim Morse, senior marketing officer, medical services division, The St. Paul Fire & Marine Insurance Companies; Ron Neupauer, underwriting manager, Medical Insurance Exchange of California, San Francisco; Douglass M. Phillips, executive vice president, Medical Mutual Insurance Company of North Carolina; William K. Scheuber, recently retired executive secretary of the Alameda-Contra Costa Medical Association and president of MIEC; and Peter Sweetland, president, Medical Inter-Insurance Exchange of New Jersey. Here is a summary of the discussion.

Dion - Physician-companies were created to fill an insurance void in the middle '70s and now provide coverage to more than half of the physicians in the nation. These companies promised to provide affordable insurance protection to physicians. Are these companies living up to their promises?

Sweetland - The fact that physician-companies are here today eight to ten years after the so-called "crisis" says that we've made progress. Many commercial carriers—and I worked for one—looked with scorn on the physician-owned carriers and predicted that they would not survive.

Phillips - Physician-companies were born of pure necessity; there was no other insurance available. Physicians wanted a company that would appreciate their concerns, do something about them, and be straightforward about what is going on. In North Carolina we feel we have very adequately served the function for which we were created. St. Paul is writing policies again in our state. Our presence has kept the competitive atmosphere over the years and that works to the advantage of all physician-insureds.

Scheuber - Our company in the San Francisco area started the same way nine years ago. We had to move into the vacuum or otherwise physicians couldn't practice medicine. Since then, we have improved the insurance environment in northern California and in Nevada, Idaho, Alaska and Hawaii where we write coverage. Maybe our policy isn't cheaper; often it costs a little more, but it serves the physician better and is more sensitive to his or her needs.

Neupauer - In the last nine years physicians have begun to realize what a wonderful resource they have in their own companies which have become so much more responsive in the area in which they feel most vulnerable. They know where their money is going and these companies are fulfilling their expectations.

Morse - The physician-sponsored professional liability insurance companies obviously are doing something right. They have over 50% of the medical liability market. As a commercial company, we welcome competition. The ultimate beneficiary

is the health care provider. Our company never said that these companies were going to fail. In fact, a St. Paul spokesman told the Physician Insurers Association of America in 1981 that we recognize that physician-companies are here, they are a fact of life, and they are going to grow and prosper. By the same token, we hope that companies like The St. Paul can do the same thing.

Scheuber - The new element in professional liability in the last decade has been the huge motivation on the part of the medical profession to try to solve this problem. The insurance industry was expected to cope with it in the past—and things just got worse. Now physicians are paying attention. They learned a real lesson from the last disaster.

Sweetland - That's right. Physician-owned carriers are dedicated to finding solutions to the professional liability problem.

Dion - Yet another "disaster" may be in the making. Is a new "crisis" now developing? If so, will the physician-companies and the commercials who have returned to the market be able to ride it out?

Phillips - We address it as a crisis in North Carolina. It's not comparable to the mid-'70s crisis in availability, but it is getting to be a crisis in affordability. Suddenly our claims expenses doubled in 1983.

Neupauer - There already is a crisis of affordability in a few states. A crisis occurs when a substantial number of physicians feel they either can't get or can't afford the malpractice insurance product.

Morse - I agree that availability doesn't seem to be a problem. Affordability is just a reaction to the claims climate. Insurance pricing is going to respond to that trend.

Scheuber - There are two types of crises. One is the local crisis occurring in places like Florida which has to do with physicians' willingness to pay high premiums and their ability to pass these costs on to patients. This is a very bad crisis but it is temporary; reform is applied because it must be. The bigger crisis is the social crisis generated by the tendency of Americans to try to insure against every peril in life. We may have gone too far in this respect. Ultimately, society may want to be less lavish in compensating people for real or fancied ills.

Sweetland - There is a crisis for those physicians who didn't expect to have to pay the real price for coverage and who anticipated early savings from their physician-companies. There definitely is a continuing problem as the number of cases and their values escalate. But it is not out of control.

Total indemnity paid by physician-owned companies: 1979-1983

Region	1979	1980	1981	1982	1983	Total
Northeast	$15,888,442	$35,699,032	$ 59,518,549	$110,935,372	$151,099,362	$373,140,757
Midwest	2,435,856	8,238,505	16,553,409	37,258,876	56,429,122	120,915,768
South	1,589,851	3,213,390	5,972,673	8,770,327	18,670,658	38,216,899
West	6,868,609	14,739,112	26,720,317	39,052,487	52,949,485	140,330,010
Total paid	$26,782,758	$61,890,039	$108,764,948	$196,017,062	$279,148,627	$672,603,434

As physician-owned companies formed in the '70s have matured, the amount of indemnity paid has grown significantly, demonstrating the "long tail" on professional liability claims. However, the steadily increasing size of awards and settlements has caused indemnities to increase at a rate beyond that which would normally occur as a result of the "long tail."

In a survey of 24 companies conducted by the American Medical Assurance Company (AMACO) in August, 1984, 17 companies linked to medical societies reported indemnity outlays in 1979. In 1980, 18 companies reported indemnities and in 1981 and 1982, 21 did. Of reporting companies 23 paid indemnities in 1983.

The AMACO survey included responses from 24 of the 30 physician-owned companies with ties to medical societies. If the experiences of these and the other approximately 10 independent physician-owned companies paralleled that of the reporting companies, then the total indemnity they paid in these years probably exceeded $1 billion.

Data source: AMACO

Dion - All of you agree that claims are again increasing and that severity of claims is going up, necessitating sometimes large premium increases to physician-insureds. Will the physician-companies be able to cope financially with this problem? In other words, how stable are these carriers?

Sweetland - I'll admit some companies may initially have underestimated their financial needs. They started out overly optimistic, they may have returned dividends to insureds too soon, and to get started they may have priced their policy below what the previous insurer charged. Such companies are now going to have to get up to speed. The companies in the firmest financial condition accepted the fact at the outset that until they actually knew what they were dealing with in terms of liabilities, rates had to be set at certain levels. Sometimes those rates were high, but in many cases, those initial higher premiums have served as a cushion during this time in which claims experience has deteriorated. It is improper, however, to assume that every physician-company is facing calamity.

Phillips - In one or two places in the nation companies face special problems—some of them political. But none of these problems are relevant elsewhere in the nation. The insurance industry has been stupid for years. When business is good, insurers underprice, and when business is bad, they drive the price back up again. It's a continual cycle. We've gone through another cycle and now prices are starting to go back up again.

Dion - In the years since the physician-companies were formed, interest rates were high and return on investment was considerable. Do you think that some companies may have relied too heavily on investment income to carry them?

Neupauer - In professional liability insurance, investment income is different and it is bigger than in other lines. You collect money in the form of premiums in the early years, but you don't pay for several years because of the long tail on claims. So you can take the money earned on invested funds and plug it into the company formula. You can't get overly optimistic about it. Actually you should treat some of it, if not all of it, as a kind of safety cushion against some of the negative volatilities that everybody has failed to predict historically.

Morse - Investment income alone cannot obscure the poor results we are seeing in medical liability. Investment income can't offset operating ratios of 149 and 142, which we have seen in 1982 and 1983. A number of companies are standing that operating loss by reducing surplus. You cannot continue to do this without financial impairment. I think you are going to see a shake-out in this marketplace. Companies that are prudent in their insurance managment eventually will leave voluntarily or be forced to leave.

Sweetland - Physicians must understand what a company surplus is. It isn't just seed money that a physician should expect to get back before retirement. It's necessary and it must grow.

Phillips - Companies that don't recognize that their surplus is being impaired are the ones that could be in trouble, if they aren't already. If a company is well managed, its reserves against losses are established realistically, and its rates adjusted properly, then I don't think there is any need for concern. But physicians must understand that they are going to have to pay higher premiums unless we can deal effectively with this professional liability issue.

Dion - There is cheaper coverage available. Maybe physicians ought to shop around—buy at the lowest price. And if they do, will this drive them away from the companies they created?

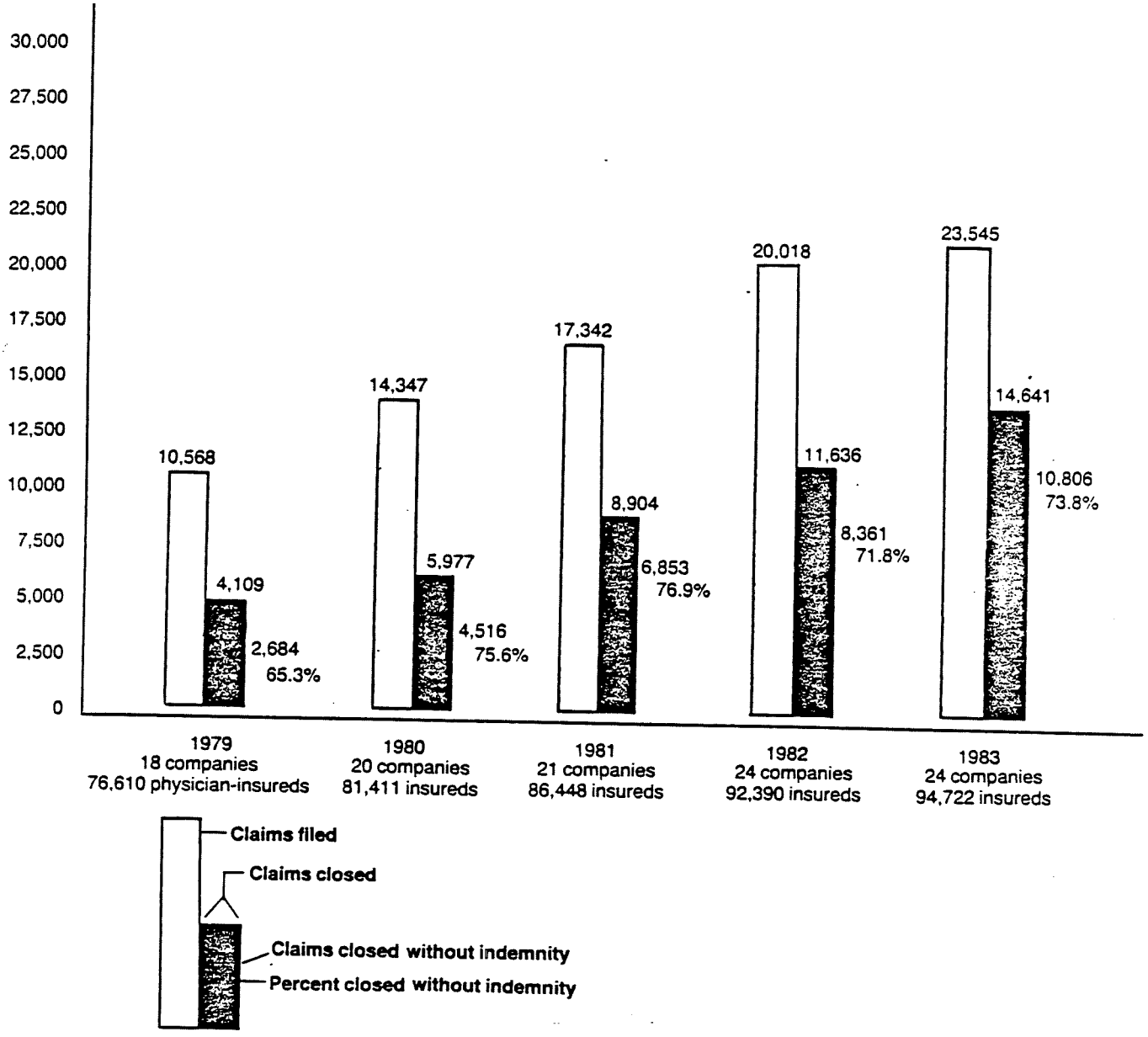
Neupauer - Some physicians always will seek the lowest cost insurance. That has always been true. Physician-owned carriers will have to learn to live with competition and to do with less than 100% of their market. In the long run, if these physician-companies are well managed, pay attention to what they are doing—and if the environment doesn't become completely unworkable, they should be able to offer the service cheaper than a commercial carrier. That won't always be true because of year-to-year fluctuations but generally it should be.

Phillips - Our North Carolina company offered a slightly lower rate than our competition until recently. Now we're considerably higher and we are gratified that we are losing less than one percent of our insureds. There is loyalty.

Scheuber - Physicians are more sophisticated about their insurance. Many physicians consciously pay a higher premium to us even though they could buy cheaper coverage. We have told them that the last thing physicians ought to be interested in is the price of professional liability insurance. In the long run, physicians don't want a gun that isn't going to shoot when you need it and they now understand that.

Neupauer - Physicians should understand and accept the fact that

Claims filed, closed, with and without indemnity: 1979-1983
(Physician-owned companies linked to medical societies)



Approximately three of four claims or suits against physicians are closed by their professional liability insurance companies without payment. That ratio has remained steady for the last four years for the physician-owned companies linked to medical societies.

Data source: AMACO

their own companies must behave responsibly and continue to support them. If these companies disappear, we'll be right back to the situation that existed in the mid-70s.

Sweetland - Don't get the mistaken impression that all physician-owned companies charge the highest prices. Today the physicians we insure may be paying more to be with us than with other carriers, but that's not the ultimate cost. Ultimately, our cost will be less. We can operate more efficiently. Our marketing system, when we have one, is less expensive. There are real savings in the management of claims. We have a vested interest in getting at the causes of the claims rather than simply finding a way to pass through money.

Dion - Let's talk for a moment about handling of claims. Are there differences in the way that physician-companies and commercial companies handle claims?

Scheuber - The physician-owned companies pay infinitely more attention to a claim and to the physician's viewpoint about that claim than a commercial carrier does.

Phillips - Physician-owned companies have a definite advantage over the commercial carriers because physicians directly participate in claims handling.

Neupauer - Yes, our company uses a multi-layered approach, including claims review with physicians participating, and over time it has led to a nicely tuned method of operating. A physician can feel more secure with a physician-owned company when a claim does have to be handled. The commercial carrier maintains an arm's length relationship with an insured.

Robert L. Dion

Sweetland - In one of my rare defenses of the commercials, I think that those still in the business have dedicated claims adjusters. But the access that a physician-owned carrier's claims staff has to the physician community is unmatched. The technical assistance that comes from physician review of cases is tremendous in terms of providing that company the ability to properly prepare the defense of a case.

Phillips - There is the danger that if physicians get too involved in the claims review process, they will want to fight every case. That's not facing reality.

Sweetland - I'll echo that concern. As much as the physician leadership may feel that the answer to the professional liability problem is to fight every last case, juries get very angry when there is clearly one that should be paid.

Morse - The point is that the medical issues and the claims issues must be decided by qualified people—and it doesn't make any difference whether you are a society-sponsored carrier enjoying a healthy relationship with your medical society or a commercial carrier who goes out and finds that same type of medical talent.

Scheuber - In northern California our medical society offered the services of its claims review committee to commercial carriers on several occasions. Usually we have been spurned. These companies said, "Naw, you don't understand the problems the way we do. We have a more realistic attitude." I think that's wrong.

Morse - I can speak only for St. Paul, but as a commercial company we must be doing something right because in about 50% of the instances, the claims departments of the society-sponsored companies are being run by people hired away from us. We do have one major advantage aside from the fact that we've been in this business for 50 years. We look at about 6,000 reported physician claims every year. That gives our claims staff, our adjusting staff and our defense counsel considerable breadth of experience.

Dion - You have spoken of physician involvement in claims review. How much physician participation should there be in their own sponsored companies?

Sweetland - Physicians must contribute time to peer review of cases. In the event that a physician is sued, he or she must cooperate in the defense—and accept the fact that court appearances are necessary and try to help us win it.

Scheuber - Yet a certain amount of intramural conflict can arise out of

differences between the company and governing bodies composed of physicians and the company management. It can be disastrous. In our company we say, "We want the physicians to be the philosophers—to set the direction and express physicians' needs and the insurance people engaged to achieve those goals in a manner that will permit the company to survive and prosper." There are two separate functions. Physicians should stay out of the day-to-day operations of the business, but the insurance people running a company should be very, very sensitive to what the medical profession has set as its goal for that company.

Sweetland - It's an interesting problem. The ones who can best determine whether a case is truly defensible are the physicians. The ones best able to determine what that case is worth, if it must be settled, are the staff.

Phillips - I think that early on, there may have been some conflicts. Now most physician-owned companies appreciate what physicians can do in determining what cases are defensible and which are not. Physicians have learned to listen to the company staff on those things about which they have expertise. I just hope that physicians understand that it isn't as easy as it looked eight years ago and the insurance problem can't be resolved in a short period of time.

Dion - You mentioned that physician-companies have found that "it isn't as easy as it looks" to provide professional liability coverage at an affordable cost. We all agree that the professional liability climate is deteriorating. Why is this happening and what can physicians and insurance companies do about it?

Tim Morse

Sweetland - One reason is that the plaintiffs' bar has improved its skill. The medical community assisted in educating plaintiffs' attorneys to the point where they are more successful in today's judicial system.

Neupauer - That's true. The plaintiffs' bar is becoming better educated. We have to educate the defense bar, help them, give them access to medical information from our medical societies to prepare and better defend cases where there is no liability.

Scheuber - Every company—physician-owned or commercial—should make the plaintiffs' attorneys earn their money and make it tough to earn. If plaintiffs' lawyers find that to earn a dollar from a professional liability company they are going to have to spend $1.02, then they are not going to fight us very hard. They are going to say, "That's no place to go for money."

Phillips - Like Scheuber, I think the solution lies in total resistance to payment of claims that are not warranted, but knowing when a claim is justified.

Sweetland - There is a need for effective risk management. Companies must work with the medical community to eliminate the causes of losses that are truly the result of negligence. There is a clear distinction between a case with no negligence but an unfortunate outcome and one involving sheer negligence. The medical profession is held to the highest standards imaginable. If batting averages were given to physicians, they would be batting .999 and still suffering over the other fraction of a percent. Because there is so much money involved, we do need to make an effort to get at the causes of loss.

Phillips - Most people don't recognize that physicians face litigation involving irreversible error. If Ford Motor Company produces a bad automobile, it can issue a recall, correct the error and control its losses. How many times have you heard a physician say when there is a claim of misdiagnosis, "Golly, I wish I could have looked at that again." But it is beyond recall.

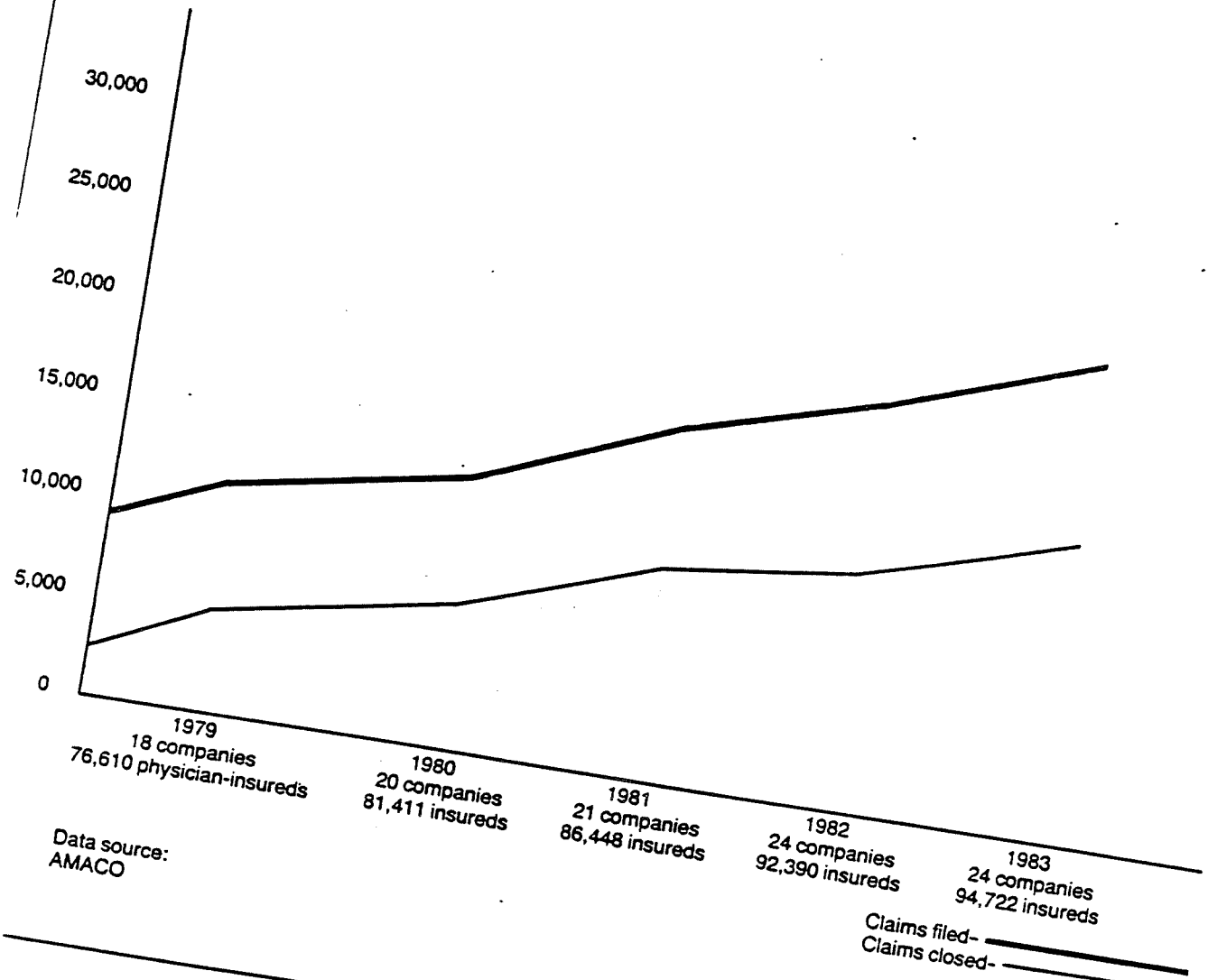
Dion - There has been criticism that physicians don't properly police themselves and that this is a reason for the increased incidence of claims and suits. Is there any truth to this criticism?

Sweetland - I think the accusation that the medical profession is not doing as good a job of policing itself is a bum rap.

Scheuber - No other professional group has done as beautiful a job of policing itself than have physicians. There also is a growing perception

Claims filed and closed : 1979-1983

In recent years the total number of claims filed each year against physician-owned companies has more than doubled. The rate at which claims are closed lags behind the filing rate, leading to a sharp increase in the number of accumulated claims still open. Because of increasing severity of professional liability claims, the longer a claim stays on a company's books, the greater the chances are that it will be more costly to resolve.



Data source:
AMACO

on the part of every physician that "This physician is risking my dollar because he and I are covered by the same insurance company." A lot of legislators and regulators think that it is bad doctors that cause malpractice. Our big losses come not from the physicians with the problems, but from highly trained physicians practicing at the far edge of a very, very dangerous specialty.

Sweetland - Our New Jersey insurance commissioner focuses the same way, suggesting that "getting rid of the bad doctors" will solve the problem. We just prepared some statistics for him showing that out of hundreds of losses over $100,000, only 21 physicians were involved in more than one case. The other losses, when analyzed, in no way reflected on the individual practice patterns of the physicians. So the next batch of big losses is going to be from a different group of physicians.

Phillips - One of the basic answers from an insurance company's standpoint, in addition to good risk management, is good underwriting. If you underwrite a physician who is not practicing medicine correctly or doing things inappropriately, he's going to get you into trouble. Even if you don't insure him, the bad publicity from the claims he generates will spill over to your company and your physician-insureds and create other losses against physicians who aren't doing anything wrong at all.

Sweetland - Yet it distresses me that we look to the insurance mechanism to restrict a medical practice.

Neupauer - It is not that difficult for any company to identify the groups or individual policyholders who could benefit from some focused education and advice. The current attention to professional liability provides us a wonderful opportunity to advance risk management programs. Physicians are particularly amenable to such efforts right now. We are seeing a big upswing in attendance at the seminars we have been giving and we have seen real improvements in such things as record-keeping—a source of claims—as a result.

Total accumulated reserves for incurred losses not including IBNR

	1983
Northeast—	$1,282,199,814
Midwest—	421,675,534
South—	100,558,041
West—	435,424,001
Total	$2,239,857,390

The total accumulated reserves allocated by 24 of 30 reporting physician-owned companies linked to medical societies in 1983 was over $2 billion. This does not include what insurers call IBNR—claims incurred but not reported. Reserves reflect an insurance company's judgment about what each possible claim could ultimately cost.

Data source:
AMACO

Ron Neupauer

Sweetland - Another study we did of the volume of claims by age group produced some interesting results. The highest concentration of claims involved physicians in their mid-40s—those at the peak of their practices. This is the same physician too busy to attend a risk prevention seminar.

Neupauer - Then companies will have to expend time, effort and money to get these physicians out. We will have to arrange the meetings at their convenience and target them to their interests and needs. We have been doing this. We have to cut down the catastrophic losses since a very small proportion of cases accounts for a very large amount of total dollars spent.

Morse - Personally, I think risk management offers the greatest opportunity to prevent losses from occurring or to minimize their impact when they do occur. The St. Paul Company is focusing a great deal of time and effort in this area as are the physician-companies.

1984 Report on physician/owned medical society created liability insurance companies

Company	Insureds	Limits	Coverage	Premium range	Average premium
Alabama	2,850	$1M/1M; 5M/5M	CM*/O	$1,159-13,555/466-3,080/ 1,237-14,729	$ 4,900
Arizona	3,010	1M/1M; 5M/5M	CM*	3,064-22,252/1,308-8,328	8,500
MIEC, CA	2,900	1M/3M	CM*	4,996-31,648/994-6,294	6,500
NORCAL, CA	5,600	1M/3M; 2M/4M	CM*	2,604-28,520/872-7,116	NA
SCPIE. CA	7,331	1M/3M; 5M/5M	CM*	3,404-29,184;1,288-10,496	6,700
Colorado	2,200	1M/1M; 5M/5M	O	1,200-14,000	5,000
D.C.	1,100	1M/3M; 10M/10M	CM*/O	1,563-26,185/513-11,385/ 1,666-26,382	7,300
Florida	4,360	500/1M; 1.5M	CM*	4,363-42,348/781-7,582	7,700
Georgia	2,400	1M/1M; 5M/5M	CM*	1,147-25,307/380-9,895	5,800
Illinois	7,986	1M/3M; 5M/5M	O	3,944-42,700	9,400
Indiana	430	100/300	O	630-5,046	1,200
Kentucky	1,723	1M/1M; 5.2M/5.6M	CM*/O	1,592-12,196/533-3,631/ 1,691-12,982	3,300
Louisiana	2,000	1M/1M; 5M/5M	O	1,841-15,284	4,500
Maine	895	1M/3M; 5M/7M	CM*	2,858-25,305/752-6,659	5,600
Maryland	2,900	1M/3M; 5M/7M	CM*/O	656-12,400/200-6,200 1,562-19,690	6,000
Michigan	4,585	1M/1M	O	3,935-44,669	5,100
Minnesota	2,203	1M/3M; 4M/7M	CM*	939-13,698/311-4,013	4,700
Mississippi	2,050	1M/1M; 5M/5M	CM*/O	1,501-17,011/461-5,222/ 2,011-22,795	5,000
Missouri	1,254	1M/2M; 2M/3M	O	2,153-21,535	4,291
New Jersey	6,850	1M/3M; 5M/7M	O	3,373-24,272	6,700
New Mexico	1,500	100/300	O	956-6,197	3,250
New York	15,830	1M/3M	O	4,541-63,311	12,500
N. Carolina	3,805	1M/1M; 5M/5M	CM*	1,600-17,129/556-7,330	2,600
Ohio	4,541	1.1M/1.3M 5M excess	O	2,047-17,944	4,080
Oklahoma	3,603	1M/1M; 5M/5M	O	922-5,234	2,903
Pennsylvania	6,200	200/600	CM*/O	2,304-19,351/648-5,443/ 2,400-20,158	4,700
Tennessee	4,830	1M/3M; 10M/12M	CM*	1,933-16,436/649-4,456	4,740
Texas	3,200	1M/2M; 2M/3M	O	1,200-16,500	4,000
Utah	1,325	1M/3M; 5M/7M	O	910-13,674	3,600
Washington	1,803	1M/3M; 5M/7M	RO**	1st 891-7,148 2nd 2,005-16,083 3rd 2,785-22,339	2,800

CM—Claims Made O—Occurrence
*First year claims made range
**Report occurrence

Premium range based on $1 million coverage except when maximum available is less. Maximum limits available are indicated also. Average premiums are estimated. Financial data based on 1983 year end statements.

Data source: AMACO

Dion - Physicians have a tremendous stake in the resolution of the professional liability problem. What specific recommendations do you have for them?

Neupauer - We have already seen a real awakening among physicians to the realization that this is a problem that threatens their ability to continue practicing medicine in the way in which they have become accustomed. If physicians treat their patients in the best way they know how, communicate with them, listen to them, and continue to be the allies, champions and supporters of their patients, this will go a long way toward avoiding a repeat of the 1975 "crisis." The patient is the physician's ally—the one who trusts him. Only when that trust is somehow breached do the other legal mechanisms begin to operate and claims and suits materialize.

Sweetland - Yet there is the highest level of frustration among physicians today than I have ever seen. Insurers like us are telling them to spend more time with each patient, test more and treat more to avoid possible mistakes but the third party providers are saying, "Treat less. Keep costs down. Spend less time with the patient." A physician should use his or her own judgment and do the best possible job with each patient. That physician should not rely on being able to blame somebody else for forcing him to do or not do something, whether it be the constrictions of DRGs or other pressures. Meanwhile, his insurers must do the best possible job they can. Together I think we can lick this problem.

William K. Scheuber

Morse - Solutions must be a shared function, involving physicians, insurers, lawyers, judges, legislators and others. There probably is no single remedy. The solution will depend upon the degree to which physicians can make their point of view known and the cooperation achieved from others with a stake in the problem.

Scheuber - I would advise a physician that this is just another problem. Don't get hysterical. That's what happened in 1975. I would counsel a thoughtful, organized study of the problem and development of some reasonable solutions, even if they are costly. Frankly, I don't think we are going to get anywhere pressing tort reform in the legislatures until the public is willing to cope with these issues—until the public is horrified with what is happening and wants to change it.

Phillips - Maybe at some point the public is gong to say, "Whoa, we have gone too far. We can't afford this anymore." But until that day comes, the only thing we can do now is to educate the physician, tell him what's going on, win his or her cooperation, and try to hold things down.

Sweetland - There are many chal-

Douglass M. Phillips

Peter Sweetland

lenges to address in the next five years, but I don't think we are going to be blown away by the problem. Physicians must realize that they can't be passive participants—they must take a strong stand and get out and do some work if any legislative reforms are to be enacted. Physicians must participate actively in those physician-company functions that require their involvement.

Dion - Some people have suggested that the insurance industry is incapable of dealing with the current professional liability problem effectively. Is federal intervention needed?

Sweetland - Maybe some assistance to the states in their efforts to reform their own laws might be helpful, but I don't think that the government has a satisfactory solution to the professional liability insurance problem.

Morse - I agree. Federal proposals to date are very vague and haven't been studied appropriately. Furthermore, the professional liability problem is a product of 50 different social, legal and economic climates in the states. I'm not sure that uniform, across-the-board federal legislation is the answer.

Phillips - The insurance industry has not failed and the medical profession has not failed to deal with the professional liability problem. We are working with a flawed system. We are trying to deliver a product to compensate patients for things that happened to them through a system that puts only 20% to 25% of the money generated into the hands of the victim. In many cases, a true victim gets nothing, and in others, a claimant able to win the sympathy of the court gets a great deal of money when there was no physician liability. If we need federal intervention, it is to restrain the whole litigious atmosphere in this nation today.

Professional Liability Tort Reform

After the professional liability crisis reached its peak in 1975, physicians and other health care providers and institutions took several steps to solve the problem; one of the most important of these steps was an aggressive campaign to reform state laws affecting medical professional liability lawsuits. The goal was to change state laws governing tort litigation in two general ways: first, to make it harder for plaintiffs to bring groundless lawsuits, and second, to limit the impact of the costs of successful suits on defendants, insurers, and the medical profession as a whole.

In one sense, the campaign for tort law reforms was immensely successful. Every state in the union, except West Virginia, enacted some reform proposals. Some states, including those with the most serious professional liability problems—such as New York, California, Florida, and Illinois—enacted comprehensive packages of legislation over the vigorous and well-organized opposition of plaintiffs' trial lawyers.

But in another sense, the campaign appears to have failed.

The expected reduction in the number and severity of professional liability suits against physicians and hospitals never happened. In the past two or three years the situation has become worse than it was before. More professional liability claims are filed now and jury verdicts against physicians are higher on the average.

According to American Medical Association figures, before 1978 an average of 3.3 professional liability claims were filed for every 100 physicians. From 1978 through 1983, an average of 8 professional liability claims were filed for every 100 physicians. For physician-owned companies in 1983 the average frequency was 20.3 claims for every 100 physicians. In those cases that go to trial and result in an unfavorable jury verdict, the size of the damages awarded has skyrocketed and the number of million-plus awards has increased each year. (See Report 1-Special AMA Task Force on Professional Liability and Insurance.)

Are tort reforms effective?

An obvious conclusion that the wave of tort reform legislation in the 1970s was a failure may well turn out to be partly or wholly inaccurate. First, without the reforms enacted, the situation might be far worse than with the reforms in place. Second, the publicity generated by the first professional liability crisis may have made the public and the legal profession more aware of the vulnerability of the medical profession to successful lawsuits.

Thus, the impact of the wave of tort reforms of the late 1970s on medical liability costs is unclear. Yet it is undeniable that these reforms have not had the effect that their supporters hoped, or at least not yet. This has been true for at least two reasons.

First, some of the reform measures have not been as effective in reducing litigation volume or severity as hoped. Some measures passed during the crisis were poorly thought out, and either had no effect at all on medical liability costs, or in a few cases had an opposite effect. For example, recovery of costs legislation designed to reduce suits without merit by requiring losers to pay costs, including attorney's fees, has

increased outlays for awards in some states.

Second, many of the potentially most effective reforms have been successfully challenged on constitutional grounds in the courts. With the exception—thus far—of contractual binding arbitration, every single major tort reform measure has been found unconstitutional by at least one state supreme court. In many states, lower courts have reached conflicting conclusions about the same statutes, and plaintiffs and defendants in many states are still awaiting higher court determinations on the validity of important provisions. Because it often takes several years for a liability case to wind its way from the trial courts through at least one intermediate appeal stage, and finally to the supreme court in the state, many tort reforms passed by state legislatures in the mid-1970s have been subject to supreme court scrutiny only in the last two to four years.

Of course, the view expressed by plaintiffs' lawyers is that physicians and hospitals are guilty of professional negligence far more often than even the latest flood of litigation indicates. These lawyers generally believe that while the tort reforms of the 1970s make their work somewhat more difficult, and treat some injured patients harshly, the tort law changes have no effect on "good" medical liability cases, either in terms of chances of success or in size of eventual settlement or verdict awards.

Whether that view is accurate or not, it does appear that some plaintiffs' attorneys are becoming more proficient at winning bigger settlements or verdicts for their medical liability clients. In recent years, many courts have taken a broader view of what constitutes adequate compensation for an injured plaintiff. The traditional goal of "making the plaintiff whole" has expanded from merely paying for medical expenses and lost wages to include lifelong compensation for rehabilitation, counseling, physical or occupational therapy and training, and lifestyle changes.

Vulnerability to constitutional challenge

The single greatest legal weakness of nearly all reform measures that have been found unconstitutional is that they apply only to medical liability cases, and no other kind of lawsuit. Plaintiffs are thus able to argue that the laws violate their constitutional rights to "equal protection of the laws." Both state and federal constitutions contain the equal protection provisions, which guarantee that no class of persons can be treated differently from the rest of the population unless there is a very good reason for doing so. When an equal protection claim arises in a case, the court first decides if there is in fact an unequal impact on one class of people. If so, then the court decides whether the unequal burden on the complaining party is justified or outweighed by the reasons given for the different legal treatment.

In the case of medical liability tort reforms, plaintiffs argue that equal protection guarantees are violated because certain measures make it harder for them to file and win a lawsuit, or limit the damages recoverable, while plaintiffs in other kinds of lawsuits faced no such barriers. The courts must determine whether the reasons for that unequal treatment of one class of people (medical liability plaintiffs) compared to other similarly situated classes (other kinds of tort plaintiffs) justify the distinction.

It is not an easy formula to apply, and it is virtually impossible to predict how courts will treat such claims. Courts may apply different standards of review. One level of review presumes that the law in question is a valid one, as long as there is any rational and proper explanation for it. A stricter level of review makes no such presumption, but instead examines the statute, its legislative history, and its current impact, to determine what its actual purpose is and whether that purpose could be achieved with a less harsh law. This latter level of scrutiny is usually applied when the person raising the issue can show that a "fundamental right" of all citizens is affected. Fundamental rights usually involve issues such as freedom of speech, freedom of assembly, and racial discrimination. Courts generally do not classify medicolegal issues as fundamental rights. The tort reform provisions have been challenged because they are special legislation; that is, legislation enacted solely to benefit physicians. This analysis is similar to the equal protection arguments.

The kinds of tort reforms most susceptible to equal protection challenges have been limitations or "caps" on liability (when the amount of money a victorious plaintiff can collect is limited) and mandatory pretrial screening panels for medical liability claims.

In tort reform challenges, the concept of free and equal access to the courts is considered by some courts to be a very important right, almost to the level of a "fundamental right." But even in those situations, different courts may reach different results. For example, both the Indiana and New Hampshire supreme court applied the stricter standard to their states' respective liability reform acts; Indiana's court upheld its entire act, while New Hampshire's struck down its entire act.

In some cases, the imposition of mandatory pretrial screening panel review, or other kinds of reforms,

have been invalidated because they were determined by the courts to violate plaintiffs' right to due process of law, or the right to a jury trial of civil claims; both rights are protected under both state and federal constitutions.

In a few cases, laws have been invalidated, or so modified by the courts as to eliminate their effectiveness, for reasons having nothing to do with unconstitutional rights. For example, many attempts to modify statutes of limitation have been blunted by court decisions on the basis of traditional common-law interpretations. The most unusual invalidation occurred in North Dakota. That state's supreme court invalidated all of the state's new medical malpractice act, primarily on equal protection grounds (much as the New Hampshire court did), but also ruled that the legislatures's attempt to modify rules of evidence was beyond its authority in the first place. The high court said that matters of pleading and evidence were court rules, and only the supreme court had the authority under the state constitution to determine such rules.

It is important to note that in a few states tort reforms have been invalidated only because they were part of a comprehensive package of statutory changes. Most such statutes contain a "severability clause," which provides that if any section is struck down, the others will remain in force. However, in New Hampshire and North Dakota, for example, high courts invalidated entire medical liability reform acts despite such clauses, under the reasoning that the measures were so interrelated that it was impossible for any part of the law to stand if one part were unconstitutional. Parts of Pennsylvania's comprehensive act received similar treatment.

Some of the tort reform measures that have survived constitutional challenges have done little to control the medical liability crisis. For example, a widely adopted reform—in at least 20 states—was the imposition of limitations on contingency fees for lawyers who win medical liability cases. Where the fee regulation generally fixed limits on the percentage of awards that plaintiffs' attorneys could claim as fees, the ultimate effect on the size of awards is probably very limited, if any. Indeed, where strict limits on fee percentages were enacted, there may have been a tendency on the part of plaintiffs' lawyers to push for higher verdicts and settlements to maximize their own fees.

Similarly, pretrial screening panels, while considered successful in many states, have been regarded as ineffective and even counterproductive in other states, in deterring the filing of frivolous claims or in making medical liability litigation quicker and more efficient. One reason for this could be the reluctance of plaintiffs' lawyers to use them.

However, other tort reforms have proved to be very effective in achieving the ultimate goal of the whole campaign: reduction of total costs of medical liability litigation. The Rand Corp.'s Institute for Civil Justice rates limitations or "caps" on awards and changes in the collateral source rule as the most effective law changes in terms of reducing the size of jury verdict and settlements. Also, changes in the laws that permit courts to order periodic payments of damages rather than lump-sum payments have been viewed as substantially reducing costs for insurance companies. A Pennsylvania study has estimated potential saving to be between 7% and 14% while a New York study suggests that potential savings might be approximately 5%. Where these reforms have passed constitutional muster, they appear to have played an important role in keeping the cost of medical liability litigation at a more reasonable level, though not necessarily affecting the number of claims filed.

Tort reforms: a closer look

The single most popular tort reform measure, in terms of the number of states which have adopted it, is a shortening of the statute of limitations for filing medical liability claims; 41 states have modified their statutes of limitation for such cases in recent years. Other popular tort reforms include elimination of "ad damnum" clauses in complaints (statements which specify, sometimes in inflated terms, the amount of money sought in damages), approved in 32 states, and the institution of pretrial screening panels for medical liability claims in 30 states.

The tort reforms most vulnerable to invalidation on constitutional grounds have been those placing limits on liability and pretrial screening panels.

While approximately 20 different categories of tort reform measures have been enacted in the United States with wide variations within those categories—six of these reforms have been most strongly recommended and most widely adopted:

(1) Pretrial screening panels. This reform was strongly recommended by the secretary of HEW's Malpractice Commission in 1973 as the primary method for speeding resolution of medical liability claims and eliminating non-meritorious suits. Many states adopted varying forms of the model system, which requires review of all medical liability claims by a panel composed of physicians, lawyers, and laypersons. The panel is not required to follow formal rules of evidence. After a pan-

el's decision is given, either party can proceed to a jury trial. Usually, a panel's conclusions can be introduced as evidence at trial.

A critical factor is whether review by the panel is mandatory or voluntary. Where it is mandatory, the plan may be declared an unconstitutional bar to free access to the courts or an impermissible limitation on the right to trial before a jury, as was the case in Missouri and Illinois. In Missouri, mandatory pretrial screening was struck down as an equal protection violation, since medical liability plaintiffs were required to go through a prerequisite before going to court not required of other tort plaintiffs.

Another important issue is whether the pretrial panel is considered to be "judicial" or not—that is, whether the panel's conclusions determine liability or whether they serve as a form of expert evidence that can be relied on later by a trial court. Illinois' pretrial panel plan was struck down as being an unconstitutional usurpation of judicial power because the panels rendered judgments on liability and damages. In Nebraska, the state supreme court said that state's screening system was constitutional since its role was merely to provide evidence to the trial court.

Where pretrial screening is voluntary, it is likely to pass constitutional muster—but according to a 1980 study by a George Washington University health policy group, voluntary panels must be mandatory to achieve the desired goal of speedy disposition of claims. The report of the Intergovernmental Health Policy Project said, "In the six states with voluntary screening panels they either have been under-utilized or are completely inactive." In Arkansas, the voluntary system is essentially inactive; in New Jersey, an under-utilized voluntary system was changed to a compulsory system, resulting in an almost immediate drop in the number of liability claims filed.

Another potential problem with pretrial screening lies in its administration. While systems in some states work efficiently and quickly, other states' systems have resulted in long delays and other problems. In Florida, for example, a pretrial screening system was originally upheld by the state supreme court in 1976. Four years later, the same court struck down the panels as "arbitrary and capricious," and violative of due process rights because more than half of all cases did not get panel hearings before expiration of the statutory time limit. The screening statute was constitutional as written, but unconstitutional in the way it operated, the court declared.

Variations exist in both structure and operation of panels and these variations have determined the success or failure of the provision when it was challenged in many state courts. Pretrial panels were originally adopted in 30 states, and have been upheld by 10 state supreme courts, struck down by four, and repealed or permitted to expire by four state legislatures.

(2) **Collateral source rule.** This rule of evidence prevents a jury from learning that a plaintiff has been compensated from another source, such as health insurance or worker's compensation, for the injury. This rule often results in a windfall for plaintiffs with insurance, since they recover twice for the same injury; although in some cases the insurer has a right of subrogation against any judgment—that is, the right to get its money back. So far, 19 states have changed the collateral source rule in an effort to reduce this potential double recovery. The changes have been upheld in four states, struck down in three, and allowed to expire in one.

Two general kinds of changes have been made. The first, adopted originally in nine states, eliminated the collateral source rule and gave either the judge or the jury discretion to consider a plaintiff's other sources of compensation in determining damages. The second kind of change, enacted in ten states, left the rule in place, but required a mandatory offset of the amount of other compensation against the award of damages. That is, the amount of any insurance benefits received by the successful claimant must be deducted from the judgment awarded by the jury.

The mandatory offset of collateral benefits against damage awards is considered by the Rand Corporation's Institute for Civil Justice to be one of the two tort reforms with the greatest impact on the size of awards (a ceiling or "cap" on awards is the other). The Institute reports that in states where a mandatory collateral offset is imposed, the severity of awards drops by 50%, on average, within two years' time.

A Kansas statute permitted evidence of insurance or other compensation, but not of "gratuitous" compensation, such as money from a family member. A federal court declared in 1981 that the distinction did not have a reasonable relationship to the law's stated purpose, and was therefore unconstitutional.

Collateral source rule changes have generally survived court tests, but how the changes are applied can cause problems.

(3) **Attorney fee regulation.** Some form of limitation or control of attorneys' fees has been adopted in 23 states, although these include a wide variety of approaches. The most common general approach is to require court review of proposed attorneys' fees in medical liability cases to determine whether they are "reasonable," but there are several variations within that category.

Several states provide that the loser in a medical liability suit must pay

the winner's "reasonable" attorney fees and costs, if the loser did not appear to have a reasonable chance of winning. The theory is that the attorneys and plaintiffs will more carefully screen cases with such a provision in place.

The other general approach is to set fixed limits on the percentage of an award that a successful attorney may claim as a fee. Most commonly, a sliding scale ensures that as the amount of an award increases, the attorney's share of it decreases. For example, in Delaware, the claimant's attorney's fee may not exceed 35% of the first $100,000, 25% of the next $100,000, and 10% of the balance over $200,000. Four states place fixed ceilings on fees, declaring that any fee exceeding from 33% to 40% of an award is presumed unreasonable and not enforceable.

Generally, limitations on attorney fees have been upheld by the courts. Only in New Hampshire has attorney fee regulation itself been declared

Florida

Florida's tort reform experience has been tumultuous. The state legislature in the mid-1970s approved a broad range of medical liability reforms, including attorney fee regulations, changes in the collateral source rule, establishment of a patient compensation fund and medical screening panels, periodic payment provisions, and changes in statutes of limitations, among others.

Most of these provisions remain in effect, despite vigorous opposition from Florida's 2,600-member trial lawyers' organization both in the legislature and the courts. Existing and proposed liability reforms remain in constant jeopardy as the result of what some physicians term "open warfare" between the medical profession and trial lawyers.

In 1980, the Florida Supreme Court declared the state's pretrial screening panels to be unconstitutional, since they were "arbitrary and capricious" in their operation. Four years earlier, the same court had upheld the reform. However, since that time the panel system had become bogged down; and fewer than half of all medical liability claims received hearings before panels before expiration of a statutory 10-month deadline. Thus, the statute was constitutional as written, but unconstitutional in its operation and effect, the court said.

A year later, the high court upheld the constitutionality of changes in the collateral source rule that mandated offsetting of any court-awarded damages by the amount of other compensation received by the successful plaintiff. The provision did not violate equal protection guarantees, the court said; the professional liability crisis affecting health care in the state justified the limitation.

A constitutional attack on the state's patient compensation fund in 1981 came from an unexpected source: 57 hospitals in the Miami area objected to a special $10.7 million extra assessment against hospitals to pay claims against the fund. A lower court held the compensation fund unconstitutional as an improper delegation of legislative power—in early 1983. But the state supreme court reversed in June, 1983, holding that the law setting up the fund provided the state insurance department with sufficient guidelines to carry out the legislature's intent. Even so, the PCF, overwhelmed by costly claims, has stopped writing new business.

After Florida's panel system was struck down, Florida's legislature passed a unique attorney fee law, requiring that in all medical liability cases, the loser, whether plaintiff or defendant, must pay the winner's "reasonable" attorney's fees. (In some recent Florida cases, the fees ran into the millions.) Fees may not be assessed, however, against poor or insolvent parties. The measure is designed to encourage continual negotiation and reevaluation before trial of the merits of each case. The law has not been tested before the state supreme court.

Florida physicians attempted to bypass the legislature and place a general tort reform referendum on the ballot in 1984. The referendum could have required mandatory summary judgment (a decision by the judge on legal issues when no material facts were in dispute), abolished joint and several liability (when there are multiple defendants, each one can be liable for the entire amount if the other can't pay), and limited non-economic damages, such as pain and suffering and mental anguish, to $100,000.

The referendum was challenged in court by Florida trial lawyers because, according to Florida law, a referendum may only raise one issue and the challenged referendum contained three. The Florida supreme court upheld this challenge on October 3, 1984. Florida physicians have not ruled out legislative proposals or another referendum attempt in 1986.

constitutionally invalid; the state supreme court ruled that the state's sliding-scale fee limit interfered with the freedom of contract between plaintiffs and lawyers, and unfairly made medical liability cases unattractive to lawyers.

Whether such limitations have had any effect on the number and severity of medical liability claims is problematic. Some experts suggest that limiting an attorney's percentage of a liability award only encourages plaintiffs' attorneys to seek even larger awards. Although the contingency fee system has been the subject of acrimonious criticism by physicians, the HEW Medical Malpractice Commission in 1973 found, and lawyers have argued, that the contingency fee arrangement operates as an effective screening device against groundless liability suits—since the lawyer who loses collects nothing. In its survey the Commission found that plaintiffs' lawyers believed that medical liability cases were the most difficult of all personal injury suits. The prospect of spending a great deal of time pursuing a suit that would ultimately be lost caused medical liability attorneys to reject 88% of all prospective plaintiffs. Since that study was done, however, physician-owned insurance companies have observed that plaintiffs' lawyers have become more proficient in developing and pressing professional liability cases.

Therefore, limiting attorneys' fees may not reduce the number or severity of suits; however, it may lead to a more equitable allocation of awards among plaintiffs and their attorneys.

(4) **Statute of limitation changes.** Statutes of limitation are fixed limits on the length of time following an injury that a person has to file a lawsuit. Every state has a statute of limitations applicable to all tort actions. Some states enacted laws shortening or clarifying these statutes for medical liability claims. This provision is the most common tort reform, adopted in 40 states. In addition, 23 of these states have modified statutes of limitation claims by minors. Claims by minors have been cited by professional liability insurers as a serious problem in setting premium rates. The primary purpose of these statutes is to require that a claim be asserted when the pertinent evidence and witnesses are available. It is generally accepted that the specter of a lawsuit should not continue for an indefinite time. The shorter statute of limitations makes writing professional liability insurance policies more actuarially predictable.

At issue is the potential "long tail" on such claims. In the past, the time period started running once the patient actually discovered the injury; for minors, the statute started running once the child reached the age of majority. But in recent years, state legislatures began changing the laws to require that claims had to be brought, for example, within two years of the injury, or within two years of the point at which the injury should have been discovered with reasonable diligence. Other state laws require that an action must be filed within a specified number of years after the injury occurred or should have been discovered, but impose a maximum time period within which the action must be brought. For minors, the usual change is to start the regular statutory time after the child reaches a certain age. For example, when a state had adopted a two-year statute of limitations, the law might provide that if a child under the age of six incurs injuries, the child has until the eighth birthday to file suit.

In general, efforts to shorten the statute of limitations have withstood court scrutiny. However, in three states the courts have struck down special rules for minors, stating that the limitations for children arbitrarily denied their right to seek redress for injuries. Further, even where statutes have not been declared unconstitutional, courts in many states have construed the statutes to mean that the "discovery rule" (when the statute only begins running after the patient has discovered the injury) still applies, either across the board or at least in regard to "foreign body" claims—such as when a sponge is left in the patient after surgery.

A change in the statute of limitations may limit the open-endedness of professional liability suits while still allowing claimants a right to redress for injuries.

(5) **Limitations on liability.** These limitations, adopted in 17 states, take two forms: one places a limit on certain kinds of damages and one places a fixed cap on a physician's liability. The former generally limits the amount a jury can award for "non-economic damages," which usually means a limit on damages for pain and suffering. No limit is placed on what can be awarded for actual monetary losses because of medical expenses or lost wages, nor are amounts available for punitive damages limited, though punitive damages are rare and awarded only where the defendant's conduct was grossly negligent or reckless. A common belief is that pain and suffering damages are the primary source of inflated awards, and these statutes attempt to control such awards by imposing a limit of, for example, $250,000 in California.

The second kind of limit on liability involves a fixed cap on awards against physicians. These caps are usually tied to a patient compensation fund, under which amounts over the statutory cap—usually $100,000 to $300,000—are paid out of a state-operated fund in which all physicians may participate. A total of 10 states have both a patient compensation fund and a statutory limit on physician liability. Where there is

a patient compensation fund the cap on physician liability is not always absolute. For example, a physician (or physician's insurer) is liable up to the cap amount, $200,000; the patient compensation fund is liable for any amount of a judgment which exceeds $200,000 but does not exceed $600,000. The remainder of an award larger than $600,000 must be paid by the physician. A few states, however, such as Illinois and Indiana, place an absolute limit on physician liability: regardless of the circumstances, no award for medical liability may be greater than $500,000.

A 1982 Rand Institute for Civil Justice report found that states with caps had an average drop of 19% in the severity of awards within two years of enactment. Liability limits generally have been extremely vulnerable to constitutional challenges. In the 17 states where liability limits were enacted, five state supreme courts have declared the limits to be invalid because they arbitrarily limited the rights of injured plaintiffs to recover for their injuries; Kentucky's provision was held to be part of an unconstitutional scheme.

Where caps on awards remain, they are still vulnerable to attack. For example, in Maryland, a governor's commission on medical liability rejected limits on liability as a solution to professional liability insurance cost problems; such limits were regarded as placing the burden of cost control on a small number of the most seriously injured plaintiffs.

Caps on awards may be one of the most effective tort reforms in reducing their size.

(6) **Periodic payment of damages.** Seventeen states have passed statutes which require or permit courts to award damage payments periodically, rather than in a lump sum. Under these statutes, courts specify that losing defendants must pay medical expenses as they are incurred, rather than speculating on the total future costs and awarding a lump sum. Criticism of lump-sum awards has been that where a plaintiff dies earlier than predicted, the heirs may receive a windfall from the portion of the award based on future damages, or the plaintiff may squander funds needed for future expenses.

The biggest battle over periodic payment legislation has occurred in California, where the state supreme court first declared the provision unconstitutional, and then a year later, in June, 1984, on rehearing the same case, declared the law valid. California law requires that compensation for future damages awards of $50,000 or more is to be paid in periodic payments. Plaintiffs argued that the law was an un-

Indiana

Indiana's medical malpractice act was the first comprehensive medical liability tort reform package in the nation when it went into effect in 1975. The act established pretrial medical review panels, shortened the statute of limitations, limited physicians' liability to $100,000 per claim, established a patient's compensation fund to pay the balance of awards over $100,000 but not more than $400,000, and limited attorney's fees to 15% of any award from the compensation fund. It did not include changes in the collateral source rule, in evidence or procedural law, or provision for periodic payment.

The act was held constitutional by the Indiana Supreme Court in 1980 in *Johnson v. St. Vincent Hospital*. The plaintiff had challenged several aspects of the act on equal protection grounds. The court agreed that the law's interference with trial by jury, right of recovery, and freedom of contract for medical liability plaintiffs was sufficient to trigger close scrutiny of the act's purposes and effects in relation to the state constitution.

It was unusual for such a strict test to be applied on behalf of medical liability plaintiffs. The stricter standard required that the separate treatment for medical injury plaintiffs must be reasonable, not arbitrary, and rest on some ground of difference having a fair and substantial relation to the object of the legislation, and all similarly situated persons must be treated alike.

The court ruled that the legislature's purpose, to prevent a loss of health care services in the state because of the crisis in insurance cost and availability, justified the law. The act's provisions were a reasonable and non-arbitrary manner of addressing the problem. The court dealt specifically with challenges to the attorney fee controls and medical review panels, finding each to be a valid and reasonable limitation on plaintiffs' rights.

Indiana's experience is widely regarded as a success story, since the act has worked well and all potential constitutional challenges to it seem to have been decisively dealt with in the *Johnson* case. Two constitutional challenges to the patient's compensation fund thus far have been rejected by state appellate courts. Although there has been some criticism that the fund system and review panels have produced larger awards than expected, insurance premiums in the state have remained moderate, despite a steady increase in the number of claims filed.

TORT REFORM PROVISIONS

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan	
Ad Damnum	1	1	1	1	1		1		1	1	1		1	2	1	1	1	2	1	1	1		
Arbitration	1	1			1					1			1					1	5			2	
Attorney Fees			1		1	1		1	1		1	5		2	1	1					1		1
Awarding Costs						1			1				1			1						2	
Collateral Source		1	2		1			1	2			5	1		2	1							
Expert Witness								1	1			2						1					1
Limits on Liability					1							5	3	2			4	1					
Patient Compensation Fund						6			2		1		1	2		1	3	2					
Periodic Payment	1	1		1	2			1	1				1			1					1		1
Pre-Trial Screening Panel		1	2	1			1	1	3		1	1	3	2		1		2	1	1	2		
Res Ipsa Loquitur		1			1			1	1				1										
Statute of Limitations	2		1		1	2		1	1	1	1		2	2	1	2	1	1	1	1	1	1	
Special Statute of Limitations for Minors	2		1		1	1		1						2		1		1		1	1		
Standards of Care	1	2	1	1				1	1			1						1				1	

EXPLANATION OF CHART

1. Provision exists
2. Provision found constitutional by highest state court
3. Provision found unconstitutional by highest state court
4. Provision not severable from an act found unconstitutional by highest state court, although provision not specifically reviewed by the court
5. Provision has been repealed or has sunset
6. Provision exists but not in effect

constitutional violation of equal protection and due process, thus an impermissible limitation on their right to redress for injuries. The NORCAL Mutual Insurance Company, a Northern California physician-owned insurance company, states that the periodic payment provision of the state's liability reform act has saved the company about $2 million.

Therefore, periodic payment provisions may lessen professional liability costs because insurers can fund them at a substantially lower cost than a lump sum payment and savings can be passed to providers in the form of lower professional liability premiums or at reduced rates that may translate into lower fees for the patient.

Other tort reform measures have focused primarily on the procedural or evidentiary structure of trials, with little noticeable effect. For example, 12 states have abolished the res ipsa loquitur doctrine, which permits a plaintiff to argue that under certain circumstances specific injuries are presumptively the result of negligence on the part of the physician or hospital; the defendant must prove that negligence did not occur. However, abolishment of this doctrine does not appear to have had a measurable impact on the number or severity of liability awards against

Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
	1	1		1		4		1	1	1		1				1			1	1	1			1		1	
											5	1						1				1	1				
				2		3	1		1				1	1	4	5			1					1		1	1
				1		4									1	5											
				2		3			1		3	1			3	1		1	1					1			
					1	3						2	1						1				1				
				2		3		1			3	1		1			1	1		1			1			1	
				2				1		1	4			1	1		1									1	1
						3		1			4			1			1							1		2	
		3	2	2	5	1	2	1	1		5	2			3	5			5				1			2	
					1	4					3		1			1			1	1							
1	1	1	1	1	1	3		1	1	1	1	1	1	1		1	1	1	2	1	2			1		1	1
	1	1				3		1	1	1		3				5		1		3	1					1	1
				1	1	4				1	4		1	1					1			1	1	2			

This chart does not include all of the court rules that affect these provisions.

Data source: AMA Division of Legislative Activities, Department of State Legislation.

physicians. Similarly, changes in the requirements for approval of expert witnesses or in the standard of care required for physicians defending themselves against negligence actions have been approved in many states, but with little apparent effect.

Moreover, where these changes in evidentiary or procedural law are limited to cases involving medical liability, they are vulnerable to constitutional attacks. Such tort law changes are widely regarded by the legal profession as "special interest" legislation that is not likely to survive. As University of Pennsylvania law professor Arnold J. Rosoff said in testimony to Congress in July, 1984, such "doctors' legislation" is one-sided and unfair, since it is intended "simply to make it harder for aggrieved patients to sue and recover for their injuries."

In general, the tort reform legislation of the middle and late 1970s has survived in some states but has been and remains vulnerable to attack in other states. Some laws are not likely to face constitutional tests for some years. In addition, trial lawyers are beginning to organize and mount aggressive attacks on some of the earlier reforms; already, 12 states have repealed or let expire some of the reforms of the previous decades, at least partly as a result of trial lawyers' lobbying.

Tort reform legislation that applies to all types of torts may be more likely to survive a constitutional challenge. However, the national awareness of the need to contain health care costs and the unique nature of medical services, such as reliance upon sophisticated new technology and the fact that every patient is different, makes a strong argument for reform that specifically applies to the medical profession.

New Hampshire

In 1977, the New Hampshire legislature approved one of the most comprehensive professional liability reform packages in the nation, including limits on liability, periodic payment provisions, attorney fee regulations, abolition of the collateral source rule, and changes in rules regarding statutes of limitation, expert witnesses, *ad damnum* clauses, *res ipsa loquitur,* and awarding of costs.

In 1980, the New Hampshire Supreme Court invalidated the entire act in *Carson v. Maurer.* The consolidated appeal challenged several sections of the act on equal protection grounds. The court determined that the right to sue and recover for injuries was not a "fundamental right" under the constitution, but was important enough that the same standard of review should be applied to the statute in question. That is, was the statutory classification (medical liability claims versus other kinds of cases) reasonable, not arbitrary, and actually based upon a difference having a "fair and substantial" relation to the purpose of the legislation? The court stated that law must be set up so that all similarly situated persons are treated equally. This standard was the one applied by the Indiana supreme court in the *St. Vincent* case.

The court then declared each challenged section of the statute to be unconstitutional. Attorney fee limits, abolition of the collateral source rule, expert witness qualifications, limitations on non-economic damages, periodic payment of damages, and changes in the statute of limitations were all unconstitutional, primarily because they were unfair burdens on medical liability plaintiffs.

All other sections of the act were also declared invalid, despite the presence of a "severability clause." The court reasoned that the legislature had intended to create an entirely new and separate comprehensive system of recovery for medical liability claims. Therefore, the valid provisions of the act could not be separated from the invalid provisions, and the entire act was declared unconstitutional. Included in the provisions declared valid but struck down were abolition of the *ad damnum* clause, reforms in the standard of care rule, evidentiary changes, and provisions awarding costs to defendants in frivolous cases.

The effect of the decision was devastating. Fortunately for New Hampshire physicians, the state has not been a hotbed of liability lawsuits and juries are regarded as conservative. According to Jury Verdict Research, Inc., the state is one of only four (the others are Maine, Idaho, and South Dakota) that has not yet had a medical liability verdict of $1 million or more.

TORT REFORM GLOSSARY

Ad damnum clauses - The *ad damnum* clause is that part of a plaintiff's initial pleadings which states the amount of monetary damages and other relief requested by the plaintiff in a court action. Most of the legislation on this subject provides for the elimination of the *ad damnum* clause altogether; legislation also often provides that the defendant be apprised of the precise amount sought by the plaintiff through the normal course of pre-trial discovery.

Arbitration - Arbitration statutes relate to voluntary procedures whereby patients and health care providers may enter into written agreements for the submission of any medical liability claims to binding arbitration. This procedure is an alternative to and in lieu of trial by jury. This procedure provides for limited judicial review of the arbitration decision.

Medical liability claims can currently be arbitrated in at least 30 states under the general arbitration statutes in those states. The chart only lists those states with arbitration legislation specifically for medical liability claims.

Most of the medical liability arbitration statutes provide that written arbitration agreements may cover present and future medical injury claims. All of the statutes generally provide that a person's right to treatment shall not be prejudiced in any way by the decision whether or not to enter into an agreement for arbitration of medical liability claims. In other words, the agreement must truly be voluntary to be binding. Also, most statutes which permit arbitration agreements to cover future medical injury claims provide for a certain period of time, either following execution of the contract or provision of the services, in which the patient may reject the arbitration agreement.

Attorney fee regulation - The most common arrangement for payment of plaintiff attorney fees in medical liability cases is the "contingent fee." Under this type of arrangement the attorney receives as his fee an agreed upon percentage (commonly 30% to 50%) of any final award or settlement made to the plaintiff.

Legislation enacted during the last few years regulating attorney fees in medical liability cases has taken several different approaches: a sliding scale for the plaintiff attorney fees in terms of a percentage of the award; court review of the proposed fees and approval of what it considers to be a "reasonable fee"; or limiting attorneys' fees to a certain percentage of the amounts recovered by the plaintiff.

Awarding costs, expenses and fees - A few states have provisions designed to deter the pursuit of frivolous medical injury claims. These statutes generally provide that where one party to the action has been found to have acted frivolously in bringing the suit, the party may be found liable for payment of the other party's reasonable attorney and expert witness fees and court costs. These provisions differ from the usual civil trial situation in which payment for attorney fees and expert witness fees are normally paid by the party who incurs them.

Collateral source provisions - The collateral source rule is a rule of evidence that prohibits the introduction into evidence at trial of any indication that a patient has been compensated or reimbursed for the injury from any source other than the defendant.

Legislation modifying the collateral source rule has taken several approaches: permitting consideration of compensation or payments received from some or all collateral sources; requiring the mandatory offset against any award in the amount of some or all collateral source payments received by the plaintiff; or allowing the defendant to introduce evidence of the plaintiff's compensation from collateral sources. The jury is instructed to make a mandatory reduction of the award for economic loss by a sum equal to the difference between the total benefits received and the total amount paid by the plaintiff to secure such benefits.

Expert witness - Expert witnesses are required to explain many of the complex and difficult issues in a medical negligence case. Legislation affects the qualifications and use of expert witnesses.

Limits on liability - Some states have enacted legislation that limits the liability of defendants in medical liability lawsuits. These statutes limit liability in one of several ways: limiting recovery of a particular type of damages; placing an absolute cap on the amount of damages recoverable; or placing an absolute cap on physician liability under a patient compensation fund.

Patient compensation fund - A patient compensation fund is a governmentally operated mechanism established to pay that portion of any judgment or settlement against a health care provider in excess of a statutorily designated amount. A fund may pay the remainder of the award or it may have a statutory maximum (e.g. one million dollars).

Patient compensation funds are generally funded through an annual surcharge assessed against health care providers, with such surcharge often being a specified percentage of the provider's annual insurance premium. Patient compensation funds are also known as "excess recovery funds."

Periodic payments - In most states, unless otherwise agreed on by the parties or mandated by the court, judgments can only be lump-sum awards. Under a periodic payments system, the payments are made over the actual lifetime of the plaintiff or for the actual period of disability.

Pre-trial screening panels - Pre-trial screening panels are prerequisites to trial. Procedures for panels usually require a mandatory pre-trial hearing to be conducted by a panel comprised of members as dictated by statute. In some states the pre-trial hearing is voluntary. The composition of the panel and its scope of inquiry vary greatly from state to state.

All statutes establishing pre-trial screening procedures provide that the panel's decision is not binding on the parties and that it does not preclude a plaintiff from initiating a lawsuit. Although some states permit the decision of the panel to be introduced into evidence in a subsequent lawsuit, the panel's decision is not binding upon a judge or jury.

Res ipsa loquitur - *Res ipsa loquitur* ("the thing speaks for itself") is a common law doctrine which applies when a plaintiff can demonstrate that the injury occurred while the instrumentality causing the injury was under the exclusive control of the defendant and which, if operated in a non-negligent fashion, does not normally cause injury. In recent years, a number of state courts have expanded the application of *res ipsa loquitur*, and increased the effect of its applicability from that of a mere inference to that of a presumption, which if not rebutted, will allow the jury to reach no finding other than liability.

Legislation enacted in several states has codified the doctrine in regard to medical liability cases by delineating those circumstances when the doctrine may be applied, such as when a foreign object has been left in a body or the patient has suffered radiation burns. However, these statutes have sought to make it clear that the mere fact of injury is not sufficient to invoke the doctrine.

Standard of care - The standard of care in a medical negligence action is that level of care to which a health care provider is held accountable to a patient, and is based upon the prevailing level of care practiced within locality (community, state, or national).

Statute of limitations - A statute of limitations is a law that bars a cause of action after the expiration of a specified time period. In many states the statute of limitations for medical liability actions begins to run only upon discovery of the injury. Injuries may be discovered several years after the treatment was provided, so the time period for filing an action may be uncertain. Some states have sought to eliminate the "long tail" by placing an absolute maximum time period within which medical liability suits may be brought. An exception to the time period is provided in some of these statutes where foreign objects are left in the body, or where the health care provider has fraudulently concealed the fact of injury.

Most state statutes of limitations provide that if an injury is incurred by a minor, the statute is tolled (i.e., stops running) on the minor's cause of action until he reaches the age of majority. Changes in the statute of limitations for a minor's actions usually provide that the statute will begin running prior to the age of majority.

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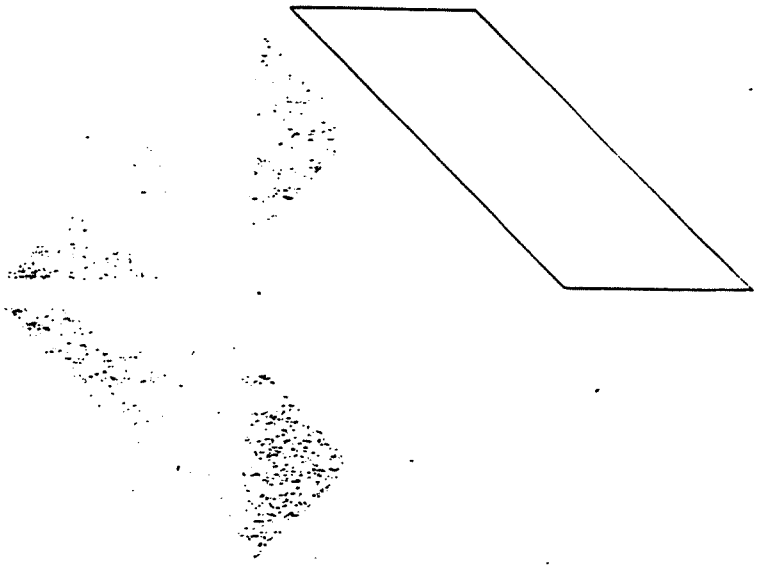
Professional Liability in the '80s

Report 3



American Medical Association
Special Task Force
on Professional Liability
and Insurance
March, 1985

AMA Special Task Force on Professional Liability and Insurance

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Dear Colleague:

The professional liability issue poses one of the most critical problems today for the medical profession and the public. The steep costs of buying protection and the growing threat of suits worry all of us.

The AMA has been working on the problem for some time. In the mid-seventies it drafted the tort reform legislation which served as a model for the legislation that was passed by many states. Since June, 1984, a special AMA Task Force on Professional Liability and Insurance has been at work intensifying and broadening the scope of the association's efforts to deal with the continuing professional liability crisis.

Effective action on this issue requires allies. The first step toward enlisting allies is to prove that a serious societal problem exists—not just a physician problem. At the direction of the Task Force, the AMA has developed the most current statistical information on claims, premiums and costs to society and presented it in a first report on "Professional Liability in the '80s", published in *American Medical News* in October, 1984.

It is also necessary to carefully determine which approaches work and which do not work. Much reform has been tried. In a second Task Force report in *AMN* in November, 1984, the experiences of professional liability insurers were presented, together with a detailed analysis of those tort and judicial reforms that, based on nearly a decade's experience, have proven most effective in reducing claims and costs.

In this third and final Task Force report, there are two major elements: (1) a summary of a roundtable discussion in which several leading physicians and attorneys suggest solutions to the professional liabilty dilemma, and (2) the AMA Task Force's recommendations for bringing the professional liability problem under control. These recommendations outline a comprehensive long-range approach to professional liability issues. The AMA Board of Trustees and House of Delegates will be reviewing those recommendations that require policy determination. Other recommendations can and are being implemented within the framework of existing association policy. The federation must work diligently to carry them out.

In the meantime, there are steps that every individual physician can take.

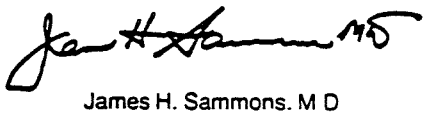
He or she can begin by improving communications with patients and by developing solid physician-patient relationships. It is increasingly apparent that one of our best protections against a professional liability lawsuit is the creation and maintenance of these good relationships.

These are difficult times for patients, too. There are increasing pressures for everyone to cut costs, and to push patients to assume more responsibility for their own health. Physicians should be the patients' strongest advocates in this effort.

Finally, all of us must strive for continued scientific excellence, practicing both the art and the science of medicine.

Please read this document carefully. Professional liability is a problem we all can—and must—do something about. Let's tackle this effort together.

Sincerely,



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Looking for answers: roundtable discussion

In November a distinguished panel of physicians and lawyers assembled in Chicago for an intensive three-hour discussion of the professional liability problem in medicine and some possible ways to minimize it. Each participant brought special insights and pertinent experience to the session:

—Brad Cohn, MD, San Francisco, is chairman of the board of governors of the Medical Insurance Exchange of California, a northern California physician-owned company with ties to several medical societies. A pediatrician, Dr. Cohn is a former president of the California Medical Association and an AMA delegate. He chaired CMA's Tort Reform Advisory Committee in 1983.

—Timothy T. Flaherty, MD, Neenah, WI, is a practicing radiologist and clinical assistant professor of radiology at the University of Wisconsin Medical School. He is past president of the Wisconsin State Medical Society and is active in its Physicians Alliance. He is air surgeon for the Wisconsin Air National Guard.

—Susan E. Loggans is a successful Chicago trial lawyer whose firm, Susan E. Loggans & Associates, handles a large number of medical professional liability cases. She received a JD degree from DePaul University in 1974. Currently chairman of the Aviation Law Section, Association of Trial Lawyers of America, she is a pilot herself. She has served on both the Tort Litigation Section and Medical Malpractice Subcommittees of the Chicago Bar Association

—Rhoda M. Powsner, MD, JD, Ypsilanti, MI, is a practicing cardiologist and clinical instructor in the Department of Internal Medicine, University of Michigan Medical School. She received a law degree from the University of Michigan in 1980. Dr. Powsner is editor of the Washtenaw County Medical Society Bulletin and subcommittee chairman, Michigan State Bureau of Insurance, Arbitration Advisory Committee.

—Raymond Scalettar, MD, Washington, D.C., is a practicing internist. He is vice chairman of the board of directors of the National Capitol Reciprocal Insurance Company, a physician-owned insurance carrier linked to the medical society, and chairman of AMA's Committee on Professional Liability. Dr. Scalettar serves on the AMA Council on Medical Service and also is an AMA delegate.

Leading the discussion was **James H. Sammons, MD,** AMA's executive vice president, who chairs the Association's Special Task Force on Professional Liability and Insurance. Here is a summary of what transpired.

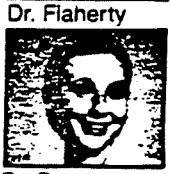
Dr. Sammons—The medical professional liability problem today is very real. More claims and suits are being filed against physicians and hospitals every year and the costs of settlements and awards continue to rise dramatically. The problems of a few physician-owned companies have multiplied in recent months.

Unless we start right now to find some solutions, we will see another full-scale professional liability crisis that could be even more serious than the one in the mid-1970s. Workable answers must be found soon or some physicians will curtail high risk procedures or quit medicine entirely, and the quality as well as the access to medical care will suffer and medical costs will continue to increase.

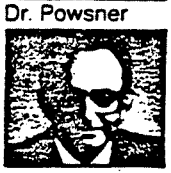

Dr. Cohn


Dr. Flaherty


Ms. Loggans


Dr. Powsner


Dr. Scalettar


Dr. Sammons

Somehow we must find some reasonable ways to resolve legitimate claims equitably, to discourage claims without merit, and to minimize the possibility that a patient will be harmed in the process of receiving medical care. The ultimate solutions must be ones that not only physicians and hospitals, but society can afford, since ultimately, it is the public that absorbs these growing costs.

You have heard physicians angrily blame lawyers for the professional liability problem and lawyers retort that the only reason for suits is what they call "medical malpractice." Lawyers also allege that insurers inflate premiums to reap great profits, thus creating an artificial crisis. You also have heard physicians, lawyers and insurers all charge that the public is at fault for being overly litigious and greedy. If we are going to get a handle on this problem, perhaps we should begin by talking about the degree to which each of these elements in society is responsible.

Dr. Cohn—I'll answer that question. Attorneys contribute greatly to the problem and there are many reasons why. The opportunities today for winning million-dollar awards without a great deal of work on their part makes filing medical liability suits very attractive to plaintiffs' lawyers. At the same time, there is no doubt in my mind that the way in which we pay defense lawyers also contributes to the costs associated with professional liability.

Nor are physicians blameless. Medical malpractice does occur.

Some physicians complain that they are held to an unreasonable standard of care in diagnosing and treating patients. That is not the problem. A physician is not held to the standard of the majority of physicians, but to the standard adhered to by "some" physicians. Then why are there more suits?

Clearly, physician-patient relations have changed. Lack of communication is a real cause of litigation. Physicians today are trained differently and tend to rely more heavily on tests and technology. This new technology itself poses new liability problems. We don't know what unforseen problems could develop in five or ten years from use of some new technologies.

Certainly the public holds unrealistic expectations of what physicians sometimes can do. When the result does not match those expectations, not because of professional negligence, but because of factors outside the physician's control, a patient may express disappointment or disillusionment by filing a claim.

We all are concerned about increasingly expensive premiums for liability insurance. We as physicians and lawyers as well must understand that the insurance industry is a cyclical industry.

Physician-companies were formed to provide insurance availability and they were very successful. Interest rates were high and claims did not immediately materialize because of the "long tail." Some commercial carriers once again sought a larger share of the market. Now investment income is being reduced as interest rates fall. Losses are mounting as claims increase.

We recently saw a physician-company approach the brink of insolvency and six other major physician-companies have financial problems. These companies have the money to pay the growing losses, but the losses are outstripping premium and investment income.

Dr. Scalettar—The liability insurance industry is capital intensive. It was undercapitalized in 1975 and it is still undercapitalized. Physicians' insurance premiums probably will have to increase even more.

I agree that the blame for the medical liability problem must be shared. We as physicians must recognize that malpractice does occur and make awards when appropriate. The problem is that many inappropriate claims are being filed as lawyers envision the possibility of huge awards. There is a growing awareness, however, that the cost of medical liability is too great for society to bear. The lawyers actually may kill that legal "Golden Goose."

Physicians are at fault, too. As a group, physicians are technologically smart, but sometimes they don't practice smart. Just to cite one or two examples, physicians tend to congregate in big cities where patient rapport sometimes is poor. They don't always keep good records which works against them when a claim or suit is lodged.

Physicians must understand that what sometimes motivates a patient to sue is often secondary to the apparent reason someone files. Sometimes that reason is avarice; sometimes it is a desire for a quick settlement. And sometimes it arises from a desire to get even with a physician a patient thinks has harmed him.

Dr. Powsner—I, too, agree with what has been said. The public IS more litigious today. The rise of malpractice litigation has paralleled the expanding scope of the health care industry and new technology. What is hard to separate out in claims is what is real malpractice and what is a medical maloccurrence without any negligence involved. This is something we must examine carefully. We all know that some of the worst examples of malpractice never result in suits.

Ms. Loggans—As a plaintiff's lawyer, I must ask: is the problem high insurance premiums for physicians or is it malpractice in general and its resolution? We plaintiffs' lawyers believe that the insurance industry is causing physicians' premiums to rise—companies raise premiums without taking into account interest being earned on reserves and make large profits. If this isn't true, as several of you have suggested, then lawyers must be educated on this point.

You obviously feel that plaintiffs' lawyers are the villains in the liability issue. Two kinds of plaintiffs' lawyers handle malpractice suits; those who are highly successful from a financial and practical standpoint in litigating these claims, and those who are seeking a quick settlement and a quick buck. Reputable plaintiffs' lawyers aren't interested in quick settlement cases. So the quickest way to end the problem of these legal "fishing expeditions" is for insurance companies to adopt a policy of defending every defensible case.

As a plaintiffs' lawyer, I have two real problems in this field of litigation: identifying the legitimate cases and doing so fast enough.

People think a long time about filing a claim against a physician. Sometimes they don't come to a lawyer until a day or two before the statute of limitation runs. Getting the medical records and getting a review on the merits of the case in such a short time is difficult. So I must make a personal decision to file or not to file. Getting a medical review is not a problem. There is no longer a conspiracy of silence in medicine. But getting a quick review IS a problem.

Yes, people are more litigious. But why do they sue? Lack of communication by physicians probably is the primary reason that patients come to a lawyer's office. They rarely come in with just one complaint, but rather, with a long list of them. So when a physician sees a number of completely irrelevant screw-ups during the care of a patient, he or she should say, "This is a potential claim."

Dr. Powsner—What Ms. Loggans says is fine and she apparently is an ethical practitioner. But rushing to file a suit two or three days before the statute runs is nonsense. The bar should make every attempt to see that such frenetic activity does not occur.

Dr. Flaherty—There is no question that it is difficult to separate the maloccurrences from the real malpractice. I come from a small state where we have had a run of fairly large settlements of maloccurrences. In one instance, a baby was delivered with a shoulder injury. The case went before one of our mandatory Wisconsin formal hearing panels and the panel rendered a 5-0 decision in favor of the physician. The family went on to court and there was a $425,000 award. No one would argue that there was a bad result, and perhaps society should compensate in some way, but unfortunately, what happened was labeled malpractice. To a physician, being sued in such an instance really hurts. The stigma persists for a long time.

In Wisconsin a fair number of frivolous suits are filed. In 1983, 31% were tossed out by hearing panels as being non-meritorious. This is a real problem. It mucks up the system, slows it down. We would like to stop this by requiring a certificate of merit to file a suit.

Sometimes several suits are filed against the same physician. The problem is that our medical society can't identify the physicians who are generating multiple claims involving actual negligence because settled claims are quiet claims. As a profession, we must identify aberrant practice and eliminate it; we cannot tolerate or afford such physicians in our midst.

Of 162 physicians found negligent, none have lost their licenses. That is a poor reflection on our state medical examining board.

Dr. Sammons—State medical examining boards have real reason to fear being sued by physicians they seek to discipline. Some boards have had sizable judgments brought against them when they tried to remove the license of a questionable practitioner. Often, when a board has done so, the courts have returned that license to the physician.

As an arm of state government, a licensing board clearly has the responsibility to weed out the bad actors in the profession. What troubles me is that we don't really have a clear definition of what constitutes actual malpractice. Did a physician deliberately do something wrong, knowing it was wrong? Or was the incident a maloccurrence—an unforseen or unavoidable situation in which the physician did the best he could?

Dr. Flaherty—One settlement against a physician doesn't equate with malpractice. But a recurring number of suits sometimes does indicate aberrant practice. Right now, we just can't get at such individuals to prevent them from doing further harm.

Ms. Loggans—Lawyers have a similar problem and would not quarrel with anything that can be done to help weed out the undesirable attorneys. There are many who have no idea what they are doing. They create problems for the rest of us. Like physicians, we just haven't found an effective way to eliminate them yet.

Dr. Sammons—I agree that this is a problem that should be addressed. In addition to policing our own ranks, what other approaches should medicine consider that would be effective in curbing the expanding medical malpractice problem?

Dr. Scalettar—Passage of tort reform obviously is one approach. States that have enacted tort reform indicate that some of these provisions may help ameliorate the problem: collateral source offsets of awards, caps on awards, caps on noneconomic damages, structured settlements, and structured contingency fees. These are some major tort reform concepts. There are, of course, others.

Dr. Powsner—In Michigan we accomplished some tort reform in 1974 and 1975 and now we are looking at proposals for caps on awards and for structured settlements. The contingency fee was moderated by the Michigan Supreme Court in the mid-'70s but the change has quietly gone by the boards. Frankly, we feel that there isn't interest in tort reform right now because plaintiffs' lawyers strongly believe that individuals have the right to have their wrongs redressed in court. Personally, I think some tort reforms are needed.

Dr. Flaherty—We have an 18-point program we will propose in Wisconsin, including a certificate of merit to file a suit, a regulated contingency fee, and some other provisions related to the funding of our state primary insurance program and patient compensation fund.

One thing we are going to seek to get through the legislature is a cap on awards. We have a good business coalition in Wisconsin and because some of our larger corporations now appreciate the costs of the liability system, there is a real concern out there and a desire to modify it. So we are going to make a legislative push.

Ms. Loggans—No plaintiffs' lawyer that I know would accept a cap on awards. Lawyers would never agree to a situation in which there is not sufficient potential compensation for an injured party.

I would like to talk for a moment about contingency fees to which so many of you raise objections. There is no doubt that if the contingency fee did not exist, a majority of plaintiffs' lawyers would not be involved in malpractice litigation. Ours is a very expensive kind of legal practice. We must pay many costs up front for a client. In the current tort system, if we cannot make substantial fees on one case, we won't be able to afford to do business in the average situation. So the contingency fee is absolutely imperative to our financial existence.

But the mere fact that an attorney makes money from prosecuting a case should not reflect negatively on the fact that a person has a valid claim.

Dr. Powsner—I am one of those people who does not think the contingency fee is all bad. I feel it does help weed out some of the non-valid claims.

Dr. Flaherty—We all have our wish list and I would like to see those frivolous suits or non-valid claims, which constitute about one-third of those filed in our state, wiped out. As for a proposal to establish a sliding scale of contingency fees, I don't think that is going to happen until the year 3000.

Ms. Loggans—You also express favor for structured settlements in cases with large awards. Historically, we have used structured settlements only for about five or six years. On balance, the record shows we haven't done a good job for our clients when we have agreed to them. Even though we use actuaries to help compute future financial needs for clients, lawyers don't favor structured settlements because we don't feel confident about them. In the future, more and more plaintiffs' lawyers will be hesitant to recommend them.

You also express concern about the million-dollar settlements and awards. Let me tell you that in Illinois we believe that a major case of baby brain damage has a settlement value in the neighborhood of $8 million. The cost of litigating the case and the legal fees also must be paid. You may suggest a structured settlement, but many people genuinely feel that they want that award money in a lump sum sitting in a bank, just in case someday a miracle remedy becomes available—even if it is a million-to-one shot.

As for the bad publicity resulting from news stories about these big awards, I for one don't understand why every insurance company doesn't require a nonpublicity agreement as a condition to a settlement.

Dr. Sammons—You have suggested some possible tort reforms that could ease the medical professional liability problem. You have also raised some key questions. Can extensive state-level tort reform be accomplished? And, can it survive the legal challenges that most certainly will be mounted? We have seen so many of these laws struck down by the courts in the last five or six years that it's no wonder that some of us get gun-shy.

Now I'd like to ask you to explore some other options—some alternate methods for handling malpractice claims that might be quicker and cheaper.

Dr. Flaherty—I believe that the panel system in Wisconsin is very fair and works well in resolving claims. There are both informal and formal panels. Even though about half of the people who go before the panels do receive some compensation, there is still a constant, never-ending effort to challenge the system.

Dr. Sammons—Would screening panels help solve the case disposition problem?

Ms. Loggans—A screening panel would be completely acceptable to most trial lawyers if it was advisory only, not mandatory. It is not the concept of the panel, but the technicalities of its execution that creates problems.

Dr. Powsner—Even the lawyers are beginning to wonder if the liability problem has not become so impossible that perhaps they should begin to consider some other kind of conflict resolution system. In Michigan we have a system of voluntary binding arbitration for medical malpractice suits in place. Patients are offered this option at the time they are hospitalized. The system seems to be working quite well. It has survived several constitutional challenges. It works more quickly than the legal system, it's cheaper, and there is far less potential for egregious, arbitrary awards.

One thing we tend to overlook is that society is currently paying the cost for professional liability. How can we devise a system that makes that cost reasonable for society? Personally, I believe arbitration will be utilized more and more in the future. We need to involve business coalitions and the public in efforts to advance the arbitration concept.

Dr. Cohn—I agree that we need to do more than we do now. Arbitration has been studied by the California Hospital Association, but unfortunately the results are not conclusive. A plaintiff must opt for arbitration and attorneys generally advise their clients against it.

Dr. Powsner—In Michigan we are seriously looking at some kind of a no fault approach to medical liability. It would be on the basis of a limited pilot study, carefully controlled and constructed by episode.

Dr. Flaherty—If we propose a no fault approach in Wisconsin, we lose the support of our business coalition. The industrialists and the employers think no fault is like workman's compensation, which hasn't worked well for them.

Dr. Scalettar—There are some basic problems with no fault. It opens Pandora's box because there are so many people working in medicine who could precipitate a claim or suit. It is not like automobile no fault where you are taking basically about two drivers and two vehicles.

Dr. Cohn—Back in 1975 and 1976 when the California Medical Association wondered if it should consider a no fault system, three exceedingly competent physicians did a medical injury feasibility study that clearly showed we could not

afford a no fault system at that time. To the best of my knowledge there has been no update of that study of a modified no fault approach.

Dr. Powsner—We are not talking about an across-the-board no fault approach in Michigan, but a specific tender offer for certain types of serious cases. Such specified offers might apply for only two or three percent of the claims but for the costly claims that represent as much as 70% of the total money expended. It might even be done on a private rather than a state basis.

Dr. Sammons—People in the insurance industry tell me they do not believe that a no fault approach is the answer. There just isn't enough money in the world to pay for no fault.

Ms. Loggans—Historically, no fault, even in auto cases, has had practically no impact on what lawyers do because no fault thresholds are so low. The same thing generally would be true in the medical malpractice area. We would not be accepting the low level cases anyway because they are not profitable.

Dr. Powsner—We are not looking to change the world or turn it upside down. When I say we should "define the limits" of awards for certain very costly kinds of claims, I mean just that. I come back again to the arbitration approach because I believe it has merit. If we reject every possible alternative dispute resolution system at the outset, I don't believe that we ever will solve our liability problems.

Dr. Scalettar—One interesting concept has been proposed by Patricia Danzon, formerly with the Rand Corporation who is now at Duke University. She has suggested the possibility of developing a compensation schedule—not a no fault system—but a kind of relative value schedule for certain types of injuries now being litigated. This compensation schedule would put awards into proper perspective, rather than leaving their determination to the whims of the juries. This may be an idea worth looking at.

Dr. Sammons—Clearly, we have to rethink the professional liability claims resolution structure. That may entail tort reform changes and changes in systems for resolving claims. Most of us probably believe that true tort reform occurs only at the state level, but there have been several proposals at the federal level for addressing the professional liability problem.

One of these bills would establish a mechanism to pay noneconomic damages to Medicare and Medicaid patients, military personnel, veterans and federal employees alleging injury stemming from medical and/or hospital care. If a physician or hospital participates in an "assigned claims plan" and makes a tender offer within six months to pay the net economic loss, the patient could not sue. A state that enacts its own comparable bill would not be subject to the federal no fault provisions. What is the view of this group of such federal legislation?

Dr. Cohn—What I have seen proposed in Congress so far is not a solution. There are other areas we must look to for more positive effects on the liability problem.

Dr. Sammons—The AMA doesn't think that the federal approach as it has been outlined so far is a good idea. The price is high. The ticket always comes encumbered with such elements as federal licensure of physicians, federal certification of physicians and federal control of graduate medical education. Some legislators would also couple the liability proposal to mandatory assignment of physicians' fees in government health care programs. So what are some of those "other areas" we should examine?

Dr. Cohn—I would suggest loss prevention. Remember than 60% of the liability dollars lost arise from approximately two percent of the cases and 70% from about three percent. If we reduced that two percent to one percent, we would reduce losses from 60% to 30%. That would reduce the cost of health care and simultaneously reduce morbidity and mortality for the patients. The trick is to know how to do that.

What we haven't done in terms of our past loss prevention programs is to develop some sophisticated techniques that would enable us to identify just where those major losses are occurring. We must find the commonality in these events and provide proper standards of care for physicians to follow.

Dr. Scalettar—Early in 1985 the Physician Insurers Association of America launched its computerized data-gathering system. This early warning program will be tremendously useful in identifying specific problems that lead to claims.

Dr. Flaherty—The data-sharing is very important to any loss prevention efforts. There are red flags that should go up when certain information is gathered and analyzed. As Dr. Cohn pointed out, we can use this information to improve medical practice patterns and make the process of medical care safer for patients.

Along these same lines, I believe we should stress the importance of developing good patient rapport. As a radiologist, I could get sued because I haven't had the time or taken the time to develop the necessary good rapport with a patient.

Dr. Scalettar—Physicians must develop better communications with patients. A Texas physician recently proposed an interesting idea. Instead of requiring patients to execute informed consent documents before a procedure is done, he says that perhaps patients should have to ask for an "informed request" form to complete. He said that rather than

the physician or hospital asking the patient to provide informed consent to do something, the patient should be the one asking.

Dr. Flaherty—The long-term goal should be to educate everyone about the liability problem, not just physicians but lawyers and legislators and the public. We need more of the kind of educational programs that the AMA, state and county medical societies, specialty societies and hospital medical staffs are conducting.

Dr. Powsner—I, too, strongly urge more education. As for physicians and lawyers, and I am both, ignorance abounds on both sides. If education is undertaken for these professions, it must be appropriately undertaken.

Ms. Loggans—I have two suggestions. First, physicians, especially young physicians, must be told how to avoid malpractice claims. But maybe you are going about the educational task in the wrong way. You learn to avoid malpractice by learning about medicine. But you learn how to avoid malpractice claims by learning about the legal system. A lawyer has to teach you. Medical schools should institute more legal education courses.

In your discussion of loss prevention, you referred to past studies and they all involved closed claims. Think for a moment. Who makes the decision about whether a malpractice claim will be brought? An attorney. We know how to identify good grounds for a potential claim even though we are untrained in medicine. So you don't need to wait years to do an historical analysis of baby brain damage cases. You could assemble a group of plaintiffs' lawyers tomorrow who could tell you immediately what the signs are and what those factors are in the treatment of such infants that precipitate suits.

Dr. Flaherty—While you are talking about birth-related suits, the increasing incidence of these claims has led 30% of the family practitioners in Wisconsin to stop doing obstetrics. They say they can't afford or don't want to pay for the very expensive liability coverage. For many people in rural areas of the state this reduces access to medical care.

Dr. Cohn—Dropping out isn't the solution. In Wisconsin and in other states we should provide a standard of care for physicians who are going to deliver babies—not to try to discourage any physicians from delivering them but to maximize the safety of those babies. If we do this, then we will once again see physicians returning to this presently high risk area of practice.

Dr. Scalettar—On the subject of allied personnel, let me warn you that many other areas in the nation will have to deal with the problems similar to those that are evolving since the Health Facilities Act was passed in the District of Columbia. This act mandates hospital privileges for allied health practitioners of various types. The critical liability question is this: who will be responsible for their medical care? Hospitals must recognize that they will have to set up specific protocols for medical care and for supervising the care rendered by these non-physicians. Otherwise, the entire liability problem within the hospital will go out of sight.

Another point I would like to make is that physicians and hospitals must cooperate more closely to reduce liability problems. There must be a moratorium on cross claims. Here is an area in which arbitration might be useful because cross claims further increase professional liability costs.

In the hospital setting new reimbursement systems—the diagnosis-related groups (DRGs)—will pose new liability problems for physicians. The physician who knuckles under to a hospital administrator and shortens a patient's stay against his better clinical judgment is looking for trouble. Other "gatekeeper"-type reimbursement systems that limit a patient's access to a specialist's care present additional liability risks

Finally, we haven't talked much about the responsibilities of the insurance companies in these efforts to stem the malpractice tide. Insurance companies must assure their financial stability. They must set aside adequate reserves based upon loss experiences and price their policies properly. They must practice sound underwriting. These insurance strategies are very important to the continuing success of these companies and ultimately to the continued availability of professional liability insurance for physicians.

Ms. Loggans—I would like to propose another idea. We need voluntary physician review committees to which a plaintiffs' lawyer could submit a possible claim for evaluation. I would like to submit a claim to such a committee and ask, "Do I have a case or not?" and get a fast, honest answer. I don't want to file if I don't have a legitimate case. I am not saying I would or would not file based upon what the physicians tell me, but I would be interested in their opinions. The positive side is that if I don't file one more person has been taken out of the claims spectrum. The only down side in giving such an opinion would be that occasionally the physicians would have to say "Yes, there is a basis for a suit."

Dr. Cohn—The down side also is that the defense has to divulge its strategy.

Ms. Loggans—Since lawyers defending physicians generally work for the insurers, I think there should be similar voluntary committees of lawyers to whom a physician could go if a suit were being threatened and ask, "What is my exposure and what should my lawyer be doing for me?"

Dr. Flaherty—We have had a series of meetings with the bar in Wisconsin on a number of issues. The conversation always comes

...Since most ...sconsin act as plaintiff ...ense attorneys, we have asked them to provide us with a list of the 10 best ones so we can put them on our side in the liability fight when possible.

Ms. Loggans—You will never completely abolish malpractice. The ...stion is how can we deal with ...legitimate instances and how can we prevent filing of non-legitimate claims, both of which should be dealt with in totally different ways? I agree this can only be accomplished via state-level changes.

However, I honestly believe that malpractice claims as we know them today will exist for only about five more years. I don't believe the system can exist because it is too costly. I think there will be major reforms.

The contingency fe... ...cated or changed an... will make the major d... never want to remove ... someone truly injured ... legal system when nee...

The common goal is t... deliver excellent medical ... and to provide recompens... persons inappropriately w... We must constantly refocus ... attention to that high purpos... work from there.

An action plan to address professional liability problems

Few issues in medicine have generated as much concern among physicians, exacted such high personal and financial tolls from them, or threatened to undermine the practice of high quality medicine as greatly as professional liability.

Efforts to resolve the problem, which reached crisis proportions 10 years ago, have been only partially successful. Now the problem has reemerged in more serious form, precipitating a new crisis that is affecting not just physicians but the entire nation.

It is time to stop arguing about whether or not a crisis exists and f... whom it exists. It does exist and it affects everyone. It plainly makes n... sense for one-quarter of the obstetricians in Florida to be forced to stop delivering babies. It makes no sense for a renowned surgeon in New York to have to pay an $80,000 a year insurance premium to practice

Action plan of AMA's Special Task Force on Professional Liability and Insurance

Four major areas are targeted in the action plan outlined in this report with specific recommendations in each one:

Education and Community Action

Public education

Professional education

Patient pamphlet

National advocacy program

Coalition effort

Expanded clearinghouse

High priority to professional liability issue

Legislation: State and Federal Tort Reform and Judicial Reform

A federal incentive program to encourage state reforms in two areas:

—Reforms to refine the method of awarding damages, including limits on non-economic damages, no punitive damages, itemized jury verdicts, structured settlements, no collateral source rule, and restrictions on attorneys' contingency fees.

—Reforms to improve the liability resolution system, including mandatory pretrial screening panels, improved standards for expert witnesses, modified statutes of limitations, affidavits of non-involvement, minimum standards for suits, penalties for frivolous suits; elimination of barriers to physician countersuits; and availability of binding, voluntary arbitration.

Legislative assistance to states

Continued study of alternative resolution systems

Defense Coordination

Hotline for physicians and attorneys on professional liability questions

Information from panel of defense attorneys retained by AMA

Liaison with defense organizations

Legal education courses for physicians

Risk Control and Quality Review

Clearinghouse of information

Practice management programs

Collection and analysis of information on quality care and implementation of findings

Use of AMA's Office of Education to track disciplinary actions against physicians by states

Expansion of peer review and self-regulation activities

Strengthening of state licensing boards

Periodic roundtable discussions on professional liability

Continued fight to retain high quality medicine in cost-sensitive environment

medicine. It makes no sense for insurance companies to pay more money to lawyers than to injured persons.

The crisis will not abate without immediate, definitive action. In fact, it will worsen as sweeping national efforts to control medical costs increase and physicians are pressured to do fewer diagnostic tests, to provide reduced amounts of care, and to hospitalize patients less.

The problem will magnify as the trend to "mass-produced" health care proliferates and patient care becomes more impersonal. It will heighten as the practice of medicine becomes increasingly complex and sophisticated and as physicians use new technologies that can save more lives but present far more risks. It will grow as Americans become increasingly quicker to sue for every real or imagined wrong. It will escalate as professional liability insurers come closer to the brink of financial insolvency in the face of multiplying claims that carry dramatically higher pricetags every year.

It should be very clear after reading the first two reports of AMA's Special Task Force on Professional Liability and Insurance that the professional liability crisis does not arise from a single source and there is no single, easy solution. "Quick fixes" have not worked in the past and will not work now. What can work—and what must work— is a broad-based, many-faceted approach.

AMA's Special Task Force was created to evaluate the professional liability problem and, with the help of all the other medical organizations working on the problem, to develop a full-scale effort to come to grips with it.

The Task Force has framed the following recommendations which fall into four major areas:

—Education and community action
—Legislation
—Defense coordination
—Risk control and quality review

Some of these recommendations will require policy action by the AMA; others can be implemented within the framework of existing policy. The goal of the Task Force is to coordinate, intensify, and direct many wide-ranging Association efforts that will alleviate the on-going professional liability crisis.

Education and community action

The following recommendations are made in this area:

(1) **Take the professional liability issue to the public.** The public has a vital stake in the professional liability problem, from the standpoints of cost, quality and access to medical care. The Task Force recommends that an intensive information campaign be conducted to improve public understanding and stress the need for legislative, judicial and other actions.

(2) **Arm state, local and specialty medical societies with information to carry the professional liability message to the public.** The Task Force will supervise the preparation of comprehensive informational materials, including background data, fact sheets, speech outlines and speeches, sample editorials, letters to the editor, display materials and other information. The materials will be distributed throughout the federation and on request to individual members who will serve as advocates on this issue.

AMA will also hold periodic briefings on professional liability activities for state, county, and specialty societies. The AMA's Washington Office will brief medical specialty organizations' Washington representatives. The innovative and aggressive risk management programs which the societies have developed deserve wide publication and should be incorporated into the broad-based national effort.

(3) **Publish a pamphlet for individual patients.** The pamphlet for patients will explain how the professional liability issue affects their own medical care, its cost, and its availability and will foster realistic expectations about medical care. It will be made available in quantity for distribution through physicians' office

(4) **Develop an effective advocacy program on the professional liability problem.** Physicians must have allies on this issue. An AMA action team composed of officers, trustees and staff representatives will carry the professional liability message to organizations and individuals that are, or should be, concerned with the issue. The exact nature of the professional liability crisis, objectively and persuasively documented, must be presented at every appropriate forum. Business groups, labor organizations, public interest groups, legislators, legal organizations, judicial conferences, academic centers, the media, insurance groups, state and national agencies, organizations such as the American Association of Retired Persons (AARP), and others will be addressed at every opportunity. The reports of the Special Task Force will be bound into one volume and distributed throughout the nation. In short, the AMA will intensify its role as the physician's national spokesperson on this issue.

(5) **Enlist the cooperation of health care coalitions composed of opinion leaders and policy makers to address the professional liability problem.** The support of health care coalitions, involved in efforts to contain health care costs by reducing the professional liability problem, will be recruited. The Task Force will develop a handbook with the AMA's Department of Health Care Coalitions for this purpose. The AMA will elicit support from groups such as the Chamber of Commerce, the Business Roundtable, and other professional and civic groups.

(6) **Expand the AMA's clearinghouse role.** The AMA can also fulfill an essential role as a national clearinghouse, assembling data, legislative information, materials from other organizations and other pertinent materials to share with physicians, medical organizations,

coalitions, legislators, policymakers and other interested individuals and groups. Plans to share information will be effected with organizations such as the Physician Insurers Association of America, the National Association of Insurance Commissioners, commercial insurance carriers, research centers such as the Rand Corporation, and individual researchers actively involved in studies of professional liability. The Task Force will prepare and distribute to the federation, specialty societies and other groups, regular reports on new data, programs and developments.

(7) **Maintain professional liability as a critical priority.** The Special Task Force, with the resources of the AMA at its disposal, will be a permanent part of the AMA professional liability program. The research effort will not stop with the work already done and published by the Task Force. The Association's Center for Health Policy Research will focus on the effort to develop and publish reliable and current information on professional liability. AMA's Committee on Professional Liability will continue its studies of the costs and effects of professional liability on physicians, patients and the nation.

Commentary: An effective national information campaign is essential to generate action on the professional liability problem. The perception persists, perpetuated by those who stand to gain most from the existing system, that there is no professional liability crisis, only a "pocketbook" concern of physicians. A similar misconception, reinforced by repetition, is that insurance companies are accumulating huge profits at physicians' expense and ample funds are available to pay claims. Those who hold these misconceptions also are convinced that physician negligence—"malpractice"—is the only reason for the professional liability crisis.

These views are wrong and must be refuted. Objective data on the numbers of claims, severity of claims, rapidly climbing cost of insurance premiums, and growing losses of professional liability insurers document a crisis far more serious than past ones. For every premium dollar earned in 1984 in the professional liability insurance industry, $1.10 was paid out just for actual losses incurred, *Best's Insurance Management Reports* found in December 1984. When loss adjustment expenses and overhead costs are added in, the combined ratio rose to approximately $1.66 for every $1 of premium last year.

The public pays for a large portion of professional liability costs in pass-throughs for physicians' increased overhead, in the enormous costs of defensive medicine—the ordering of tests and procedures primarily to protect against lawsuits—and in the staggering waste of an inefficient legal system. The public also pays for a system that is encouraging, almost forcing, physicians to avoid high risk patients and specialties.

Physicians pay, too, not just in high insurance premiums, but in the personal anguish of claims and suits filed, especially if these actions are without merit. It is often not how physicians practice, but the fact that they practice ever closer to the edges of technological frontiers that place them at greater legal risk. Physicians are among the nation's best and brightest—highly educated, motivated for the most part by humanitarian concerns, yet held accountable for complex judgments made under pressure of life-and-death considerations. No other professionals are held to such standards. Though negligence does occur, physicians are too often sued for adverse events—bad results—beyond their control. Even when negligence exists, the system for compensating patients is being crushed by almost limitless awards and the costs of determining liability.

The realities of the professional liability situation must be brought to the public, to legislators, to lawyers, and to those in policy making positions. The record must be set straight—the situation put into proper focus.

Legislation: state and federal tort reform and judicial reform

A major thrust of the AMA Task Force plan is to achieve legislative and judicial reform that will:

—Assure fair and adequate compensation for injuries arising from medical negligence

—Resolve professional liability claims speedily and efficiently

—Recognize the unusual vulnerability of physicians providing medical care

—Provide a reasonable degree of protection from suits without merit so that access to care and costs of care are not negatively affected

The following recommendations are made in this area:

(8) **Propose to the AMA's Council on Legislation and Committee on Professional Liability a federal incentive program to encourage state tort reforms.** Ten years have passed since the initial movement to enact tort reform. Virtually every state passed some form of tort reform legislation. Some reforms were not as effective as hoped. Some were declared unconstitutional. Experience has indicated which reforms work and which do not work. The design of many of the reforms can be improved so that they will be more effective and will withstand constitutional challenge.

The purpose of the reforms is not to shield physicians and to reduce their insurance premiums, but to cut the waste and unfairness from a legal system that has become outrageously expensive and imprecise in determining liability and assessing damages.

The Task Force proposes federal incentive legislation to ease the crisis. The legislation will not impose a federal program on the states. Instead, it will provide monetary and other incentives for states to pass specified tort and judicial reform legislation. The Task Force recommends this approach because it believes that

federal action on professional liability is justified and inevitable, yet it also believes that the states are in the best position to evaluate the nature and dimensions of the problem they face.

How federal incentives would work

The federal incentive approach will not involve enormous new government expenditures or responsibilities. It leaves the fault system intact. Thus, it will not encourage greater government regulation of health care or worsen the federal deficit. Monetary incentives may be available through existing federal programs. Even if that were not feasible, necessary funding would be modest. Most importantly, the Task Force believes that any additional spending for this legislation can be demonstrated to be cost beneficial. The government, which pays at least 40% of the nation's health care bill, will be a primary beneficiary of the reforms.

No state need pass every reform to qualify if certain key reforms are enacted. A state that has already enacted similar or otherwise effective reforms may qualify for the federal incentives to aid the implementation and monitoring of the reforms.

The description of the legislation here is in general terms so that refinements from outside the Task Force are not foreclosed. The drafting of the legislation will be the responsibility of the Council on Legislation, which has already received the proposal. The Task Force will present to the Council its detailed views on the design of specific provisions and reforms.

The federal incentive proposal is divided into two general types of reforms. The first set of reforms holds particular potential for refining the way in which damages are awarded. The uniquely emotional and speculative aspects of medical negligence damage awards—which are now commonly in the multi-million dollar range—must be brought under control. Reasonable and fair awards must be established or the entire compensation system is threatened.

The second set of reforms is aimed at improving the liability resolution system. More money is spent today determining liability than compensating the injured. That result makes no sense and there are ways to change it.

Reforms to refine the method of awarding damages

—Limit non-economic damages. Pain and suffering, mental anguish, and loss of consortium are examples of non-economic damages. They were not a part of the common law of damages in tort cases. These damages are impossible to accurately ascertain, can be manipulated by emotion, and are inevitably subject to speculation. They are a primary cause of the grossly distorted awards in professional liability cases. Non-economic damages should be limited.

Even if non-economic damages did not cause distorted awards, they are less justified in professional liability cases than in other tort cases because of the unique risks inherent in medical treatment, the need to encourage physicians to aggressively find and apply cures, and the recognition that even competent physicians can make errors of judgment. Estimated savings: 5% to 19% of medical liability litigation costs (Rand Corporation study); 25% if a $100,000 cap on non-economic losses is instituted (New York State Medical Society).

—Eliminate punitive damages. The damages awarded in a professional liability lawsuit are intended to provide compensation for injury. They are not a mechanism to punish. By definition, punitive damages are in addition to full compensation for a plaintiff's injuries. Punitive damages are particularly inappropriate in medical professional liability suits because state licensing boards, medical society and hospital peer review systems, and the criminal justice system provide adequate mechanisms to discipline physicians.

—Itemize verdicts. Jury awards should relate to reasonably certain and specific amounts and types of damage. Speculation and emotion have no place in the calculation of damage. Awards should relate to actual and available rehabilitation techniques. The jury should, therefore, be required to specify the amount of an award attributed to medical expenses, lost earnings, non-economic damages and other items. This kind of itemization will structure jury awards so that compensation is reasonable and rationally related to injury.

—Structure settlements. Structured settlements with periodic payments over an injured claimant's lifetime, rather than a lump sum payment, should be permitted and encouraged. Periodic payments are less expensive to finance and they assure that financial resources will be available to an injured person over time as needed. Payments should end if a patient dies, thus eliminating "windfall" payouts to persons other than the injured person. Estimated savings: 7% to 14% (Pennsylvania Medical Society).

—Establish patient compensation funds. Patient compensation funds (PCFs) are state operated programs established to pay a portion of any settlement or judgment against a health care provider in excess of a statutorily defined amount. The fund may be responsible for the remainder of the award or its liability may be limited. If the fund's liability is limited, the provider may be responsible for any excess amount or the total liability may be the fund's limit.

PCFs are funded through a surcharge on health care providers and institutions. Participants in the fund must maintain medical liability insurance in an amount no less than at the amount that the fund becomes operational or demonstrate financial responsibility in this amount.

PCFs allow risk spreading over statutorily specified health care providers and thus help ensure that professional liability insurance remains available and affordable. PCFs have been upheld by the state Supreme

Courts in Florida, Indiana, Louisiana, and Nebraska.

–Eliminate the collateral source rule. The collateral source rule prohibits the introduction into evidence of any information about compensation a plaintiff may receive from sources other than the defendant. Therefore, plaintiffs may receive a double recovery – one from an insurer or employer and one from the defendant. The rule should be changed to require a mandatory offset of the collateral source income. Amounts spent by the plaintiff to obtain the additional compensation, i.e. insurance premiums, would be offset against any deduction. Estimated savings: up to 18% (Rand Corporation study).

–Restrict attorneys' contingent fees. The Task Force does not recommend abolition of the contingency fee system. However, a sliding scale for attorneys' fees should be established. Customarily, attorneys accept personal injury cases, such as professional liability actions, on a contingent fee basis. The attorney may receive from 25% to 50% of any award eventually won. A sliding scale for such fees, with declining percentages paid to an attorney as the size of the award increases, would insure that the bulk of the award goes as compensation to the injured party, not to the lawyers.

The American Bar Association, in a report on a five-year study that was issued in August, 1984, found that when lawyers reduce the amount of time spent working on a lawsuit, the savings are passed on to clients only if the clients are paying an hourly rate. When lawyers work on a contingent fee, "lawyers are benefiting" not clients, the report said.

The California Supreme Court recently upheld a sliding scale of contingency fees.

Reforms to improve the liability resolution system

There is growing discontent with the costly, complicated, and slow American legal system. The American Bar Association has itself stated that "the high litigation cost and the slow pace of justice" is leading to widespread cynicism about the legal profession. Harvard University's Derek C. Bok concluded in a 1983 report focusing on the American legal system that "Our legal system leads to much waste of money that could be put to better purposes." The system, he said, is "among the most expensive and least efficient in the world."

Chief Justice Burger, who has been leading a campaign for reform of the legal profession in recent years, sounded out other distinguished lawyers on needed reforms. A common theme was reflected by the response of one noted lawyer: "Some basic institutional reform in the legal profession is what is needed–lawyers have got to stop using the court system as a means of enriching themselves at the expense of their clients. And the courts have got to stop allowing the lawyers to do it."

Professional liability actions, as much as any kind of court action, bring into play the worst aspects of the system. Common in these cases are non-meritorious claims, drawn out discovery, complicated and artificial rules of evidence, sensational and emotional appeals to juries' prejudices, and imprecise or ineffective judicial control of the merit and speed of the caseload.

Reform is needed in this system, even apart from the professional liability problem. Because of its adverse effects on the cost and quality of medicine, the professional liability crisis provides a unique opportunity to put into effect and to perfect some elementary improvements in the legal system. Thus, as part of the proposed federal legislation, the following reforms are included:

–Create mandatory pretrial screening panels. Too much time, money, and other resources are spent resolving the issue of liability. Both defense and plaintiff lawyers wait too long to settle meritorious cases, deal too often in frivolous cases, and try many cases that should not be tried. An important element in this process is the ability to promptly evaluate a claim.

Pretrial screening panels can determine promptly, without elaborate evidentiary or discovery procedures, whether or not negligence occurred in a claim and, depending on the structure and range of authority, recommend an appropriate award. The composition of the panels varies, though usually lawyers, physicians, and members of the public constitute the panels, sometimes with a judge as chairperson.

As an additional incentive for early resolution, parties can be charged with the other side's attorney fees when plaintiffs try cases the panel finds frivolous or defendants fail to make prompt, good faith settlement proposals of plainly meritorious claims.

The panels in Illinois and Florida have been found unconstitutional but panels have been upheld in several other states. How they are constituted and how they operate determine their effectiveness and constitutionality. A carefully drafted statute can create an efficient, constitutional system.

–Establish fair and appropriate standards for expert witnesses. Today physicians from around the country routinely serve as expert witnesses for plaintiffs in professional liability suits. Many of them advertise widely in medical and legal journals and compete agressively for the business of providing expert testimony. These traveling experts often have little actual experience in the particular specialty of the defendant physician or knowledge of the appropriate standard of care. The qualifications of an expert witness should require that the expert be familiar with the standard of practice in the locality where the lawsuit arose, when the incident occurred, and practice in the same specialty as the defendant.

In addition, minimum rules must be established to provide juries with instructions regarding the standard of care. The standard should be the normal practice and actual custom of physicians and courts must require careful adherence by juries to the

standard. As the Committee on Professional Liability stated in its 1984 report "... expert medical witnesses in the business of medical advocacy translate normal or customary medical practice within close range or at the level of ideal medical practice. Their courtroom standard from the point of view of hindsight is too frequently geared to that of the infallible physician, a sort of God-like individual who always chooses the right course of treatment when alternatives are available."

—Modify statutes of limitation. The time period in which a patient has the right to file suit against a physician for an alleged injury should be reasonable. Many states still have statutes that permit suits to be filed many years after the alleged negligence occurred.

For minors, the statute of limitations in many jurisdictions begins to run when a minor reaches the age of majority. Physicians who treat infants and children thus face potential liability for more than 18 years. The statute should provide a reasonable period to discover any injury and file a claim—perhaps to age six or eight—but not extend liability decades into the future.

—Require an affidavit of non-involvement. Not infrequently, plaintiffs name everyone remotely connected with the defendant's allegedly negligent treatment when filing a lawsuit. Many of these defendants will be dropped from suit before trial. In most states, this dismissal from suit comes at the summary judgment stage, after the suit has been filed, discovery has occurred, and the insurance company has recorded that a claim was filed. To eliminate this situation, any defendant should be able to file an affidavit denying involvement in the allegedly negligent care. A hearing would be held shortly after the affidavit is filed, during which the plaintiff must present evidence that establishes a reasonable basis for the defendant being named. If not, that defendant should be dismissed and the costs paid by the plaintiff.

—Establish minimum standards to sue, impose penalties for frivolous suits and facilitate filing of physicians' countersuits. Procedures have been developed to provide some restraint against frivolous claims and lawsuits including:

Filing notice of intent to sue. The plaintiff should file notice of intent to sue. This notice period would provide the defendant an opportunity to evaluate the claim and make an offer to settle, when appropriate.

Permitting a physician to recover costs in a frivolous suit.

Eliminating the rule requiring that a physician demonstrate "special injury" before that physician can countersue a plaintiff in a malicious prosecution action.

—Make available a system of binding, voluntary arbitration. The entire litigation process can be avoided by voluntary binding arbitration. Using a professional arbitrator, a physician and a patient can reach a decision about a claim, its merits and compensation quickly, inexpensively and fairly.

Arbitration may be particularly useful in resolving less complex cases. It can be incorporated as an option after the notice of intent to sue has been given.

Arbitration provisions can be drafted to avoid being struck down as invalid contracts of adhesion, as some have been. Most states now have statutory provisions allowing voluntary private binding arbitration procedures.

In recent years, courts, too, have developed a variation of private arbitration called court-ordered or court-annexed arbitration. Arbitrators hear cases and render verdicts, but verdicts are not binding. According to a 1984 report of the Rand Corporation's Institute for Civil Justice, arbitration should increasingly be used as a faster, less expensive means of disposing of small claims.

(9) **Furnish legislative assistance to states.** The federal incentive bill proposed by the Task Force will encourage state legislatures to enact needed tort reforms. In addition, while the AMA pursues the federal incentive approach, state medical societies must take the initiative in promoting needed tort reforms. Many state medical societies have taken aggressive action. Where necessary, the AMA will assist state medical societies in presenting tort reforms and will develop and update model bills. AMA staff and officials will work with state societies to encourage prompt enactment of the reforms. The AMA will monitor tort reform activities and keep the federation informed about their progress.

(10) **Study other approaches to resolving professional liability claims.** Several federal proposals applying to professional liability have been introduced into Congress. These proposals have provided opportunities for thoughtful discussion, but have not been endorsed by the AMA. One proposal was based on a modified no-fault approach. Other proposals that would provide federal aid or protection to physicians against liability actions have little chance of success in light of budget pressures, political and constitutional considerations, or would tie professional liability relief to unacceptable restrictions on physicians.

Further study of other alternatives to the tort system, such as the development of schedules of benefits for certain injuries, or the creation of a partial no-fault compensation system and equitable financing methods, will be undertaken. Implementation of any new systems—through legislation, contracts, or other means—will be examined.

Defense coordination

The AMA will develop a defense coordination system for physicians and their attorneys to aid in defending lawsuits. The plaintiffs bar already is well organized. Expanded services to physicians and their attorneys to successfully defend against professional liability lawsuits are necessary.

The following recommendations are made in this area:

(11) **Provide defense coordination services.** Among the recommended services are:

–Hotline for professional liability questions from physicians and their attorneys. The hotline, staffed by an attorney in the Office of the General Counsel, has been operating since late 1984. The Task Force has responded to several hundred telephone inquiries. The number is (800) 552-4642 nationwide; (800) 821-5309 in Illinois.

–Information from a panel of nationally prominent defense attorneys retained by the AMA. The panel will assist physicians' attorneys on professional liability cases. The panel's experience in successfully defending medical professional liability cases will be pooled and the information utilized to develop specific and general defense approaches.

–Liaison with defense organizations. AMA will work with organizations that represent or assist defense lawyers and enlist their aid in legislative activity, to establish comprehensive brief banks for professional liability cases and to perform other related research and activities. The Task Force will coordinate its activities with organizations, such as the Defense Research Institute (DRI), to provide access to their information and resources for physicians' attorneys. The AMA will also explore with the DRI methods to expand the DRI's computerized brief bank.

–Legal education courses. Programs to give physicians a better understanding of the legal system and how to minimize liability exposure will be encouraged. The need to educate physicians more fully about their liability exposure requires development of legal education courses in medical schools and at the postgraduate level. In addition, the AMA will develop publications explaining the legal process.

Risk control and quality review

There is no evidence that the increase in the number of professional liability claims and the severity of awards are related to a decline in the quality of medical care in this country. To the contrary, the evidence is that the quality of care and skill of physicians have never been higher.

Ironically, the professional liability problem is caused to some extent by the increase in the quality and possibilities of medicine. The public's expectations, based on an explosion of publicity about medical miracles, are high, probably too high. Medicine is a complex, rapidly changing, inexact science, and patients' needs, histories and responsiveness to treatment vary greatly. Results also may vary greatly. Many claims involve no negligence at all, only unfulfilled expectations.

Moreover, the practice of medicine, more than any other profession, requires the making of numerous difficult judgment calls, often in a very short time. Mistakes of judgment are made even by good physicians.

But negligence does occur, and effective risk management and peer review can reduce it. Medical specialty societies and insurance companies already have made great strides in identifying the common causes of professional liability claims and proposing remedies. More must be done.

The primary role that individual physicians can play in easing the professional liability crisis is to participate actively in risk management and peer review activities. If physicians are to attract the allies they need to resolve the professional liability crisis, they must demonstrate their commitment to increased quality control efforts. Thus, the Task Force proposes the following recommendations in this area:

(12) **Provide a clearinghouse for information and offer practice management programs.** The AMA will serve as clearinghouse for information and assistance to physicians, the federation, medical specialty societies and physician-owned insurance companies about methods to minimize professional liability exposure.

The work of AMA's Committee on Professional Liability, the Center for Health Policy Research, AMACO, specialty societies, the Council of Medical Specialty Societies and professional liability insurance groups to identify specific areas leading to less than ideal care–and sometimes to lawsuits–will be regularly reported.

In addition, the AMA's Department of Practice Management, through publications and workshops, will provide practical advice on how to minimize liability exposure in physicians' offices. Special emphasis will be placed on improving communications with patients. Physicians must volunteer more information, encourage more questions, and, in general, make the physician-patient relationship as strong and open as possible.

(13) **Collect and analyze quality of care information and implement findings.** The AMA will provide expanded support for data gathering projects, such as the computerized data collection program currently undertaken by the Physician Insurers Association of America (PIAA), that will provide information on the causes of both legitimate and non-supportable claims.

As PIAA and other data become available, the AMA will work with specialists to analyze the information, isolate specific and broad causes of liability and develop methods to eliminate those causes. Claims data must be subject to detailed, procedure specific, analysis by physicians. The AMA can aid this process and identify trends that span the specialties.

The AMA itself maintains the largest and most accurate medical data base on physicians, medical procedures, diseases, technology and drugs. Putting these data bases together with claims data, such as that collected by insurers, hospitals, state societies and state licensing boards, will enable the

AMA to track the national quality of health care and of health care providers.

The AMA will evaluate utilization patterns and variations in health care on national, regional, state and local levels. This analysis will provide a better understanding of health care differences and the opportunity to correct inappropriate variations in treatment patterns and procedures.

New technology brings the promise of continuing, dramatic advances in health care. It also increases the complexity of the practice of medicine and contributes to professional liability exposure. Physician awareness and understanding of technology—its strengths and weaknesses—is essential to medical practice. The AMA is intensifying its role as the leader in medical technology assessment. DATTA, the AMA's data base of medical technology and assessment, will be expanded to include devices as well as procedures. DATTA evaluations will be disseminated broadly through the AMA's Medical Information Network (MINET) and AMA journals to give specialty societies, and physicians generally, the best information about the technology being used to care for patients.

(14) **Utilize the resources of the AMA Office of Education Research.** The AMA has created an Office of Education Research. One of its functions will be to examine adverse actions taken by state boards against physicians to determine whether any relationship exists to the physician's educational performance or background and to provide this information to the academic community.

(15) **Expand peer review activities.** The AMA will ask physicians to be alert to procedures and physicians that do not conform to appropriate standards of care and to be active in reviewing their peers. Hospital medical staffs, in particular, can be more effective in their self-regulation. The institutional setting of the hospital offers the best opportunity for peer review. The AMA will work with government agencies, such as the Federal Trade Commission, to obtain their support for expanded and vigorous self-regulation and peer review by the profession.

In addition the AMA, working with the federation, will explore ways to expand peer review and quality assurance activities beyond hospitalized patients.

(16) **Strengthen state licensing boards.** Most states have legislation which gives state licensing boards effective investigative and disciplinary powers. These boards must have adequate resources to fulfill their functions. The AMA will encourage state medical societies and hospital medical staffs to report flagrant and recurring negligence by particular physicians to these boards. Through its computerized system, and in cooperation with the Federation of State Medical Boards, the AMA is already actively assisting state boards in identifying physicians who have lost their license in one state, but remain licensed to practice in others.

(17) **Sponsor a series of roundtable discussions on professional liability issues.** The discussions will be sponsored by the Task Force in conjunction with the American Medical Assurance Company (AMACO), the AMA's wholly-owned professional liability reinsurance company. The roundtables will focus on various aspects of the insurance and reinsurance industries and on risk control activities. The information and suggestions that emerge from these meetings will be published in a series of reports entitled "Issues in Professional Liability" and as videotapes that will be available to state, local and specialty medical societies.

(18) **Continue to fight for high quality medicine while recognizing that competition and cost containment are permanent aspects in the practice of medicine.**

Cost containment measures can increase professional liability exposure, and reduce the quality of medical care, if they are arbitrarily and exclusively aimed at cutting costs. What may appear to be overutilization in one context might, under other circumstances, be essential to providing good patient care.

Physicians must be leaders in cost containment and utilization review so that it is done intelligently, fairly and with an overriding concern for patient welfare. Physicians must oppose cost containment efforts when they plainly endanger quality of care. Physicians will be credible in this process if they, through the AMA and other medical organizations, document the pervasive changes in place which can and will provide effective cost and price control. Combinations of health care purchasers, intense competition among providers in a variety of new health care delivery systems, increasing supply of physicians and non-physician health care providers, advertising, increased patient awareness, peer and utilization review, changes in hospital ownership and management, and changes in insurance coverage – many diverse forces – increasingly restrain the pricing and utilization of health care. Government officials and legislators must recognize the rapidly increasing cost containment forces already at work so that quality of care is not sacrificed in new and unncesssary regulatory approaches.

The Task Force's recommendations are designed to create a climate in which the nation's physicians can provide high quality medical care without fear of undue liability exposure and in which victims of actual negligence can be fairly and efficiently compensated. This climate does not exist today.

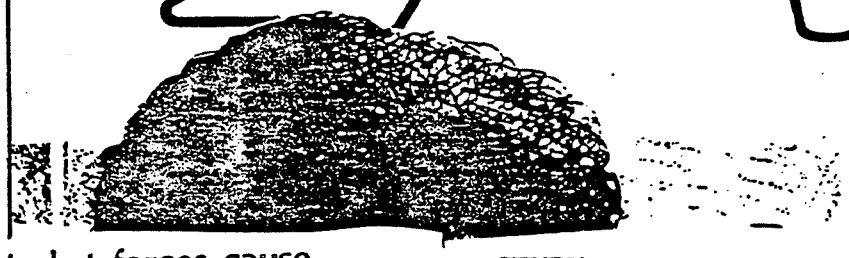
The action plan is a blueprint. Implementation of the plan will require the dedication of physicians and the commitment of resources.

The professional liability problem is urgent. The Task Force recommends that this action program be implemented immediately.

Attachment III

Reader Survey Inside

THE PENNSYLVANIA
Lawyer
JUNE 15, 1985



Market forces cause of crisis, study says

Instituting a no-fault system for handling medical malpractice claims, putting a cap on awards or doing away with contingency fees would not solve the problem of rising medical malpractice insurance premiums in Pennsylvania, says a study partially funded by the Pennsylvania Bar Association.

The study concludes that it's not increasing malpractice claims that are driving up premiums, but rather a cyclical insurance market that's catching up from an earlier period when rates were too low.

"Premium rates have risen since 1983 because they were inadequate prior to 1983," declare the authors of the study, Dr. Alfred E. Hofflander, a professor of finance and insurance at the University of California at Los Angeles, and Dr. Blaine F. Nye, an associate with Management Analysis Center in Menlo Park, Calif.

"The important point to be made is that the current crisis in Pennsylvania is not based on increased malpractice occurence," they say, underscoring that the "false perceptions of health care providers as to the roots of the developing malpractice crisis" have left the tort law system

STUDY (Continued from Page 1)

as the "convenient public 'whipping boy.'"

In fact, according to the study, "tort law, in establishing fault, performs an indispensable role in permitting the provision of incentives to reduce medical malpractice."

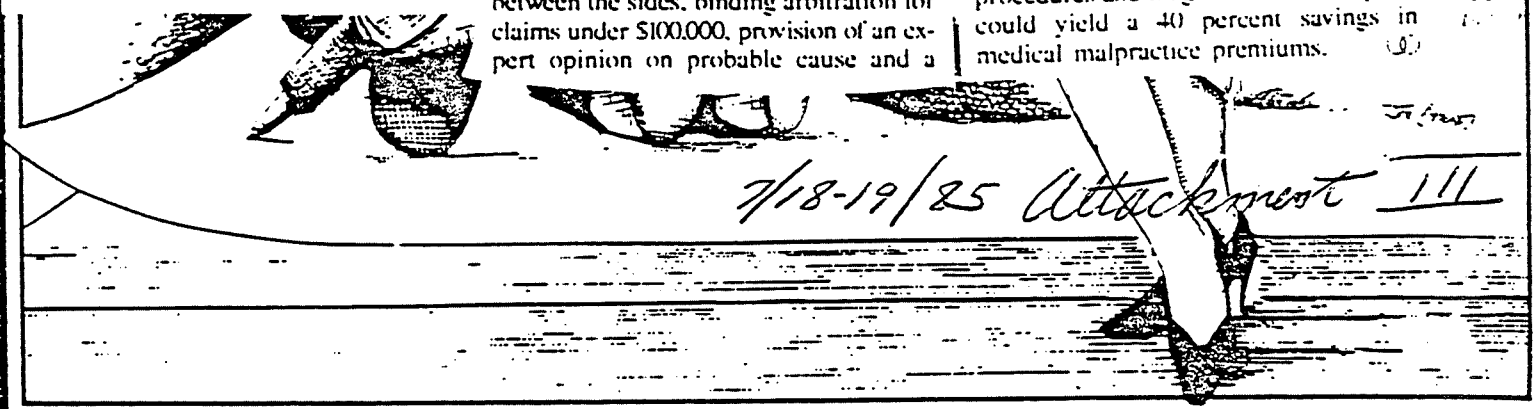
The PBA contributed $10,000 toward the $140,000 cost of the study. Joining the PBA as sponsors were the Allegheny County Bar Association, the Hospital Association of Pennsylvania, the Lawyers Malpractice Task Force, the Pennsylvania Defense Institute, the Pennsylvania Medical Society, the Pennsylvania Trial Lawyers Association, the Philadelphia Bar Association and the Philadelphia Trial Lawyers.

In one area the study does take issue with the legal profession. It says a "large percentage" of claims are settled without payment and "some attorneys seem to exhibit a propensity to bring claims that result in zero payment."

It says more careful evaluation and earlier resolution could provide a 15 percent savings in malpractice premiums and recommends a screening and conciliation procedure that would include provisions for more open exchange of information between the sides, binding arbitration for claims under $100,000, provision of an expert opinion on probable cause and a mandatory conciliation hearing prior to trial. Among other things, the study also recommends a "substantial softening" of the doctrine of informed consent, enactment of a statute of repose that would affect claims after 10 years and elimination of punitive damages except in cases of intentional malpractice.

Overall, the study says, the addition of screening and conciliation along with changes in the regulation of rates and the operation of the Pennsylvania Medical Professional Liability Catastrophe Loss Fund (the CAT Fund), tighter hospital procedures and tougher doctor discipline could yield a 40 percent savings in medical malpractice premiums.

...g & Writing ... Profit



7/18-19/85 Attachment III

Provided By: PA Bar Assn

Management Analysis Center, Inc.

Medical Malpractice Insurance

In Pennsylvania

Alfred E. Hofflander, Ph.D. and Blaine F. Nye, Ph.D.*

Management Analysis Center, Inc.
1000 El Camino Real, Suite 250
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* Alfred E. Hofflander is Professor of Finance and Insurance at the Graduate School of Management, University of California, Los Angeles, and Faculty Principal with Management Analysis Center, Inc.; Blaine F. Nye is an Associate with Management Analysis Center, Inc.

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ACKNOWLEDGMENT

We were most fortunate to obtain the expertise of Alfred E. Hofflander, Ph.D., and Blaine F. Nye, Ph.D., who combined to perform a study of medical malpractice and medical malpractice insurance in Pennsylvania on our behalf.

It is our hope that this jointly sponsored independent study, to our knowledge the first of its kind in the nation, will contribute to a better understanding of the complex issues involved, and enable equitable, constructive and cooperatively achieved improvements based on its findings and recommendations.

We wish to acknowledge the sponsors of this study and the members of the Select Committee on Malpractice who gave unselfishly of their time and energy to this project.

Organization	Name	County
Allegheny County Bar Association	Thomas L. Cooper, Esquire	Allegheny
	Dennis C. Harrington, Esquire	Allegheny
Hospital Association Of Pennsylvania	W. Scott Murray	Delaware
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Sincerely,

James F. Mundy, Esquire

Immediate Past President
Pennsylvania Trial Lawyers Association

Chairman
Pennsylvania Bar Association
Medical-Legal Committee

Co-chair
Select Committee on Malpractice

John Y. Templeton, III, M.D.

Immediate Past President
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Chairman
Pennsylvania Medical Society
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Select Committee on Malpractice

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EXECUTIVE SUMMARY

INTRODUCTION

Medical malpractice insurance has been, and continues to be, a relatively minor line of insurance in terms of premium volume written, however, it has never been a "quiet" line of insurance. Problems first occurred in the 1930's when a rising malpractice frequency trend began to attract close scrutiny. After a short respite during World War II, this upward trend renewed itself with vigor and by the 1960's had aroused substantial concern. In 1971, President Nixon initiated a study, to be done by HEW, of the growing medical malpractice insurance problem. The results of the study, issued in 1973, indicated that the postwar rise in malpractice claims was attributable to the greater affordability and availability of medical care subsequent to the war, as well as the increasing complexity of medical procedures during the period. However, the study did not provide a solution to the problem.

At the time the study was released, the malpractice insurance market was entering a period of turmoil which would become the "availability" crisis of the mid-1970's. Rate increases of up to 100% per year were not unusual during this period and some leading carriers withdrew from some, or all, markets. Physicians were, thus, confronted with rapidly increasing malpractice premiums and lack of availability in some areas.

Legislative action was taken in every state in the mid-1970's aimed at mitigating the effects of the malpractice crisis. These tort "reform" measures were intended to limit the medical liability of health care providers, i.e., legislators were apparently attempting to treat the "symptoms" rather than the "disease." Many such reforms faced constitutional challenges, both successful and unsuccessful, in their home states. In any event, the results of such tort reform measures have been mixed and, more importantly, as indicated by the current malpractice insurance crisis did not solve the malpractice insurance problem.

For physicians as a group, surprisingly, the cost of medical malpractice insurance as a percentage of gross income has changed little since 1970. A leading researcher found premiums in 1982 averaged 3% of physician gross income, with a

range from 1%-2% for general practitioners to 6% for some surgical specialties, representing only a slight increase over more than a decade. From 1977 to 1981 the average premium paid per physician declined. Recent surges in malpractice premium rates, however, have resulted in claims of another crisis in the malpractice insurance marketplace, not of "availability" but of "affordability". The validity of this "affordability crisis" in Pennsylvania is the subject in this report.

PERCEPTION versus REALITY

The medical malpractice insurance delivery system in the State of Pennsylvania is currently in a state of developing crisis. Insurance premium rates charged by primary insurance carriers have been climbing rapidly. The surcharge percentage of those primary premiums that must be paid to the CAT Fund has risen from 0% in 1979 to 52% in 1984, and will rise further in 1985. Thus, not only is the primary malpractice premium rising but the proportion of that premium required in addition for the excess malpractice coverage provided by the CAT Fund is rising as well.

Health care providers, alarmed by rising malpractice insurance costs, have raised questions as to the efficacy of the existing medical malpractice insurance delivery and claims adjudication systems as well as the conduct of the various groups affecting and effected by medical malpractice and medical malpractice insurance, i.e., health care providers, primary insurers, CAT Fund, legal profession, and victims of medical malpractice. These charges by health care providers have spawned countercharges by other industry participants with the result that virtually every involved group has expressed an assessment of the current state of medical malpractice insurance coverage in Pennsylvania including where fault lies and necessary remedial action. Needless to say, recommended action varies by participant perspective. The purpose of the section is not to examine the crisis or the conduct of any of the participants but to examine the rhetoric of the crisis and to ascertain the validity of this rhetoric, i.e., to separate "myth" from reality.

Many of the statistical claims provided in evidence of the existence of such a crisis are based on malpractice losses actually paid by the CAT Fund and primary carriers. In order to draw inferences regarding malpractice losses or frequency from such statistics, however, adjustments must be made in consideration of:

1. normal statistical variation of losses actually paid;

2. any possible effects of the constitutional review process of the Act 111 arbitration procedure;

3. "pseudogrowth" of malpractice losses paid that inevitably occurs during start-up phase of a malpractice insurance operation;

4. the delayed impact on paid malpractice loss experience of Section 605 liability (CAT Fund only); and,

5. that malpractice losses would be expected to grow at a rate closer to that of the Medical Care Index (MCI) than the Consumer Price Index (CPI).

For example, the implied two year growth rate in malpractice losses paid by the CAT Fund between 1981 ($19.5MM) and 1983 ($54.2MM) is 178%. Before any inference can be drawn as to the growth in malpractice occurrence based on this figure, however, it must be adjusted as indicated above. When the required adjustments are made, it is revealed that this entire 178% two year growth in malpractice losses paid by the CAT Fund is explained by considerations other than an increase in medical malpractice occurrence in Pennsylvania, i.e., the quoted 178% growth in CAT Fund loss payments is entirely compatible with perfectly normal growth (at the MCI) in incurred losses over the period.

Appropriate analyses of incurred losses and frequency based on both CAT Fund and primary carrier experience revealed no indication of any upward trend in malpractice claim frequency or real, i.e., constant dollar, losses incurred. In fact, there were indications of declines in these regards in 1983 and 1984. The important point to be made is that the current crisis in Pennsylvania is not based on increased malpractice occurrence.

The ultimate solvency of the CAT Fund has come into question recently, probably as a result of increasing surcharge payments, increasing CAT Fund unfunded liability, and implications that this unfunded liability is "out of control". In fact, CAT Fund surcharge premium payments and its unfunded liability are increasing exactly as should have been predicted under its "pay as you go" funding mechanism. The only problem is one of physician perception that earlier, lower surcharge

percentages represented appropriate premiums and that current higher percentages represent radical increases based on some underlying problem with the CAT Fund and/or the malpractice insurance system. Under the "pay as you go" funding mechanism employed by the CAT Fund, health care providers effectively pay the appropriate premium to themselves and must hold this premium in reserve. CAT Fund surcharges are actually calls on these health care provider reserves which naturally increased rapidly during the early years of Fund operation because of the absence of past Fund liability and the time required for losses incurred in these initial years to be reported. Further, it is shown that the CAT Fund unfunded liability is mathematically capped given the growth pattern of incurred malpractice losses. Since CAT Fund incurred losses are not "out of control," the CAT Fund's unfunded liability is not "out of control."

Another major area of concern in which perception and reality appear to differ is that of primary insurer profitability. Health care providers experiencing rapid growth in malpractice insurance premium costs have developed a mentality that primary carriers are benefiting at their expense in terms of excessive profits. In fact, in the aggregate, primary carriers did not experience excessive profitability in 1982 and 1983, the years analyzed, nor could their loss reserves be considered excessive at the end of 1983, i.e., they appear to have no profit hidden in the form of excess loss reserves. However, it is important to note that the profitability of individual carriers differed widely.

THE REAL MALPRACTICE CRISIS

In the absence of any increase in medical malpractice incurred real losses or frequency in Pennsylvania, and if primary insurers are not reaping excessive profits, what is the basis for the recent surges in malpractice insurance premium rates for all primary insurer risk classifications, i.e., what is the real malpractice insurance crisis in Pennsylvania?

As of the end of 1984, roughly 50% of physicians in Pennsylvania pay premiums for primary coverage of less than $3,500 per year and roughly 80% pay premiums less than $10,000 per year. On the other hand, independent neurosurgeons (1% of all Pennsylvania physicians) currently pay premiums in the neighborhood of $30,000.

Analysis of the average annual compound growth rates in primary coverage premiums over the period 1976 through 1985 reveals that, in fact, for only a selected few specialties, i.e., orthopedic surgery, neurosurgery and emergency medicine, did premium rates rise at an average rate significantly exceeding the rate of growth in the Medical Care Index over the same period. However, all risk classes have experienced very large premium rate increases since 1983. The implication is that, in general, rates grew at a rate below that of the MCI prior to 1983 and that recent rate increases have been an attempt to correct (over-correct?) slower growth earlier in the period, i.e., premium rates have risen since 1983 because they were inadequate prior to 1983.

Market Structure

In order to understand recent events in the marketplace for medical malpractice insurance in Pennsylvania, it is necessary to analyze the conditions under which malpractice insurance is bought and sold. Insights into the characteristics of demand and supply resulting from these analyses then permit appraisal of the current state of the market, the efficacy of the existing regulatory structure, and, finally, recommendations for regulatory improvements.

Industry demand for malpractice insurance is highly inelastic. Under Act 111, each health care provider has legally required coverage limits which must be obtained from primary insurance carriers. Excess liability insurance of $1,000,000 per health care provider per claim is supplied by the Pennsylvania Medical Professional Liability Catastrophe Loss (CAT) Fund. At any given time, then, the demand for malpractice insurance coverage from primary carriers is a fixed amount which is independent of price. Of course, at increasingly high prices, some health care providers may decide to reduce or leave their practice, self-insure, or leave the state, which would result in somewhat lesser demand, and conversely, at increasingly low prices some health care providers may be encouraged to purchase excess coverage above the limits supplied by the CAT Fund. Over any reasonable price span, however, the demand for medical malpractice insurance is highly inelastic at any given point in time.

While industry, or overall, demand is highly price inelastic, the demand facing individual primary carriers is highly price elastic, i.e., the market is highly price

competitive. Traditional bases for non-price competition in other lines of insurance which, in some lines and in some cases, permit the establishing of substantial market power are simply not relevant to medical malpractice insurance in Pennsylvania. The product is not complicated in terms of varying coverage types, coverage limitations or coverage needs. In addition, whether valid or otherwise, there is the perception among Pennsylvania health care providers that the CAT fund will honor claims against a health care provider should his primary carrier go bankrupt or out of business. The implication is that financial strength is not even a requirement of a malpractice insurer in Pennsylvania. Indeed, the only effective alternative basis for competitive purposes is an insurer reputation for "fighting" claims.

In the health care industry, a good reputation is a valued asset, and health care providers will pay incremental premium to a malpractice insurer that has a reputation for fighting claims to the extent desired by the health care provider. However, 1) because claims that health care providers may choose to fight against common opinion are a subset of claims overall, 2) because of the lack of public information about or awareness of events of medical malpractice, and 3) because of the high cost of medical malpractice insurance for many health care providers, the incremental premium that can be charged by firms that have a "we fight claims" reputation is a small percentage of overall malpractice insurance premiums. In addition, while non-price competition in the form of building a reputation for fighting claims can differentiate one group of insurers from another, it does not permit differentiation among firms with similar reputations. Thus, the demand facing individual malpractice carriers is still highly price competitive. Indeed, consider a physician in the process of choosing between two insurers with roughly comparable reputation for fighting claims. If one premium is even a few percent lower than the other, the physician will obviously choose the lower price coverage. Larger health care providers, e.g., hospitals or nursing homes, are even more price sensitive and are likely to employ or retain risk management expertise in order to keep malpractice insurance costs at a minimum.

An important consideration, in terms of the supply of medical malpractice insurance is the cost structure of the industry. In industries characterized by the typical decreasing returns to scale, individual firms can expand output in response to positive demand shifts and do, but only at increased price and to limited extent.

insurance is, in general, supplied under conditions of roughly constant returns to scale. This eventuality has been substantiated in numerous econometric studies of industry cost structure and is highly intuitive conceptually as well. The implication of constant returns to scale in the Pennsylvania medical malpractice insurance market is that existing carriers can expand output, or premiums written, in response to a shift in demand by any desired amount and at constant price.

Another source of supply is from entering firms. Barriers to entry into the medical malpractice insurance business are extremely low for existing carriers of other lines of insurance and, when reinsurance is available, extremely low for new insurance carriers as well. Indeed, because of the long claims tail of medical malpractice coverage, reported claim frequency in the first few years of operation is very low. A new insurer literally only needs to sell policies and collect premiums. The central theses of these supply discussions is that the medical malpractice insurance industry in Pennsylvania is in a state of chronic potential oversupply.

The market equilibrium in medical malpractice insurance under the demand and supply conditions discussed above might be described as that of a hockey puck resting on a flat frictionless table. As long as the puck is not touched it will remain where it is, but any small shock will start the puck moving toward the edge of the table and eventually onto the floor below. A stable equilibrium analogy would have the puck nailed to the table.

Any insurer that attempts to increase premium rates above actuarially sound levels will lose its policyholders to other insurers, either existing or new, based on the chronic potential oversupply problem discussed above. Fleeing policyholders will find other malpractice insurers waiting to supply coverage at the policyholder's previous premium rate. Thus, premium rates are highly resistant to upward movement.

On the other hand, any insurer that lowers premium rates below actuarially sound levels will attract substantial numbers of new policyholders. There are several possible motivations for this type of price cutting behavior. One obvious motivation occurs when the insurer management team is evaluated based on short-term premium growth and/or profitability. A premium reduction strategy in the medical malpractice insurance market will result in substantial growth in premiums

written; and, because of the long tail inherent in medical malpractice coverage, an appearance of high profitability can be maintained under such strategy on a short-term basis. The long-term strategy of such a management team is to be elsewhere employed when the strategy sours having long since moved on to bigger and better things based on their past "success." Another motivation for a price cutting strategy might be as a means to gain market share. The idea is to penetrate the market quickly and then raise premium rates to a level sufficient to cover losses absorbed during entry. Finally, an insurer may not even be aware that its rates are actuarially unsound because of the lack of available information on the malpractice experience of health care providers in general.

Whatever the motivation for a premium reduction strategy the results are identical. Because of the highly inelastic overall market demand, any premium volume gains by any insurer are necessarily at the expense of other insurers. Also, because of the relatively small overall market volume (in insurance terms) and the ability of insurance firms to expand almost without limit, the price reducing firm can make substantial inroads, in terms of premium volume and market share, in the premium volumes of its competitors. As a result, competing firms must meet the price reduction or effectively leave the business. While leaving the business may be the expedient course of action, it is obviously not a well trodden path. The net effect on the industry equilibrium is to leave overall premium volume unchanged but to reduce the premium level below an actuarially sound level.

Information Availability

Extending malpractice insurance coverage to a health care provider under conditions of incomplete or totally unavailable information regarding that health care provider's past malpractice experience is patently absurd, and yet it happens quite frequently. Indeed, there exists no comprehensive database containing the malpractice experience of individual health care providers. Insurers collect such data for their policyholders but over 60% of premiums written in Pennsylvania are written by insurance companies that are less than nine years old. Assuming the accuracy of the CAT Fund's 1983 "Actuarial Analysis" estimate of a 13-year payout pattern for losses incurred in a particular year, these companies have not yet closed the books on losses incurred in their first year of operation. Thus, even for health care providers that the particular insurer has insured for the life of the

company, experience ratings are incomplete; and, for those with lesser tenure, even less complete as insurance companies rarely, if ever, communicate insured's malpractice experience to each other.

As a result, insurers rely on class rating. In the mid- to late-1970's, five different risk classifications were typically employed. Some insurers defray their experience information needs by limiting the number of risk classes in which they compete and/or establishing minimum experience standards for underwriting. In implementing the latter screen, insurers emphasize "knowing" their insureds, i.e., checking references, verifying reputation in the medical community, etc. There is not a bona fide attempt to experience rate individual insureds but such companies are effective in not extending coverage to health care providers whose malpractice risk exceeds a company-specific maximum risk profile. Other insurers, on the other hand, e.g., residual market insurers and health care provider association insurers, are prohibited by charter from withholding coverage from health care providers on these bases. Insurers of this type are much more dependent on experience rating for good underwriting results; and, indeed are aware of this fact as the number of classes recognized by one such insurer has grown from five to eleven most recently and most such insurers are more active in assessing premium surcharges than their more selective counterparts.

The direct effects of incomplete information on the market equilibrium in medical malpractice insurance in Pennsylvania are twofold. First, incomplete information makes sound underwriting a virtual impossibility. Even limited underwriting schemes, e.g., class underwriting, require full information regarding the malpractice experience of members of the specific classes. Data insufficiency in this regard leads to diverse estimates of appropriate premiums for a particular class by different insurance carriers depending on company-specific class population. In addition, because the primary data insufficiency is omission of adverse malpractice experience, this diversity of rate estimates is highly likely to be uniformly inadequate. In terms of the market structure discussion earlier in this section, incomplete information as to the malpractice experience of health care providers implies a high level of uncertainty in appropriate premium rate levels, i.e., generates market conditions under which insurers do not know appropriate malpractice insurance premium rates. Further, due to the competitive nature of the market the lowest of the diverse company-specific appropriate premium rate estimates is highly likely to dominate in terms of the industry class premium rate levels that

ultimately evolve. In other words, inadequate information in the medical malpractice insurance market induces a very strong tendency toward inadequate industry premium levels.

The second way in which incomplete information effects market equilibrium is by inducing changes in the policyholder portfolio risk of insurers with different underwriting screens or methods. As a simple example of this phenomenon, consider two firms writing policies in a single commonly defined risk classification. If one of the two firms accepts all health care providers in this class but the other accepts only those applicants meeting a specific maximum risk requirement. The latter company can charge lower premium rates than the former based on its lower risk exposure. The former insurer must meet these rates or lose the quality risk portion of its portfolio. If it does set its rates at this lower level, its rates will be inadequate overall by construction of the example. On the other hand, if it does not meet the lower rates, it will lose its quality risks and even its higher rates will become inadequate. Either strategy will result in inadequate premium rate levels for the class in question and push the nondiscriminating insurer toward insolvency. Again, the example is highly idealized, but there are "cream skimming" insurers active in the Pennsylvania malpractice insurance marketplace, and residual market and health care provider association insurers in Pennsylvania are having a difficult time competing with them in the current absence of complete malpractice experience information with which to set appropriate premium rate levels.

Malpractice Premium Rate Cycle

The economic structure of the medical malpractice insurance market combined with inadequate malpractice experience information induce a premium rate cycle around actuarially sound premium rates over time (Figures III-1 and III-2). Basically, downward pressure on premium rates, discussed above, prohibits appropriate rate increases during Phase I of cycle with the result of increasing rate inadequacy. Eventually, as the malpractice tail begins to come in, insurer awareness of inadequate rates becomes too acute to ignore and, in tacit collusion, all insurers effect sharp rate increases in Phase II. Insurers not in financial difficulty, e.g., "cream skimming" firms are more than happy to cooperate with their less fortunate competitors. As premium rates rise through those rates that

are actuarially sound, new entrants to the market (and insurers seeking to expand market share) are alerted and begin entry. In Phase III, rate increases slow overall because of increasing competitive pressures and rates begin to level off. Those insurers which require even higher rates to, in effect, break even because of past rate inadequacy may become insolvent and/or leave the market. Phase III may be characterized by regulatory intervention, changes in the legal system, etc., as well, depending on the depth of the industry crisis that inevitably develops in the middle of Phase II. When the malpractice insurance market regains stability, Phase III ends and Phase I of the next cycle begins.

The malpractice insurance market in Pennsylvania, would currently appear to be somewhere in the middle to the end of Phase II, i.e., rates are felt to have been inadequate in the past, they are rising rapidly, some insurers are under some financial strain, and others are poised for active market expansion.

Recommendations

The problem of incomplete information in the market for medical malpractice insurance in Pennsylvania can and must be greatly improved. Improvement in this regard will eliminate the market structure problem of inadequate premium rates based on the current inability of malpractice carriers to properly rate malpractice risks. It will also greatly reduce the ability of some insurers with the foresight and/or charter flexibility to effectively reduce their exposure through risk selection processes of various kinds at the expense of their less discriminating competitors, i.e., reduce the inherent advantage in the current market structure accruing to "cream skimming" carriers.

The recommendation is for the establishment of a comprehensive malpractice experience database on a health care provider basis that is available to all insurance carriers and health care employers. This will eliminate the two basic information problems inherent in the current malpractice insurance delivery system, i.e., the high cost of gathering information that is available and incomplete information.

Data reporting must be mandatory for all insurance carriers writing malpractice coverage for Pennsylvania health care providers. The database should be housed in a state agency, e.g., the CAT Fund, and should be autonomous in terms of operations and budget authority. These latter considerations reflect the need for 1) free authorized access to the database, and 2) guarantees that the database housing agency have the necessary authority to provide adequate staffing, budget, and decision-making capacity in order to maintain database integrity. The design of the database, where it is housed, the extent of its operating and budget authority, to whom and in what format the data is to be made available, etc., all should be determined as part of a major design study to be undertaken by the State on a timely basis and in conjunction with all involved parties.

The second major generic problem with the current medical malpractice insurance delivery system in Pennsylvania is related to the fact that free competition and/or ineffectively regulated competition in the malpractice insurance market is destabilizing. The recommendation is to establish a deviation type rating scheme under which deviating carriers must justify and receive approval to set divergent premium rates. Much of the administration required for this type of rating scheme is already in place in Pennsylvania. With the advent of the health care provider malpractice experience database discussed above the major ingredient for effective deviation rating will be in place. The emphasis in establishing bureau-type rates should be placed directly on the estimated risk of the specific health care provider rather than on particular specialties. Under such a structure it would be entirely possible for a "risky" general practitioner to pay higher malpractice premiums than a "careful" neurosurgeon. One possible structure might be to set premiums for one hundred different risk exposures with individual health care providers assigned a particular risk based on specialty and his ongoing malpractice experience. The most important feature of such a structure is that it comprise a large enough number of risk classes to provide as effective a resolution of different health care provider exposures as permitted by information quality. While true that perfect experience rating is unobtainable in an imperfect world, it is clear that information of sufficient quality does exist to permit effective rating improvement. Deviation rating would presumably eliminate the destabilizing effects of cost cutting strategies by insurers to effect entry into the market or due to agency problems based on short-term insurer management incentives. However, if deviation rating proves inadequate in this regard, it may be necessary to implement a minimum rating structure in which charging rates below designated minimum amounts would be prohibited.

The two major recommendations of this section, i.e., establishing a health care provider experience information database and deviation rating would help to stabilize the malpractice insurance market in Pennsylvania. Such stability is essential to avoiding cyclically recurring crises of the type currently developing.

CAT FUND

The original and principal purpose (mid-1970's) of the CAT Fund was to provide excess claim coverage above primary carrier limits and full coverage for claims reported more than four years from occurrence. It was felt that such truncations of malpractice insurer liability would induce independent private carriers to enter the Pennsylvania market and thereby alleviate the existing availability crisis. The idea, apparently, was to induce private insurers to resume writing malpractice coverage in Pennsylvania by offering added structure to the malpractice risk they were expected to underwrite. Presumably, it was felt that 1) insurers could effectively rate and market malpractice insurance as defined in the context of the CAT Fund, 2) that they would be eager to do so, and 3) that health care providers themselves, through the CAT Fund, were in the best position to cover that portion of the overall malpractice risk not covered by private carrier coverage as defined. To provide coverage for those risks not found to be attractive by private carriers, i.e., the residual market, the Pennsylvania JUA was established concurrently with the CAT Fund.

Unfortunately, despite the fact that medical malpractice insurance did become available in Pennsylvania, Act 111 solved none of the inherent problems in the malpractice insurance market, and neither did any of the above three presumptions in establishing the CAT Fund prove to be correct. As evidenced by the current developing crisis in the malpractice insurance marketplace, it is not significantly easier to rate a structured portion of the overall malpractice risk than it is to rate the full risk, i.e., if you cannot rate malpractice insurance you cannot rate a scaled down version of it. Further, independent private carriers have not contributed greatly in terms of volume of premiums written in Pennsylvania since the establishment of the CAT Fund. Indeed, in 1982, roughly two-thirds of the total volume of premiums written in Pennsylvania were written by health care provider association companies, their subsidiaries, or the JUA, all of which began operations since 1976.

"Pay as you go" Funding

The "pay as you go" funding mechanism employed by the CAT Fund has many beneficial facets, particularly for the funding of medical malpractice insurance by a new state-run agency, in that it permits the truncation or elimination of several activities that must normally be performed by an insurer. The whole claims reserving and investment processes are obviated in that reserves are held by health care providers and of substantial magnitude in the form of the aggregate personal wealthes of health care providers. The unfunded liability of the CAT Fund is an issue only in the partial context which fails to recognize this location of CAT Fund reserves. Indeed, CAT Fund liability is mathematically bounded, as shown in Section II, and probably far better reserved than claims against any other insurer.

On the other hand, there are problems with the use by the CAT Fund of the "pay as you go" funding method. Health care providers are not aware of the fact that they, personally, hold CAT Fund claim reserves and that the difference between premiums required to fully reserve incurred losses and those premiums actually paid will eventually have to be paid into the system. Indeed, health care providers tend to view this difference, which naturally occurs prior to fund maturity, as premium savings rather than required additions to their individually held fund reserves. The only real danger inherent in this type of situation is that health care providers, as a potent political lobby, will over-react and induce unnecessary or inappropriate changes in the malpractice insurance delivery system. However, underwriting results can vary widely from expectations based on normal statistical variation which implies that calls on health care provider held loss reserves are subject to possibly wide variation. It is far from evident that all individual physicians have the desire or capacity to absorb this type of variance within the context of their personal finances, i.e., the efficacy of health care providers being in the insurance business is highly questionable.

A major problem with the "pay as you go" funding mechanism as currently administered by the CAT Fund has to do with the allocation of malpractice costs through the existing surcharge mechanism. Current procedure calls for a constant percentage, as estimated by expected Cat Fund loss experience over the coming year, of the premiums charged by primary carriers to be collected from each

health provider in the form of surcharge premiums. The theory seems to be that primary carriers perform the rating function in assigning varying premiums for primary coverage according to risk exposure, and that the maintenance of primary coverage rate differentials on a proportional basis by charging a constant percentage of primary premiums as surcharge premiums satisfies rating requirements for the total primary carrier/CAT Fund coverage required in Pennsylvania. Table IV-1 illustrates the inadequacy of this procedure in terms of allocative efficiency.

Another problem with the CAT Fund surcharge methodology in assessing surcharge premiums is the basis for application of the constant surcharge percentage. Different primary carriers can offer different premium rates to the same health care provider for any number of the reasons discussed in Section III. The CAT Fund surcharge procedure compounds any such differentials in partially (if the surcharge percentage is less than 100%) including them in CAT Fund surcharge premiums. It hardly seems appropriate for the CAT Fund to aid a particular primary carrier engaged in a cost cutting strategy by offering reduced surcharge premiums as well, but this is precisely the effect of the constant surcharge of primary coverage premiums algorithm used by the CAT Fund. The principal implication of these latter discussions is that if the CAT Fund is to be an excess coverage insurer it must appropriately set premium rates for this coverage to avoid the provision of undesired and inappropriate incentives in the malpractice insurance marketplace and as a matter of simple equity.

Other Problems

There are several other problems that inhibit the effectiveness of the CAT Fund in its role as the designated excess loss insurer in Pennsylvania.

1. A major problem lies in the inherent disincentives for primary carriers to maintain their level of effort in defense of claims when it becomes apparent that the claim value will exceed primary carrier limits.

2. Another disincentive founded in the joint liability structure of the existing malpractice insurance delivery system in Pennsylvania is a primary carrier disincentive to settle claims with estimated claim values in the "neighborhood" of primary coverage limits.

3. The problem of adequate staffing at the CAT Fund was often mentioned during the information gathering segment of this study. Existing inadequate claims expertise tends to put the Fund at a distinct disadvantage in attempting to settle claims effectively. In addition, the present five CAT Fund examiners are each responsible for monitoring on average in excess of 500 claims by health care provider count with estimated claim value in excess of $60MM. Apparently, despite the fact that it is self-supporting, the CAT Fund does not have the authority to hire adequate staff to fulfill its charter.

4. The CAT Fund policy of requiring lump sum payment of surcharge premiums within 60 days of primary coverage policy renewal would seem to impose a needless hardship on many physicians.

5. The CAT Fund does not have effective resourse against primary carriers whose actions adversely affect the Fund.

Recommendations

The major recommendation is that the role of the CAT Fund as an insurer be greatly reduced and eliminated, if possible. If the CAT Fund is to play the role of an insurer, it must become an insurer. However, since there are more appropriate roles for the CAT Fund and since the process of making an insurer of the CAT Fund would be tedious to no purpose, it seems expedient to grant insurers the role of writing insurance.

In terms of proactive roles for the "new" CAT Fund, it is recommended that the CAT Fund be made the repository of malpractice experience information which would be mandatorially reported by all insurers. In addition, the CAT Fund should be responsible for establishing, maintaining, and approving deviations from the malpractice rate structure recommended in Section III. The CAT Fund should also establish a research function for the purposes of analyzing and recommending solutions to problems that arise in the malpractice insurance market, e.g., how to most effectively provide coverage for the end of the long malpractice tail, or defining and appraising the efficacy of standardized medical procedures in various health care situations, or establishing a minimum standard in terms of malpractice experience for mandatory license suspension, etc. Finally, it is imperative that the

authority to establish budget and staffing to effectively
plish its goals.

HEALTH CARE PROVIDERS

The recommendations to this point have dealt with stabilizing and improving the malpractice insurance delivery system in Pennsylvania given the level of malpractice occurrence that is inherent in the current health care delivery system in terms of the overall quality of licensed health care providers, the quality of existing licensing procedures, etc. This section will recommend ways to achieve improvements in these latter health care delivery system characteristics.

Hospitals

In terms of the malpractice experience of hospitals, the raw data suggest that excessive offenders are responsible for a high proportion of the CAT Fund's malpractice losses attributable to hospitals. However, because hospitals are not homogenous in terms of the types, complexity, and quantity of health care provided such data require appropriate interpretation before an inference of this sort may be drawn. During the course of this study, the notion was frequently expressed that greater malpractice incidence could be expected from larger and/or teaching hospitals. Regression analysis of hospital malpractice claims experience in terms of hospital size (designated by number of beds) and teaching status (designated by the assignment of medical residents) revealed that both size and teaching status are highly significant predictors of malpractice claim experience. While the relationship between size and claims experience is entirely as expected, the relationship between teaching status and claims experience raises serious questions. It is possible that teaching hospitals are subjected to a higher required standard of medical care induced by such institution's typically higher prestige and status. It would be highly inappropriate, however, to label as malpractice health care which would be acceptable at a non-teaching hospital but which fails to meet any such higher standard imposed on a teaching hospital. It is also possible that a greater proportion of medical procedures performed at teaching hospitals are of a more complex nature with the presumed unfortunate implication that malpractice incidents would tend to have more severe and thus more readily observable results,

i.e., would be more likely to result in a malpractice claim. Finally, it is possible that teaching hospitals actually do commit more malpractice, e.g., because of inadequate supervision of residents. Whatever the source, however, remedial action to the extent appropriate should be undertaken based on the recommendations of an hereby proposed future investigation of the quality of health care expected and provided at teaching hospitals particularly in terms of differentials relative to non-teaching hospitals.

The regression analysis permitted estimation of "normal" malpractice experience, i.e., average malpractice experience after adjustment for hospital size and for any problems based on teaching status. The difference between the actual number of malpractice claims experienced and the number predicted by the regression equation, i.e., "normal" experience as adjusted, represents a particular hospital's departure from "normal" malpractice experience. The results of this analysis suggest that if only the ten worst hospitals in Pennsylvania, in term of departure from above defined "normal" malpractice experience, could improve their malpractice experience to just "normal", CAT Fund medical malpractice losses attributable to claims against hospitals would be reduced by 20%. In other words, it can indeed be inferred from the data that excessive offenders are responsible for a high proportion of CAT Fund malpractice losses attributable to hospitals.

There are myriad reasons why a given hospital would exhibit inferior adjusted medical malpractice experience including a simple run of "bad luck", i.e., adverse statistical variation. However, one major consideration is related to the quality of their medical staff, as hospitals are frequently sued in conjunction with the administering physician. To the extent the hospital is able to limit and deny staff privileges to unqualified and incompetent physicians, respectively, it can reduce its malpractice exposure in this regard. The problem of physicians performing procedures for which they are unqualified can probably be mitigated to large extent by structuring staff privileges with physicians that prove to be qualified granted higher level privileges. The recommendations of this study presented in Section III, designed to actuarially permit sound experience rating of health care providers, will increase hospital incentives for maintaining the quality of their medical staff by increasing the cost of providing staff privileges to unqualified or incompetent physicians in the form of increased hospital malpractice insurance premiums.

Another major contributing factor to adverse malpractice experience by hospitals is the failure to require or enforce standardized hospital procedures under high risk or difficult circumstances or in terms of being prepared for the development of such circumstances, i.e., there is a need for better risk management in hospitals. A study done at the University of Minnesota of all closed claims in obstetrics cases (for the entire U.S.A.) for 1980 through 1982 of the St. Paul Fire and Marine Insurance Company revealed that obstetric claims, in which indemnity was paid or in which in excess of $1,000 was expended in defense regardless of outcome, were frequently characterized by risk factor mismanagement that could have been avoided by hospital diligence to ensure performance of known effective standard procedures. Of the 220 obstetrics cases investigated by a panel of five OB/GYNs at the University of Minnesota, the physicians judged that malpractice had probably occurred in about 2/3 of the cases. For example, 44 cases were deemed by the investigating panel to have exhibited the need for fetal monitoring with the medical facility to act appropriately in response. In only 17% of the 44 cases was the situation correctly managed in the panel's opinion.

Improved risk management is essential to reducing medical malpractice in all health care settings. The recommendation is to establish a statistical research function at the CAT Fund which would serve to identify health care situations in which standardized medical care responses are, or could be, beneficial and to evaluate health care provider performance in these regards. A centralized statistical research function of this type would provide reliable information at the lowest possible cost, i.e., it would require much greater aggregate expenditure of resources for hospitals or other health care providers to perform the required statistical analyses on an individual basis. The result will be maximum economic incentive to employ and enforce the use of standardized medical procedures in various health care delivery situations with resulting substantial improvements in the quality of health care delivered in Pennsylvania and thus malpractice losses and malpractice premium rate levels.

Physicians

In terms of physicians, one of the major deficiencies of the current malpractice insurance delivery system is its inability, because of the lack of reliable information on malpractice experience, to effectively evaluate insurer exposure by

individual insured. The current system employing class rating would be improved to some extent by moving to medical specialty rating, but, even under specialty rating, malpractice costs are not efficiently allocated. An analysis of multiple malpractice offenders, i.e., physicians with more than one claim against them, by specialty reveals that 228 physicians, or 1% of all physicians that pay CAT Fund surcharge premiums, are responsible for over 25% of all CAT Fund loss payments (actual and expected) on claims reported to the CAT Fund since its inception. In neurosurgery, 10% of neurosurgeons by number account for 47% of CAT Fund loss payments on behalf of neurosurgeons. The corresponding figures for orthopedic surgeons are 4% accounting for 45%. On the other hand, multiple offenders in internal medicine represent only .1% of all internal medicine specialists and they account for only 4% of CAT Fund loss payments on behalf of internal medicine specialists. In terms of frequency, multiple offenders account of 25.2% of CAT Fund claims against all physicians. This figure compares closely with that found in a study of Florida malpractice experience in which it was found that multiple offenders were responsible for 24.4% of claim frequency against physicians.

Experience rating as opposed to class or even specialty rating would not only permit reduced medical malpractice insurance premiums for quality physicians in terms of eliminating the problem of intra-class or intra-specialty subsidization, i.e., non or single offenders subsidizing multiple offenders of the same class, but would also provide economic incentive to reduce malpractice incidence overall. If physicians could expect prompt adjustment of their malpractice insurance premium rates based on their individual malpractice experience, it is evident that strong economic incentive could be brought to bear on the problem of malpractice.

The other principal means, i.e., other than required experience rating, at the disposal of regulators by which medical malpractice may be reduced is to strengthen both licensure requirements and their enforcement. The general intuition in Pennsylvania is that physician disciplinary procedures are not effectively or widely enforced. This intuition is apparently well founded.

> "According to the Federation of State Medical Boards, the approximate number of disciplinary actions in 1982 ranged from 0 to 7.4 per thousand licensed physicians, with the rates between those extremes varying by more than 20-fold. Whereas 17 states reported 3.0 or more actions per thousand, 15 reported 1.0 or less. Of the states with 10,000 or more licensed physicians, Florida had the highest rate (7.4) and Pennsylvania the lowest (.5)."

This failure to discipline negligent or incompetent physicians in Pennsylvania and elsewhere is a direct result of physicians marked reticence to be involved in policing their own profession. However, they must recognize that "the practice of medicine is a privilege granted by the people acting through their elected representatives. It is not a natural right of individuals." While few physicians would take issue with this notion, they, as the most qualified members of the general public, must also take an active part in determining to whom this privilege should be granted. Indeed, they bear a responsibility as members of the general public and an interest as physicians in ensuring that the privilege to practice medicine is appropriately granted.

In any event, it has not been the case that the medical profession has effectively policied itself. The anonymous malpractice review process suggested in Section V might encourage greater activity in this regard. Such a reviewing process would eliminate the major hurdle in achieving effective physician self-discipline in avoiding face-to-face confrontation between physicians, and it would also eliminate any effect of the various possible relationships among physicians. Any resultant increase in reports of malpractice combined with the malpractice experience data base recommended should provide the Board with sufficient verifiable information on which to base a much needed expansion of disciplinary procedures.

An additional recommendation is for the establishment of criteria requiring a mandatory suspension of license pending disciplinary review. The public safety requires that incompetent physicians be prohibited from practicing medicine as soon as there is reasonable evidence of incompetence. In other words, it is the responsibility of the physician to prove that he is worthy of the privilege to practice medicine, and not the responsibility of the public to prove physician incompetence in denying that privilege. This fact is recognized by The Federation of State Medical Boards as evidenced by the following quotation: "The Board should be authorized to summarily suspend a license prior to a formal hearing when it believes such action is required to protect the public health and safety."

One possible set of criteria would require a mandatory six month suspension of license subsequent to Board verification of three medical malpractice claims requiring compensation in excess of $200,000 in any ten-year period. The available data suggest that such criteria would effect only .2% of all physicians but who

account for nearly 6% of CAT Fund reported losses. Indeed, only one opthalmological surgeon would be effected who has accounted for more than 25% of CAT Fund losses attributable to opthalmological surgeons. During the suspension period, the Board should review the physician's qualifications and determine additional disciplinary measures necessary, if any. It seems evident that three proven incidents of severe medical malpractice in a ten-year period is reasonable evidence of incompetence and justification for a mandatory suspension of license pending verification of the physicians qualifications to practice medicine safely and in the public interest.

LEGAL SYSTEM

The two major thrusts of the negligence system relative to the occurrence of medical malpractice are: 1) to provide compensation to victims of medical malpractice; and 2) to provide incentives to health care providers to eliminate careless behavior. It might be argued that victim compensation could be accomplished at lower overall cost under a no fault system of medical malpractice insurance. Indeed, the cost of finding fault represents a very high proportion of the overall costs of the existing malpractice system in that "for every dollar that reaches plaintiffs as compensation, one dollar is spent on litigation..." However, such a no fault system for medical malpractice would inevitably result in the filing of a medical malpractice claim for every bad medical outcome whether or not negligence had occurred. Medical malpractice professional liability insurance would effectively become health and disability insurance for bad outcomes as well as malpractice insurance, which eventuality would hopelessly blur the distinction between bad outcomes and malpractice and prohibit the provision of any form of economic incentive to health care providers to reduce malpractice occurrence. Thus, the cost of such a system, at least to health care providers, would very likely far exceed the cost of the negligence system. Even worse from a public interest perspective would be the complete loss of the deterrent effect of the negligence system. Tort law, in establishing fault, performs an indispensable role in permitting the provision of incentives to reduce medical malpractice. This second thrust of the negligence system is so important in medical malpractice because the large gap in knowledge between patients and health care providers, in terms of the appropriate relevant standard of care, inhibits patients from providing this type incentive to health care providers directly, i.e., "if the patient were as knowledge-

able as the physician about the costs, benefits, and risks of alternative treatments and the quality of care being received, the patient could protect his own interests."

A major criticism of the tort law system is its cost both in terms of the legal costs of claims processing and the purported high aggregate level of malpractice awards. Presumably, the purported excessive costs inherent in the tort law system result in higher malpractice insurance premiums which, in turn, result in higher overall health care costs. However, "since 1976, the cost of malpractice insurance (nationwide) has actually been steadily declining as a percentage of total health care costs, until it now, at $1.5 billion in 1983, is less than one-half of one percent of total health care costs ($355.4 billion)." Since the cost of the tort law system is a fraction of this $1.5 billion estimate, it represents an even smaller proportion of total health care costs. The clear implication is that the cost of malpractice insurance is an insignificant contributor to total health care costs. In fact, it is hard to believe that even if medical malpractice liability were completely eliminated that there would result any reduction in the cost of health care. On the other hand, the cost of medical malpractice injuries based solely on the presence of malpractice has been estimated at $24 billion (nationwide). If the tort law system provides incentives which result in the prevention of an additional 10% in malpractice costs that would be incurred in its absence, the benefits of the tort law system, i.e., $2.4 billion in reduced malpractice costs, would clearly outweigh the costs of less than $1.5 billion. While the precise effect of incentives to reduce malpractice incidence awaits further and more rigorous analysis, the 10% figure mentioned above is clearly not excessive, and is precisely the estimate made by Danzon in (4). In addition to the direct dollar benefits of any reduction in malpractice incidence induced by the tort law system, substantial, but less quantifiable, benefits also accrue as the result of prevented injuries to would be malpractice victims in terms of eliminating pain and suffering, inconvenience, etc. Finally, given the current poor quality of the "signal to reduce malpractice" provided by the tort law system because of insurer inability to effectively experience rate health care providers, it is evident that the tort law will be much more effective in these regards in the future when experience rating is introduced on a wide scale, at least in Pennsylvania. In fact, it is remarkable that the tort law is as effective as it is considering the current lack of effective experience rating.

A second major criticism of the tort law system is that it induces the use of defensive medicine by health care providers in an effort to avoid malpractice

liability in the event of a bad outcome. Presumably, the cost of defensive medicine increases health care costs without commensurate benefits in the form of higher quality health care. The notion of "defensive medicine" has severe definitional problems in that different health care providers can obviously mean very different things in reporting what they think constitutes defensive medicine. In one sense, the practice of defensive medicine implies the use of "extra care" in order to avoid the performance of malpractice. It is very difficult to construe defensive medicine in this context as unnecessary or not cost justified in that very few patients would be unwilling to pay such costs. Indeed, the existence of defensive medicine practiced on this basis is indicative of the effectiveness of malpractice insurance costs in providing incentive to reduce malpractice. It is also evident that the use of "extra care" by health care providers can contribute substantial cost savings in early detection of medical conditions, use of correct procedures, etc. Thus, while many health care providers as well as patients may include "extra care" in their personal definition of defensive medicine, no one would include the use of "extra care" induced by the tort law system as a liability of that system.

The only way in which the practice of defensive medicine induced by the tort law system can be viewed as a liability of that system is the extent to which procedures, that serve no medical purpose, are performed to reduce the chances of a successful malpractice law suit, i.e., those procedures that are viewed as unnecessary by the attending health care provider but as necessary by his peers in establishing appropriate standards of care. This latter dichotomy reveals the inherent illogic in any definition of unnecessary defensive medicine induced by the tort law system.

In any event, the costs of defensive medicine, however defined, are substantially smaller (roughly 10% in Pennsylvania) than the costs of malpractice insurance and thus represent an even smaller proportion of overall health care costs. It is likely that the combined costs of malpractice insurance and defensive medicine are less than one-half of one percent of health care costs. It is inconceivable that any patient would forego the opportunity of paying $201 for every $200 worth of health care purchased to provide his health care providers with strong additional incentive through the tort law system to avoid malpractice and to perform all procedures required by the relevant standard of care. The apparently widespread belief that large amounts of defensive medicine are practiced as the result of the existence of

the tort law is a tribute to its efficiency and not a detraction. The surprising aspect is how cost effective the tort law system really is in providing incentives to reduce medical malpractice.

Many suggested modifications to the tort law system, e.g., caps on malpractice awards, reductions in the statute of limitations applicable to malpractice claims, or elimination of the collateral source rule, are merely cost shifting devices that partially shift the costs of medical malpractice from health care providers and their insurers to other forms of insurance, to state programs (taxpayers), and/or to malpractice victims themselves. They do not save money in the aggregate! In addition, such reforms diffuse the incentives to reduce malpractice incidence by reducing the cost impact of malpractice on health care providers and actually induce increased malpractice incidence and cost in providing reduced incentives to avoid malpractice.

The tort law system appears to have been cost effective in accomplishing its goal of providing incentives to reduce malpractice incidence even under conditions of poor information quality for purposes of experience rating health care providers. Upon implementation of the recommendations of this study, the environment in which the tort law operates will be much more conducive to effective experience rating and thus to "signal" clarity in providing incentives for the reduction of malpractice. The basis for the current criticism and suggested modifications of the tort law undoubtedly lies in the false perceptions of health care providers as to the roots of the developing malpractice crisis in Pennsylvania. The recent surge in malpractice premium rates have erroneously led health providers to the conclusion that insurers and/or attorneys are "milking" the system at their expense. Insurers have been effective in defending themselves to some extent by erroneously citing rising (see Section II, Primary Carriers: Frequency and Severity) frequency and severity of claims as the basis for rising premium rates. This result has left the tort law system as the convenient public "whipping boy". As discussed throughout this report, however, no group of system participants can be given complete, or even major, responsibility for the current crisis, and as discussed later in this section, the tort law system can be improved in terms of efficiency in processing claims.

Contingency Fees

Plaintiff's attorney remuneration in the form of contingency fees has been described as "the poor man's key to the courthouse." There is no question that the availability of contingency fee remuneration has permitted the bringing of malpractice claims by victims of malpractice who could not otherwise afford to bring a claim. One basis on which contingency fees are criticized is that victorious plaintiff's attorneys receive compensation that is disproportionate to their efforts with the effects of greatly reducing the proportion of award proceeds accruing to the victim and increasing the overall cost of health care by increasing the cost of malpractice insurance losses.

Empirical studies of the effects of various tort reforms on medical malpractice costs reveal that limits on plaintiffs' attorney contingency fees do not bear a statistically significant relationship to malpractice claim severity or total costs. The results of this research combined with the intuitive notion that juries, etc. do not consider contingency fees in establishing malpractice award levels imply that contingency fees do not in any way result in increased health care costs, i.e., the costs of contingency fees are borne solely by malpractice victims.

Further, contingency fees compensate plaintiffs' attorneys not only for legal work performed but for accepting the risk of receiving zero compensation in the event of an adverse claim outcome. While plaintiffs' attorney remuneration may, at times, seem substantial on an individual claim basis, it must be remembered that remuneration of any amount is received in only 25 percent (see Table VI-1) of claims brought, i.e., expected remuneration per claim brought is only 25 percent of actual average remuneration claims settled with payment. Clearly, plaintiffs' attorney expected remuneration per claim is much less substantial on average than indicated by consideration of a single large and victorious outcome. In addition, this expected compensation can be highly variable. A "losing streak" can result in zero plaintiff's attorney income for an extended period of time.

Finally, malpractice victims are perfectly free to choose an hourly compensation formula in lieu of contingency fees. Since the victim alone compensates his attorney, and since he can freely choose the contingency fee format only when appropriate, it is apparent that contingency fees add much to the legal processing of malpractice claims and detract nothing. An additional consideration in this

regard is that if existing contingency fee rate schedules do result in an excessive profit for plaintiffs' counsel, market forces can be expected to correct the imbalance through the emergence of increased numbers of malpractice trial lawyers willing to offer discounted contingency fees. The crucial point is that legal restrictions on the level of contingency fees or their structure, e.g., sliding scale structures, add nothing to the system and serve only to limit the alternatives available to malpractice victims in compensating their attorneys.

The finding of this study is that contingency fee plaintiffs' attorney compensation formulae provide a distinct benefit to the malpractice claims processing system, as such formulae permit greater numbers of malpractice incidents to result in claims brought. In terms of excessive plaintiff's attorney compensation resulting from high contingency fee rates, "what little empirical evidence is available confirms that, averaging over cases won and lost, the effective hourly earnings of attorneys paid on a contingent basis are similar to the hourly earnings of defense attorneys paid by the hour." In addition, it is evident that market forces provide sufficient regulation of such fees and their structure over the long term.

"Bad" Claims

Another basis on which the existing legal system is criticized is that it purportedly induces, or at least permits, the bringing of poor, or even fraudulent, malpractice claims by opportunistic plaintiffs' attorneys with the result of increased malpractice costs. In other words, the tort law system provides a forum in which plaintiffs' attorneys are able to exploit health care providers and malpractice insurers by bringing, and receiving settlement for, "bad" malpractice claims.

Since most malpractice claims are brought by malpractice victims through their counsel, it seems appropriate to analyze any incentives inherent in the tort law compensation system to bring "bad" claims. Clearly, hourly compensation of plaintiffs' attorneys limits claims brought to only those large and meritorious claims that are brought by the relatively affluent malpractice victims who can afford to pay hourly rates for legal services. Attorneys may have an incentive under this regime to file "bad" malpractice claims, but victims have no such economic incentive. The small probability of receiving even a large settlement would be more than offset by the substantial legal fees entailed in bringing such a claim in all cases short of explicit fraud.

On a contingency fee basis, incentives for both the victim and his attorney reverse. Malpractice victims would have an incentive to bring marginal, or even false, claims as they risk nothing in return for the probability of receiving some form of settlement. Plaintiffs' attorneys, on the other hand, in the absence of explicit fraud, have no economic incentive to bring false claims in that their expected compensation would be zero, and would have an incentive to bring poor claims only to the extent that their expected remuneration exceeds the cost of their time and effort expended in bringing the claim. Highly active malpractice plaintiffs' attorneys are, in fact, inclined to accept only highly meritorious claims, as their limited time is best spent on such claims. Indeed, contingency fee remuneration provides what might be deemed ideal economic incentives in the selection of malpractice incidents on which to bring malpractice claims in terms of screening marginal claims out of the system. Presumably, if a licensed attorney feels that the claim has enough merit to warrant the required expenditure of his time and effort, the claim is worthy of being processed by the tort law system. In fact, from an analyst's perspective, both hourly and contingency fee compensation schemes can be criticized for their roles in economically screening claims from the legal process in terms of inhibiting the bringing of claims that are not felt to potentially offer adequate plaintiff's attorney compensation.

As discussed above, plaintiffs' attorney compensation schemes provide no economic incentives that induce the bringing of "bad" malpractice claims. First, the characterization "bad" is often a self-serving and irrelevant description of some claims by the health care provider community. It is the role of the courts, not health care providers or attorneys, to decide which malpractice claims are "bad." Second, plaintiffs' attorney compensation schemes actually discourage the bringing of malpractice claims in refusing to bring claims that are economically unjustified in terms of providing adequate legal compensation.

On the other hand, evidence does exist that, 1) a large percentage of claims are settled without payment, 2) claims settled without payment represent a major loss adjustment expense item, i.e., roughly 40% of loss adjustment expenses (see discussion of Table VI), and 3) some attorneys seem to exhibit a propensity to bring claims that result in zero payment.

Based on the evidence provided in this report, it is evident that alternatives to existing claim processing procedures aimed at providing incentives for plaintiffs

attorneys to more carefully evaluate claims brought and at providing mechanisms for earlier resolution of claims for which early resolution is either appropriate or beneficial, would result in substantial savings in malpractice costs. These savings could comprise up to 15% of malpractice premiums as well as greatly improved timeliness of claim settlement outcomes.

Experts in the legal field have long believed that an appropriate claim screening and conciliation procedure could achieve efficiencies in the above regards. As part of this study, various such procedures in use, or under discussion, in a number of different states were examined. The recommended screening and conciliation procedure is based on the system put forth in the "Report of the Medical Malpractice Insurance Advisory Council" to Florida Insurance Commissioner with modifications and "improvements" as deemed appropriate. Interestingly, the group which produced the above report comprised health care providers, insurers, and both defense and plaintiffs' attorneys. The major provisions of this procedure include:

1. Within ninety days of receipt of notice of a malpractice claim the defendant must respond in one of the following ways:
   a. reject the claim.
   b. make an offer of settlement.
   c. make an offer of judgment.
   d. make an offer to admit liability and submit damages to arbitration.
   e. make an offer to submit both the issues of liability and damages to binding arbitration, which offer may be rejected by the claimant.

2. Enhanced availability of relevant information to both plaintiff and defendant.

3. After receipt, of notice of claim, the defendant may request in writing, a written expert opinion which indicates by reference to the available data that there is probable cause to believe that malpractice has been committed. The plaintiff shall have thirty (30) days to comply or suffer dismissal with prejudice with limited exceptions as noted.

4. In cases involving multiple defendants, individual defendants may settle with plaintiff separately and relieve themselves of any additional obligations.

5. Claims entailing damages of $100,000 or less will be arbitrated in accordance with Pennsylvania existing arbitration procedures. However, all parties retain an absolute right of appeal which requires the posting of a $2,500 bond, all or part of which may be ultimately forfeit, or application to proceed in forma pauperis by the appealing party.

6. A mandatory conciliation conference must be held at least thirty days before trial is scheduled to commence at or before which expert reports will be exchanged. At this conference each side will file a memorandum with the court which:
   a. outlines the evidence each side intends to present.
   b. identifies all witnesses and exhibits.
   c. specifies plaintiff's demands in settlement as well as defendant's offer, if any.

Plaintiff's costs incurred from the conference forward, exclusive of attorney's fees, are chargeable against the defense up to amount not in excess of $5,000 per defendant if the resultant verdict exceeds the settlement offer made by the defense at the conference. Similarly, such defense costs are chargeable against the plaintiff up to $5,000 if the resultant verdict is less than any settlement offer by the defense at the conference.

Other Legal Considerations

Other recommended modifications of the legal system as it applies to medical malpractice that are discussed fully in the main body of the report include:

1. A substantial softening of the doctrine of informed consent as it currently stands against health care providers.
2. The enactment of a statute of repose for malpractice claims which becomes effective ten years from the date of the malpractice occurrence but not before the victim has reached twenty years of age or in cases involving fraudulent concealment of malpractice.

3. The elimination of punitive damages except in cases of intentional malpractice.
4. The provision of a "cooperation clause" in malpractice insurance policies which could require health care cooperation with his insurer in terms of assessing malpractice culpability.
5. The elimination of any exclusive authority of the insured to veto a proposed settlement.
6. Setting the post-judgment interest rate to that charged for pre-judgment interest, or 10%.

CONCLUDING COMMENTS

The preceding executive summary highlights the more thorough contents of the main report. The implementation of the procedures and systems recommended in this report should result in the stabilizing of the malpractice insurance market in Pennsylvania. This result alone would eliminate much of the current crisis as stable malpractice premium rates would provide both health care providers and insurers with substantial benefits in terms of reduced uncertainty. Under such conditions health care providers could accurately anticipate and plan for malpractice insurance coverage expenditures, and adjust the prices of their own services accordingly. Insurers would be relieved from market destabilizing competitive pressures and be in a substantially stronger position in terms of premium rate adequacy. Most importantly, malpractice victims would retain their full rights under the law to be compensated for their unfortunate circumstances.

However, more than market stability can be expected. Resulting improved experience rating will provide much improved incentives to avoid malpractice. If Danzon's estimate that health care costs based solely on the pressure of malpractice would be 10% higher without current tort law induced incentives to avoid malpractice, can be extrapolated to actual malpractice losses, it seems reasonable that such incentives as improved by sound experience rating can provide twice this benefit, i.e., a 10% reduction in malpractice losses from current losses. In this case, malpractice premiums would be reducible by roughly 10% as well. In addition, improved experience rating would greatly increase the efficiency of malpractice cost allocation. Most health care providers, i.e., those with good malpractice experience, would pay reduced premiums as a result. Based on CAT

Fund experience with multiple excessive offenders, i.e., 25% of CAT Fund total reported losses attributable to physicians are accounted for by multiple offenders and 20% of CAT Fund such losses attributable to hospitals are accounted for by the ten hospitals with the worst claims experience as adjusted for size and teaching status, an average premium reduction of 20% does not seem unreasonable with some health care providers receiving a greater such discount and others a smaller one. Of course, health care providers with bad malpractice experience would pay higher premiums. Also, if improvements in the processing of claims resulting from recommended improvements in this regard, could eliminate roughly half of the loss adjustment expenses attributable to claims that are settled without payment, an additional premium savings of roughly 15% could be expected. Finally, the elimination of problems based on the joint CAT Fund/primary carrier(s) relationship in handling claims, improved risk management, etc. may be expected to result in further premium savings.

If malpractice insurance premium rates are currently at or near appropriate levels, then, health care providers with good malpractice experience might expect to eventually receive premium reductions on the order of 40% from those now in effect, i.e., in the absence of health care cost inflation future premium rates might be expected to be 40% lower than current rates based on recommended improvements to the malpractice insurance delivery system.

It must be pointed out that this 40% reduction figure is only an "enlightened estimate" in anticipation of the more sound actuarial analysis that will ultimately be done, but if the assumption that current rates are adequate is valid, substantial reduction in "real" premium rates can be expected.

Provided By — Kansas Bar Association

M·A·C

MEMORANDUM

TO: The Select Committee on Medical Malpractice

FROM: Alfred E. Hofflander and Blaine F. Nye

DATE: June 12, 1985

SUBJECT: Malpractice Study

Subsequent to our final report on "Medical Malpractice in Pennsylvania", we have had the opportunity to discuss our findings and results with several involved parties including Ronald T. Kuehn, FCAS, MAAA, CPCU, ARM, consulting actuary, and Lawrence E. Smarr, Vice President - Data Processing and Research, both of the Pennsylvania Medical Society Liability Insurance Company; Allan Kaufman, FCAS, consulting actuary of the Pennsylvania Medical Society; and, The Medical Malpractice Task Force of the Pennsylvania Medical Society.

Pursuant to our discussions with these parties and others, we felt that it would be appropriate to prepare an Addendum to the report for the purpose of clearing-up any misunderstandings, misinterpretations, or errors of fact or omission in the final report.

Please find this Addendum enclosed.

cc: Senator Robert C. Jubelirer

Enclosure

ADDENDUM

Subsequent to our final report on "Medical Malpractice in Pennsylvania," we have had the opportunity to discuss our findings with various involved parties. The purpose of this addendum is to clear up any misunderstandings, misinterpretations or errors of fact or omission in the final report, as well as to comment on any resultant effect on our conclusions and recommendations for the medical malpractice insurance delivery system in Pennsylvania.

Our contention that there has been no verifiable upward trend in "real" malpractice incurred losses has been interpreted by a few observers as implying no growth in incurred losses. On the contrary, no growth in "real" losses, as they are defined in the report, is entirely equivalent to nominal growth in losses at the same rate as the Medical Care Index (MCI), i.e., 10-11% per year since 1978. Similarly, our intuition that premium rates may now be at roughly appropriate levels in an actuarial sense has been interpreted as implying that we do not expect any further increases in malpractice premium rates. Again, on the contrary, we expect that premium rates will continue to grow at roughly the rate of the MCI.

We feel that growth in losses, and thus premiums, at the MCI is entirely normal and as should be expected. The MCI was chosen as a readily accessible and highly appropriate surrogate for actual "claim cost inflation." If the exact same set of malpractice events occurred in two subsequent years, the cost of settling those claims would be higher in the second year by the amount of claim cost inflation, regardless of the medical malpractice insurance delivery system in place, the level of health care provider income, or the extent of any crisis in medical malpractice. Premiums must grow to cover these increased costs. During the early stages of the study, we attempted to construct a "claim cost inflation" index for Pennsylvania but were unable to gather the required data. As a result, we settled on the MCI as the most appropriate of the readily available indices of inflation.

If health care provider income does not keep pace with "claim cost inflation," then health care providers will definitely find themselves in a cost squeeze, i.e., their

malpractice premiums will rise faster than their income. While such a problem lies outside our pervue in studying the malpractice insurance delivery system, we fully recognize the possible existence of such a problem and hope that further analysis from a "social equity" perspective will yield an acceptable solution. In any event, to the extent that our recommendations are adopted and premiums are reduced in "real" terms, this cost squeeze will be ameliorated to some extent.

During our conversations with PMSLIC's consulting actuary, it came to our attention that, for whatever reasons or based on whatever misunderstandings, our data from PMSLIC was not in the form in which we had thought, with the result that our analyses based on Tables II-9 and II-10 had to be reconsidered. It should be noted that we were concerned with the apparent decline in frequency and losses illustrated in these two tables, and limited our conclusion by stating only that "...there has been no verifiable upward trend in real (discounted at the MCI) malpractice losses or malpractice frequency of occurrence..." We have since been provided with PMSLIC's estimates that incurred losses are rising at 13.1% per year, that frequency is rising at 5.5% per year, and that severity is rising at 7.2% per year. Correcting the loss and severity trend estimates for claim cost inflation yields a real loss trend of 2% to 3% per year and a real severity trend of negative 3% to 4% per year. In the first place, these trend estimates are entirely compatible with the analysis presented in the report in that the central thesis of the report in this regard is that the huge rate increases experienced by Pennsylvania health care providers during 1983 and 1984 cannot be justified based on incurred loss trends. Secondly, they are not statistically incompatible with the zero frequency trend and zero real loss and severity trends hypothesized in the analysis of the report, i.e., the 95% confidence intervals around PMSLIC's sample estimates include the zero trend in all three cases. As a digression, it should be noted that an insurer, for planning purposes and for setting premium rates, would justifiably tend to use the actual sample trend estimate, or an even higher value out of "conservatism," while an analyst, in attempting to verify the actual existence of the trend would be more concerned with whether or not the sample estimate is statistically different from zero, i.e., with whether or not the 95% confidence interval includes the zero trend.

In terms of our recommendations for the CAT Fund, several concerns were expressed, but the two major concerns had to do with the feasibility of phasing the

CAT Fund out as an insurer given current conditions in the reinsurance market, and the financial burden that would be imposed on health care providers in paying off the CAT Fund's existing unfunded liability. As mentioned in the report, the CAT Fund will undoubtedly have to be phased out as an insurer on a graduated basis over time. The real question is not whether it can be phased out but precisely how this should occur and in what time frame. In any event, any time frame is superior to having health care providers remain in the insurance business. It is important to note that whether or not the CAT Fund is phased out of the insurance business will have no impact on the existing unfunded liability of the CAT Fund.

This existing unfunded liability, however, is a serious problem. Health care providers have not held their early premium savings in reserve in anticipation of future claims payouts and, since many physicians have retired or left the state, a retroactive premium assessment could not even reach all those who benefitted in the late 1970's and early 1980's. In any event, finding an equitable solution to the unfunded liability is an extremely important issue. This present dilemma reinforces the need to find appropriate solutions to current medical malpractice problems so that future such dilemmas are not created by present actions.

It was pointed out that a quotation presented in the report comparing medical malpractice premiums with total health care costs underestimated total premiums by excluding premiums paid to JUAs, CAT Funds, and reinsurers. We concur with this insight and would alter the quotation to say that total medical malpractice premiums amount to less that one percent of total health care costs rather than ". . . less than one-half of one percent . . ." This change has no substantive bearing on the conclusions and recommendations of the report.

A consistent theme voiced by various parties throughout the course of the study was that there may be valid "social," as opposed to pure economic, considerations in setting premium rates. While we did not address any such "social" considerations in our report, our position should not be construed as antagonistic to any mutually agreeable social solutions.

Finally, it seems important to carefully list the benefits that will accrue to health care providers as the result of the implementation of the recommendations made in the report.

1) Premium rate stability, i.e., premium rates will rise much more predictably at the claim cost inflation rate. The major element of the crisis is not rate levels per se but the rapid and unpredictable way in which they have been rising and are expected to continue to rise. (Stability should not be construed as implying constant rates over time.)

2) Experience premium rating will substantially increase the cost allocation efficiency of malpractice losses with the vast majority of health care providers paying lower "real" malpractice premiums.

3) Recommended legal changes will save premium dollars by reducing the costs of legally processing malpractice claims.

   a) Requiring an expert report within 30 days of request by the defense will effectively require plaintiff to have an expert when the claim is filed. This result will reduce the number of claims which amount to little more that legal harassment.

   b) Recommended streamlined claims processing procedures and penalties depending on the relationship of any settlement offer to the ultimate verdict will speed up the claims process and provide incentives for earlier settlement of many claims.

   c) Arbitration for smaller claims (less than $100,000) will facilitate their earlier resolution.

4) Improved physician discipline will save premium dollars by reducing malpractice.

   a) Mandatory license suspension criteria.

   b) Enhanced information availability which will permit earlier and more effective disciplinary action.

5) Improved risk management will also save premium dollars by reducing malpractice.

a) Compliance with approved standardized medical procedures.

b) Incentives to independently improve risk management provided by experience rating.

6) Recommended changes in the CAT Fund will stabilize premiums, save premium dollars, and more efficiently allocate claims costs over health care providers.

a) Health care providers will be removed from the insurance business, i.e., their personal incomes will no longer be subject to the variability of actual malpractice loss payments as they are under the "pay as you go" funding mechanism.

b) The inefficiencies of joint CAT Fund/primary carrier handling of claims will be eliminated.

c) Insurance operations, e.g., claims adjustment, will be more efficiently handled by an insurance company than they have been by the CAT Fund.

d) Appropriate premium rating for excess coverage will greatly improve cost allocation efficiency over the current constant surcharge rating procedure.

We feel that the recommendations provided in the report, if implemented, will bring substantial relief to health care providers and the medical malpractice insurance delivery system in Pennsylvania, by solving the current major problems with the system. On the other hand, we by no means wish to imply that we consider the system to be "perfect" in areas in which we made no specific comment. Indeed, like the ongoing attempt to solve the current malpractice insurance "affordability" crisis, we consider the report to be a "living" effort, i.e., one that will be discussed, added to, improved, refined, etc. and ultimately implemented through the joint efforts of all involved parties.

Alfred E. Hofflander, Ph.D.
Blaine F. Nye, Ph.D.

Attachment IV

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UHLIG, SECRETARY
ELIZABETH W. CARLSON, EXECUTIVE SECRETARY
DONALD G. STROLE, GENERAL COUNSEL
503 KANSAS AVENUE, SUITE 500
TOPEKA, KANSAS 66603-3449
PHONE (913) 296-7413

TO: Chairman Joe Knopp and Members of the Special Committee on Medical Malpractice

FROM: Don Strole, General Counsel

RE: Recommendations to Improve Board's Ability to Deal With Malpractice

DATE: July 8, 1985

1. Authority should be given to the Board to adopt rules and regulations or perhaps just guidelines establishing minimum standards of medical practice in any particular area. Special Committee should be established consisting of members of plaintiff's bar, defendant's bar, expert witnesses who testify in medical malpractice cases, specialists (including family or general practice) from KU Medical Center, Kansas City Osteopathic College and other areas of the State. Special exemption should be made to rule and regulation statutes to allow any particular standard to be changed with simply notice in Kansas Register and holding of public hearing. Standards should be standard to be used in medical malpractice cases or at least should be admissible in such cases. Georgia, Arizona and Maryland have attempted to adopt such standards.

2. Legislation requiring licensees to report to appropriate person in hospital regarding any staff members (doctors, nurses, other support staff) who fall below minimum standard of care required of such person. Failure of such reporting should result in the Board being able to institute immediate suspension of license. In Olsen v. Younglove, one particular doctor testified for 10 pages in the trial transcript that nurses fell below minimum standards of care in

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Attachment IV

5. Legislation should be passed to make disciplinary actions of the Board inadmissible in medical malpractice suits involving the same doctor. This may make it easier for certain persons to report to us, and also would make it less likely that attorneys representing the doctor in malpractice suits would be representing doctors before the Board attempting to prevent the Board from taking action during the pending of the malpractice suit.

6. Specific requirements should be placed upon Insurance Department to inform the Board whenever the Department possesses information that a particular licensee of the Board may be incompetent. We do not necessarily need the specific information in their files, we simply need to know that we should begin an investigation of a certain doctor.

7. Legislation should be passed which specifically allows the Board upon probable cause to require a licensee to take an examination on competency which is approved by the Board. If licensee fails the examination, the Board should be given authority to order the licensee to attend a course or courses in whatever areas the licensee is deficient or to take whatever other disciplinary action is appropriate.

8. Legislation should be passed which requires hospitals to submit to the Board peer review records on particular doctors when the hospital makes reports pursuant to K.S.A. 65-28,121.

9. A special committee should be established to review peer review records submitted to the Board and any other peer review records the committee may choose

commissioner, the state agency which licenses, registers or certifies the named insured and the named insured. Such notice shall be provided no less than 30 days prior to the effective date of any termination initiated by the insurer or within 10 days after the date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

(3) Any professional liability insurance policy issued, delivered or in effect in this state on and after the effective date of this act shall contain or be endorsed to provide basic coverage as required by subsection (a) of this section. Notwithstanding any omitted or inconsistent language, any contract of professional liability insurance shall be construed to obligate the insurer to meet all the mandatory requirements and obligations of this act. The liability of an insurer for claims made prior to July 1, 1984, shall not exceed those limits of insurance provided by such policy prior to July 1, 1984.

(b) Unless a nonresident health care provider is a self-insurer, such provider shall not render professional service as a health care provider in this state unless such provider maintains coverage in effect as prescribed by subsection (a) of this section, except such coverage may be provided by a nonadmitted insurer who has filed the form required in paragraph (1) of subsection (b) of this section.

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any nonadmitted insurer may file such a form.

(2) Every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (a) of this section.

(c) Every health care provider that is a self-insurer shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 and amendments thereto directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (a) of this section.

History: L. 1976, ch. 231, § 2; L. 1984, ch. 238, § 2; July 1.

CASE ANNOTATIONS

2. Cited in upholding shortening of statute of limitations in actions against health care providers. Stephens v. Snyder Clinic Ass'n, 230 K. 115, 118, 631 P.2d 222 (1981).

3. "Occurrence" form policy construed as "claims made" policy to conform to statute, limits not changed to statutory minimum; award of attorney fees. Missouri Medical Ins. Co. v. Wong, 234 K. 811, 817, 821, 676 P.2d 113 (1984).

40-3403. Health care stabilization fund; establishment; administration; liability of fund; payments from fund; qualification of health care provider for coverage under fund. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

(b) (1) There is hereby created a board of governors. The board of governors shall provide:

(A) Technical assistance with respect to administration of the fund;

(B) such expertise as the commissioner may reasonably request with respect to evaluation of claims or potential claims;

nually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney's fees payable from such installment shall be similarly prorated.

(e) In no event shall the fund be liable to pay in excess of $3,000,000 pursuant to any one judgment or settlement against any one health care provider relating to any injury or death arising out of the rendering of or the failure to render professional services from and after July 1, 1984, subject to an aggregate limitation for all judgments or settlements arising from all claims made in any one fiscal year in the amount of $6,000,000 for each provider.

(f) A health care provider shall be deemed to have qualified for coverage under the fund: (1) On and after the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective date of this act, at such time as basic coverage becomes effective; or (3) upon qualifying as a self-insurer pursuant to K.S.A. 40-3414 and amendments thereto.

(g) Notwithstanding the provisions of K.S.A. 40-3402 and amendments thereto, if the board of governors determines that an individual health care provider presents a material risk of significant future liability to the fund, the board of governors is authorized by a vote of a majority of the members thereof, after notice and an opportunity for hearing, to terminate the liability of the fund for all claims against the health care provider for damages for death or personal injury arising out of the rendering of or the failure to render professional services after the date of termination. The date of termination shall be 30 days after the date of the determination by the board of governors. The board of governors, upon termination of the liability of the fund under this subsection (g), shall notify the licensing or other disciplinary board having jurisdiction over the health care provider involved of the name of the health care provider and the reasons for the termination.

History: L. 1976, ch. 231, § 3; L. 1980, ch. 143, § 1; L. 1983, ch. 160, § 1; L. 1984, ch. 238, § 3; L. 1984, ch. 178, § 1; July 1.

CASE ANNOTATIONS

1. Cited in upholding shortening of statute of limitations in actions against health care providers. Stephens v. Snyder Clinic Ass'n, 230 K. 115, 118, 631 P.2d 222 (1981).

40-3404. Levy of annual premium surcharge; amount; collection by insurer; penalty for failure of insurer to comply; setting amount of premium surcharge. (a) Except for any health care provider whose participation in the fund has been terminated pursuant to subsection (g) of K.S.A. 40-3403 and amendments thereto, the commissioner shall levy an annual premium surcharge on each health care provider who has obtained basic coverage and upon each self-insurer for each fiscal year. Such premium surcharge shall be an amount equal to a percentage of the annual premium paid by the health care provider for the basic coverage required to be maintained as a condition to coverage by the fund by subsection (a) of K.S.A. 40-3402 and amendments thereto. The annual premium surcharge upon each self-insurer shall be an amount equal to a percentage of the amount such self-insurer would pay for basic coverage as calculated in accordance with rating procedures approved by the commissioner pursuant to K.S.A. 40-3413 and amendments thereto.

(b) In the case of a resident health care provider who is not a self-insurer, the premium surcharge shall be collected in addition to the annual premium for the basic coverage by the insurer and shall not be subject to the provisions of K.S.A. 40-252, 40-1113 and 40-2801 *et seq.*, and amendments to these sections. The amount of the premium surcharge shall be shown separately on the policy or an endorsement thereto and shall be specifically identified as such. Such premium surcharge shall be due and payable by the insurer to the commissioner within 30 days after the annual premium for the basic coverage is received by the insurer, but in the event basic coverage is in effect at the time this act becomes effective, such surcharge shall be based upon the unearned premium until policy expiration and annually thereafter. Within 15 days immediately following the effective date of this act, the commissioner shall send to each insurer information necessary for their compliance with this subsection. The certificate of authority of any insurer who fails to comply with the provisions of this subsection shall be suspended pursuant to K.S.A. 40-222 and amendments thereto until such insurer shall pay the annual premium surcharge due and payable to the commis-

65-1909.

Law Review and Bar Journal References:

"Medical Malpractice—The Kansas Law," Wayne T. Stratton, J.D., 81 J.K.M.S. 505, 508 (1980).

65-1914. Public policy relating to provision of health care. It is the declared public policy of the state of Kansas that the provision of health care is essential to the well-being of its citizens as is the achievement of an acceptable quality of health care. Such goals may be achieved by requiring a system which combines a reasonable means to monitor the quality of health care with the provision of a reasonable means to compensate patients for the risks related to receiving health care rendered by health care providers licensed by the state of Kansas.

History: L. 1984, ch. 238, § 1; July 1.

65-1915. Peer review; health care providers, services and costs; definitions; authority of peer review committee; records privileged; exceptions. (a) As used in this section, "health care provider" has the same meaning as the definition of that term in K.S.A. 40-3401 and amendments thereto.

(b) As used in this section, "peer review committee" means a committee of, or appointed by: (1) A state or local association of health care providers; (2) the board of governors created under K.S.A. 1984 Supp. 40-3403; (3) an organization of health care providers formed pursuant to state or federal law and authorized to evaluate medical and health care services; (4) a review committee operating pursuant to K.S.A. 1984 Supp. 65-2840b to 65-2840d, inclusive; or (5) an organized medical staff of a licensed medical care facility as defined by K.S.A. 65-425 and amendments thereto, or by a health care provider as defined in K.S.A. 40-3401 and amendments thereto, which committee provides peer review pursuant to written bylaws that have been approved by the governing board of such medical care facility or health care provider as defined in K.S.A. 40-3401 and amendments thereto, if the committee so formed by organizations described in parts (1), (2), (3), (4) or (5) of this subsection (b) is authorized to perform any of the following functions:

(A) Evaluate and improve the quality of health care services rendered by health care providers;

(B) determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care;

(C) determine that the cost of health care rendered was considered reasonable by the providers of professional health services in this area;

(D) evaluate the qualifications, competence and performance of the providers of health care or to act upon matters relating to the discipline of any individual provider of health care;

(E) reduce morbidity or mortality;

(F) establish and enforce guidelines designed to keep within reasonable bounds the cost of health care;

(G) conduct of research;

(H) determine if a hospital's facilities are being properly utilized;

(I) supervise, discipline, admit, determine privileges or control members of a hospital's medical staff;

(J) review the professional qualifications or activities of health care providers;

(K) evaluate the quantity, quality and timeliness of health care services rendered to patients in the facility;

(L) evaluate, review or improve methods, procedures or treatments being utilized by the medical care facility or by health care providers in a facility rendering health care.

(c) Except as provided by K.S.A. 60-437 and amendments thereto and by subsections (d) and (e) of this section, the reports, statements, memoranda, proceedings, findings and records of peer review committees shall be privileged and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible in evidence in any judicial or administrative proceeding. This privilege may be claimed by the legal entity creating the peer review committee, or by the commissioner of insurance for any records or proceedings of the board of governors.

(d) Subsection (c) of this section shall not apply to proceedings in which a health care provider contests the revocation, denial, restriction or termination of staff privileges or the license, registration, certification or other authorization to practice of the health care provider.

(e) Nothing in this section shall limit the authority, which may otherwise be pro-

Identifying violators and establishing proof of misconduct are only some of the problems inhibiting regulatory boards.

By Charlotte L. Rosenberg

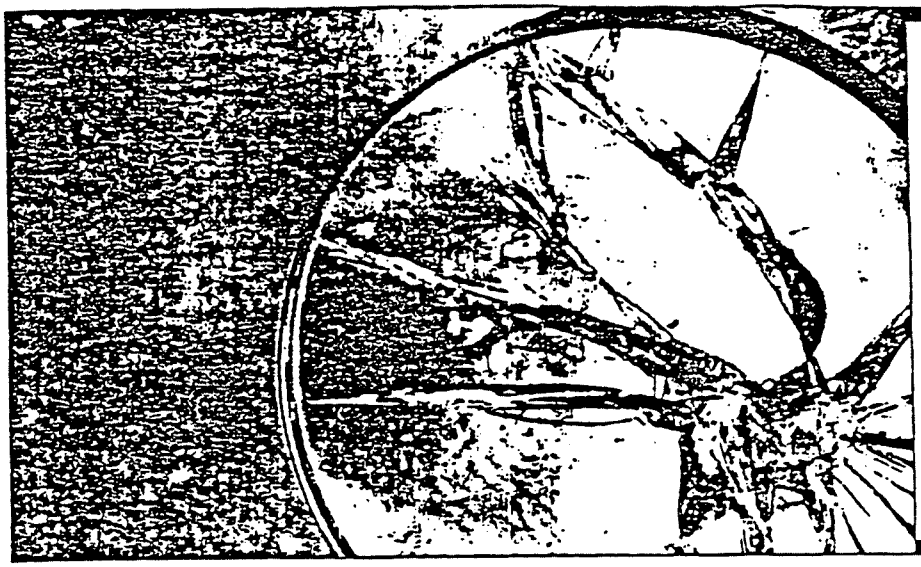
"We had one doctor with a long record of appearances before us whom we could never manage to nail down," says internist David Ben-Asher, a member of Arizona's board of medical examiners. "What finally enabled us to suspend his surgical privileges throughout the state was an appendectomy audit—but we had to get a complaint about an improper appendectomy before we could send in our investigator. He found that 70 percent of the physician's last 50-odd appendectomies involved normal appendixes.

"Following our action," Ben-Asher continues, "his own hospital suspended him completely and turned over to us records of a group of his emergency-room cases. Our review of them, together with the appendectomy audit and his long track record with the board, led to the total revocation of his license."

A disciplinary success story? Not altogether. The physician slapped a $17 million lawsuit on the board of examiners and filed separate actions against individual board members. "He's suing me for $500,000," says Ben-Asher. Though Arizona's statute provides immunity from liability for board activities and, in fact, the state is paying all legal costs for the board members, the law doesn't give them immunity from the suit process. They'll still have to respond to the charges.

That's an example of some of the factors obstructing progress in doctor-policing, a field where all 50 states have had a difficult time in bringing errant physicians to justice. According to the Federation of State Medical Boards, Florida meted out punishment to 167 physicians in 1982, making it tops in the nation in disciplinary actions. Yet the penalized physicians represent only 1 percent of the 17,000 physicians providing patient care there—and if you count all the state's licensed physicians, the percentage is even less.

California's Board of Medical Quality Assurance (BMQA) took sanctions against 147 physicians in 1982. That's less than Florida's tally, and with almost three times as many M.D. practitioners in the state, California's ratio is only a



If a problem doctor is primarily in office practice, it's almost impossible to get a handle on him.

Lawmakers had high hopes that requiring insurers to report malpractice settlements would turn up a lot of incompetent physicians, but that isn't proving to be the case. Says a Washington board spokesman: "Last year we had 75 reports from insurance carriers, and not one pointed to a doctor whose license warranted being acted upon." Adds C. William Howe, a bureau director in Michigan's Department of Licensing & Regulation: "We haven't been doing malpractice review for at least a year, but we've reinstituted it again as the best way to uncover patterns of incompetence or negligence."

Where malpractice reports could help is in showing whether the negligent incident stemmed from a physician's underlying problem. "We had an orthopedist in this state," says Georgia's Anthony, "who punctured the inferior vena cava during a disk operation, and the patient bled to death. It wasn't because of the accident that the board got involved with the doctor—but because he was operating under the influence of alcohol."

Board members agree that hardest to ferret out are doctors who simply practice incompetently. Some states have gone so far as legislating minimal practice standards. Georgia, for instance, recently set up guidelines delineating the elements of appropriate diagnosis, treatment, and record-keeping. Maryland's law spells out 25 acts that constitute professional misconduct; Arizona lists 20, including overcharging, keeping inadequate records, and prescribing controlled substances to a relative.

The problem of insufficient resources

Though some complaints—especially those originating in the

staffers, the "old boy" system still prevails. Says medical coordinator James Anthony of Georgia: "It's almost impossible to get a doctor to review certain cases, especially if the physician in question is a powerful figure in the community." In one case, Anthony had to call 16 doctors before he found one willing to look over the subpoenaed records. "The 17th doctor reviewed the file and told me, 'This guy is bad.' But when I asked if he'd say that before the board, he refused."

"The hardest doctor to prosecute," says Arizona board member Ben-Asher, "is the likable, even dedicated, physician who's practicing outdated medicine. He's not a crook, he isn't getting rich, but he's just not cutting it." Knowing the difficulty of getting testimony in such cases, the board can order the doctor to take a competency examination. If he fails, the board has leverage to force him to turn in his license.

A California law that's effective next year authorizes the BMQA to compel a physician under investigation to take an oral exam. "There are many instances," says the board's medical consultant Antony Gualtieri, "where we don't want to file a formal charge. The new mechanism allows us to draft an allegation of incompetence, which gives us the right to ask for the exam." The doctor gets two chances before different teams of examiners. "Failure to pass both times isn't in itself proof of incompetence," says Gualtieri, "but together with the original complaint, it's enough to justify a formal hearing."

The problem of due process

The boards try to move expeditiously, but they don't want a case overturned on procedural grounds. They're careful, therefore, to give the accused doctor his rights—to bring in experts, to present even extraneous material, to get endless extensions for still one more witness or one more bit of information.

"In many instances," observes New York chairman Naomi Goldstein, "we're dealing with doctors who have a big income at stake and fight tooth and nail to preserve it. They may be the worst doctors—those making a fortune doing something improper—but they can afford high-powered lawyers who use every delaying tactic in the book. They can keep the process going forever."

Says general surgeon Karl F. Mech Sr. of Maryland's board of examiners: "We've had two recent cases that went to 15 hearings apiece; yet the commission on medical discipline meets only 32 times a year." Most state board members agree that if a case goes through each stage of the process—peer review, investigation, hearings, and appeals—it will take about a year and a half to complete.

In New York, so many cases went to multiple hearings that the board asked the legislature to amend the statute to reduce the number of physicians on the

They don't want cases overturned on procedural grounds, so they're careful to give the accused doctor all his rights.

sion of his license and surrender of his controlled-substances registrations, he was put on a 10-year probationary period, during which he was prohibited from dispensing any medications or performing surgeries requiring a general or spinal anesthetic without approval of the board. He was also to submit periodic reports to the board, giving detailed data on each patient seen, each service rendered, each medicine administered.

Once a board makes a disciplinary decision, it has its own report to issue—to the Federation of State Medical Boards, which disseminates it to every state, to all health-care agencies responsible for third-party reimbursement, the hospitals, the state medical society, and the hospital association. About 15 state boards publish the names of doctors they've disciplined in their own newsletter. Whenever final action is taken, most insert a notice in the public papers.

The boards are obviously trying to do their job. But it's also obvious that a discipline mechanism in any state isn't enough to ensure that doctors who aren't safe aren't in practice. "That," says Kathleen Tanner, director of New York's Office of Professional Conduct, "requires the cooperation of other doctors and hospitals, aggressive peer review, strong credentialing programs, financial support, and enlightened statutes. Together, they may get the disciplinary process working; but the disciplinary boards are only a piece of the pie." ■

Attachment 2

KANSAS MD EXPERIENCE
CALENDAR YEARS 1975-1984

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984
POLICYHOLDER COUNT	876	943	1,064	1,104	1,112	1,165	1,201	1,250	1,257	1,152
DIRECT PREMIUMS WRITTEN	1,082,383	703,768	1,327,522	1,713,940	1,823,778	2,039,630	2,118,131	2,230,644	2,463,776	3,403,694
DIRECT PREMIUMS EARNED	885,084	671,768	1,199,892	1,603,885	1,783,394	2,011,890	2,122,643	2,216,951	2,417,997	3,429,926
INCURRED LOSSES	645,100	362,885	588,288	1,189,445	1,569,903	1,238,305	1,927,589	1,533,971	3,154,758	1,574,329
INCURRED ALE	187,969	180,162	180,191	285,725	322,153	663,985	297,978	520,366	433,626	588,593
ULE PAID	141,922	79,835	123,540	249,783	313,981	247,661	366,242	276,115	504,761	251,893
PREMIUM TAXES PAID	21,648	14,075	26,550	34,279	36,476	40,793	42,363	44,613	49,276	68,074
TOTAL INCURRED	996,639	636,957	918,569	1,759,232	2,242,513	2,190,744	2,634,172	2,375,065	4,142,421	2,482,889
UNDERWRITING GAIN (LOSS)	(111,555)	34,811	281,323	(155,347)	(459,119)	(178,854)	(511,529)	(158,114)	(1,724,424)	947,037

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EXHIBIT C

KANSAS MD EXPERIENCE
CALENDAR YEARS 1975-1984

ACCIDENT/ REPORT YEAR	NUMBER OF INSUREDS	NUMBER OF CASES AGAINST INSUREDS	NUMBER OF CASES WITH LOSS PAYMENTS	TOTAL LOSS PAYMENTS
1975	876	59	53	1,144,500
1976	943	26	26	718,045
1977	1,064	17	17	528,410
1978	1,104	43	43	462,711
1979	1,112	62	60	784,463
1980	1,165	52	51	997,111
1981	1,201	68	66	1,596,705
1982	1,250	100	92	1,901,472
1983	1,257	88	60	1,052,000
1984	1,152	106	47	281,028
TOTALS		621	515	9,466,445

THE COMPANY IS UNABLE TO DETERMINE THE NUMBER OF JURY AWARDS DURING THIS PERIOD.

Attachment VI

Attachment VI

7/18-19/85

attachment VII

A Model Act
(The Indiana Plan)

The total approach to balancing malpractice issues.

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Attachment VII

MAJOR ELEMENTS OF THE INDIANA MEDICAL MALPRACTICE LEGISLATION

1. The various limitations on liability serve as restraints on the dollars required to effect reasonable resolutions of claims while preserving the claimant's ability to receive an equitable award.

   a. Total recovery payments are limited to $500,000 but structured settlements can stretch the amount far beyond that, if needed or desired.
   b. Individual liability is limited to $100,000, after which the Patients Compensation Fund is activated. This forces review of all major cases to the state Insurance Department automatically for whatever further action is indicated.
   c. Vicarious liability obligations do not exist as a financial obligation.

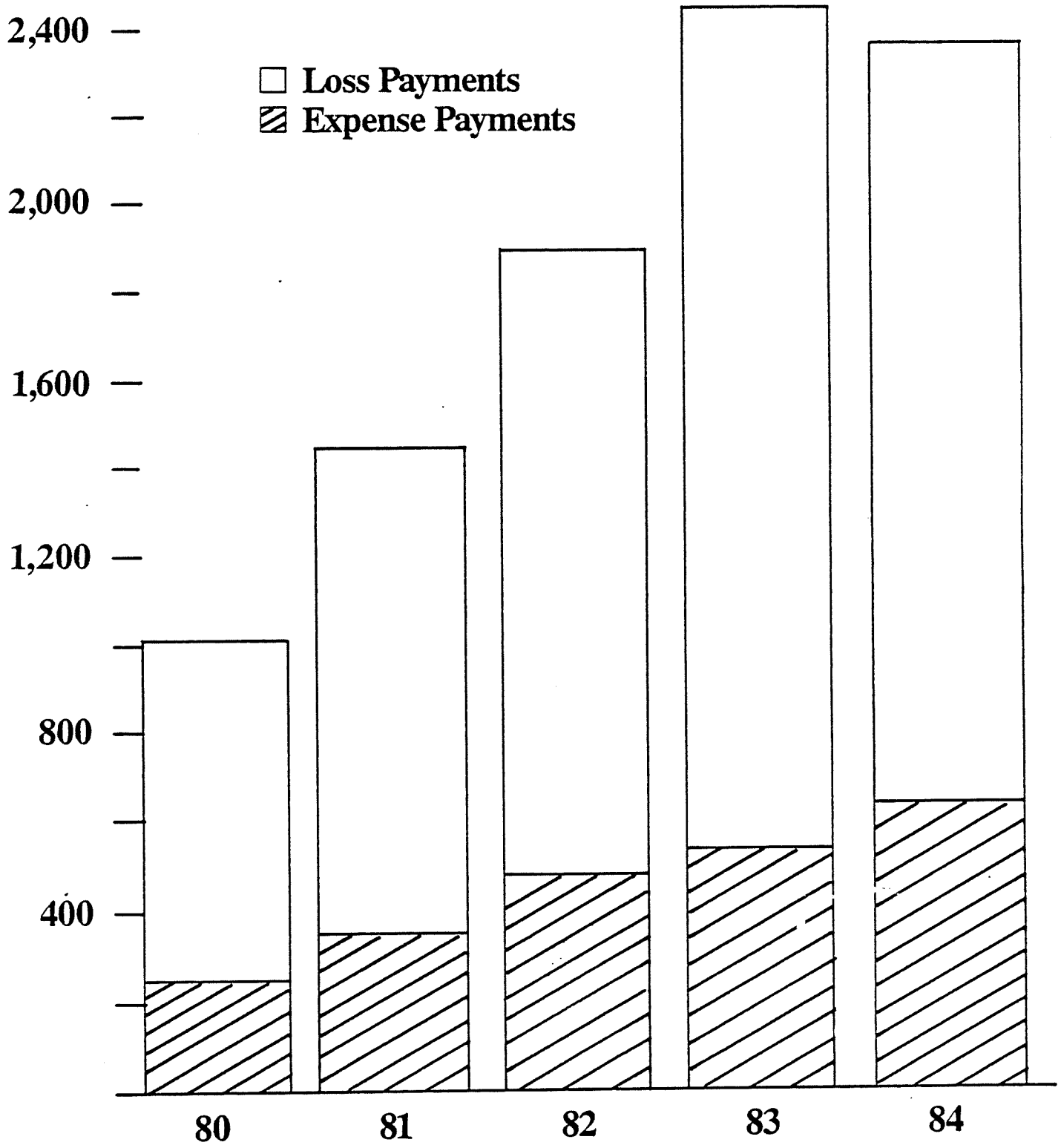
2. The strict Statute of Limitations requiring filing within two years from the date of services (tolled until age 6 for minors) keeps the time interval between the date of services to date of claim filing (the "tail") to reasonable proportions in Indiana.

3. The Patient's Compensation Fund, limited to a maximum payment of $400,000 per claim, funded by a surcharge on health care providers, does not contest liability once primary limits have been paid -- the only question is economic value. This provides incentives to plaintiff's attorneys sufficient to offset the 15% maximum allowed on fees out of the Fund.

4. All claims must pass before a Medical Review Panel of 3 health care provider voting members and one attorney chair prior to filing a lawsuit. Consequently, few suits ever need to be filed since the panelists and their opinions are available for later court use. Early settlement is encouraged by the process of the panel addressing ONLY the question of the professional standard of care.

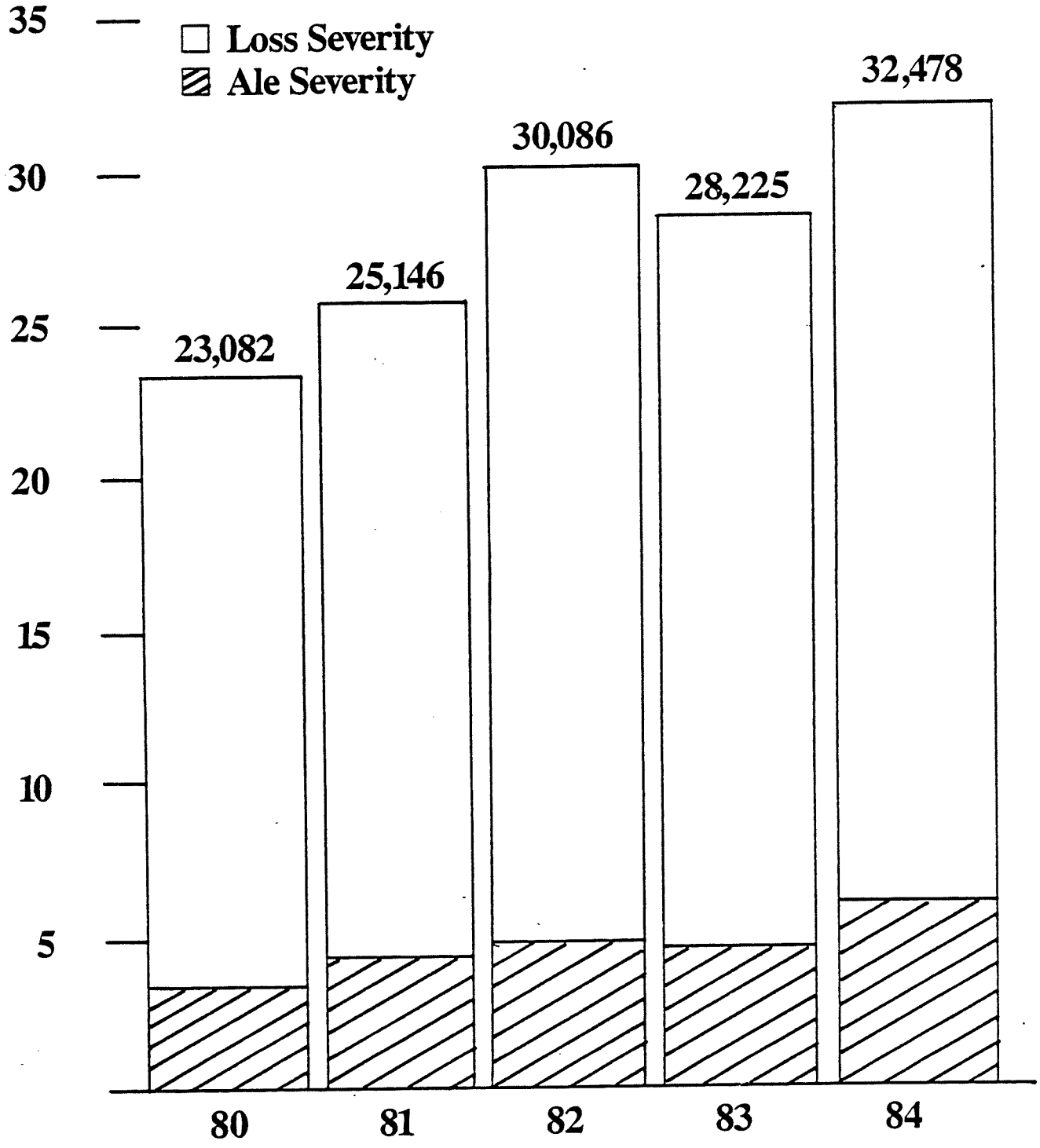
5. A non-competitive market for health care providers was established - a market of last resort as a safety value.

Kansas MD Experience
Calendar Years 1980-1984
(in thousands)



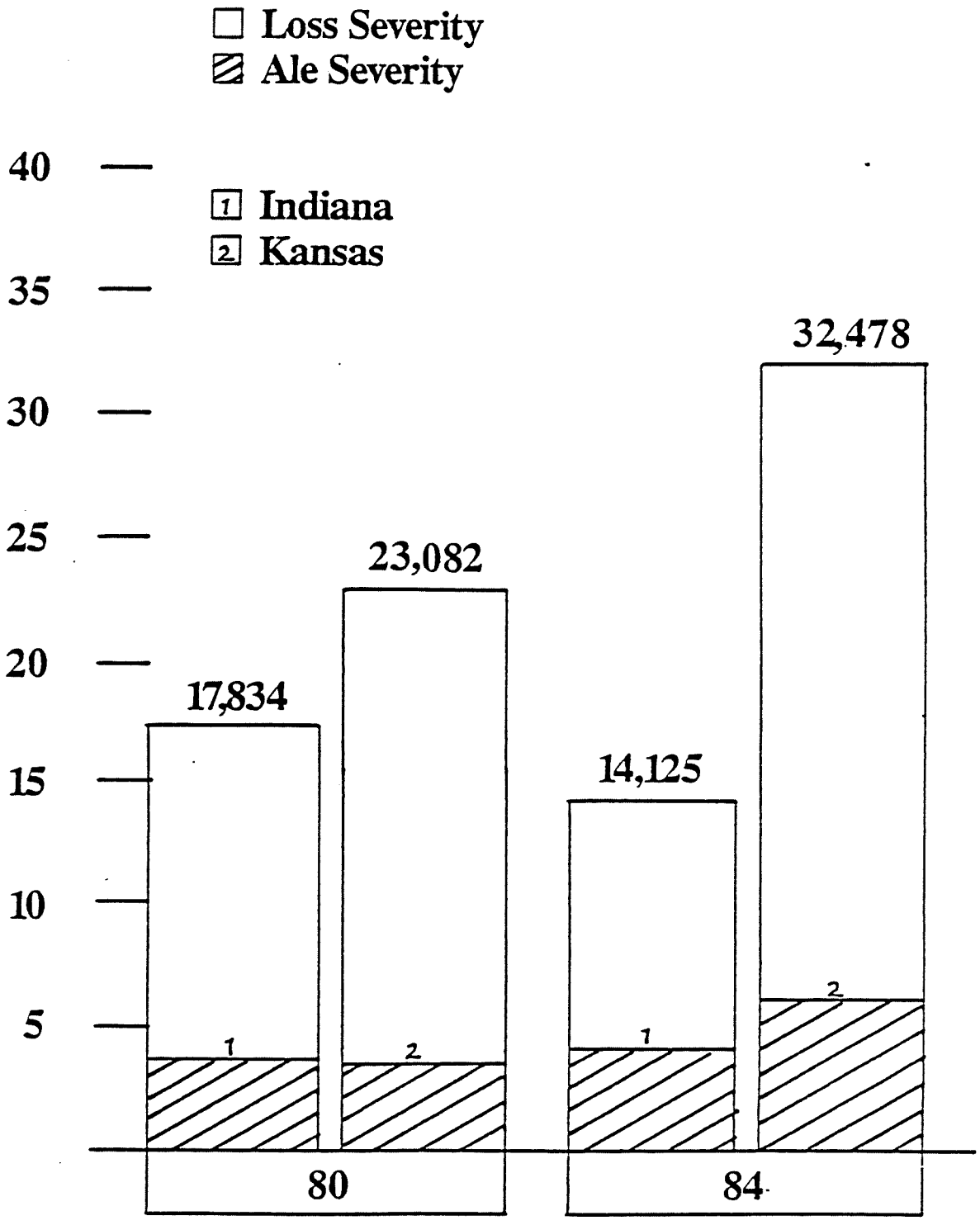
Paid Average
(in thousands)

Kansas MD

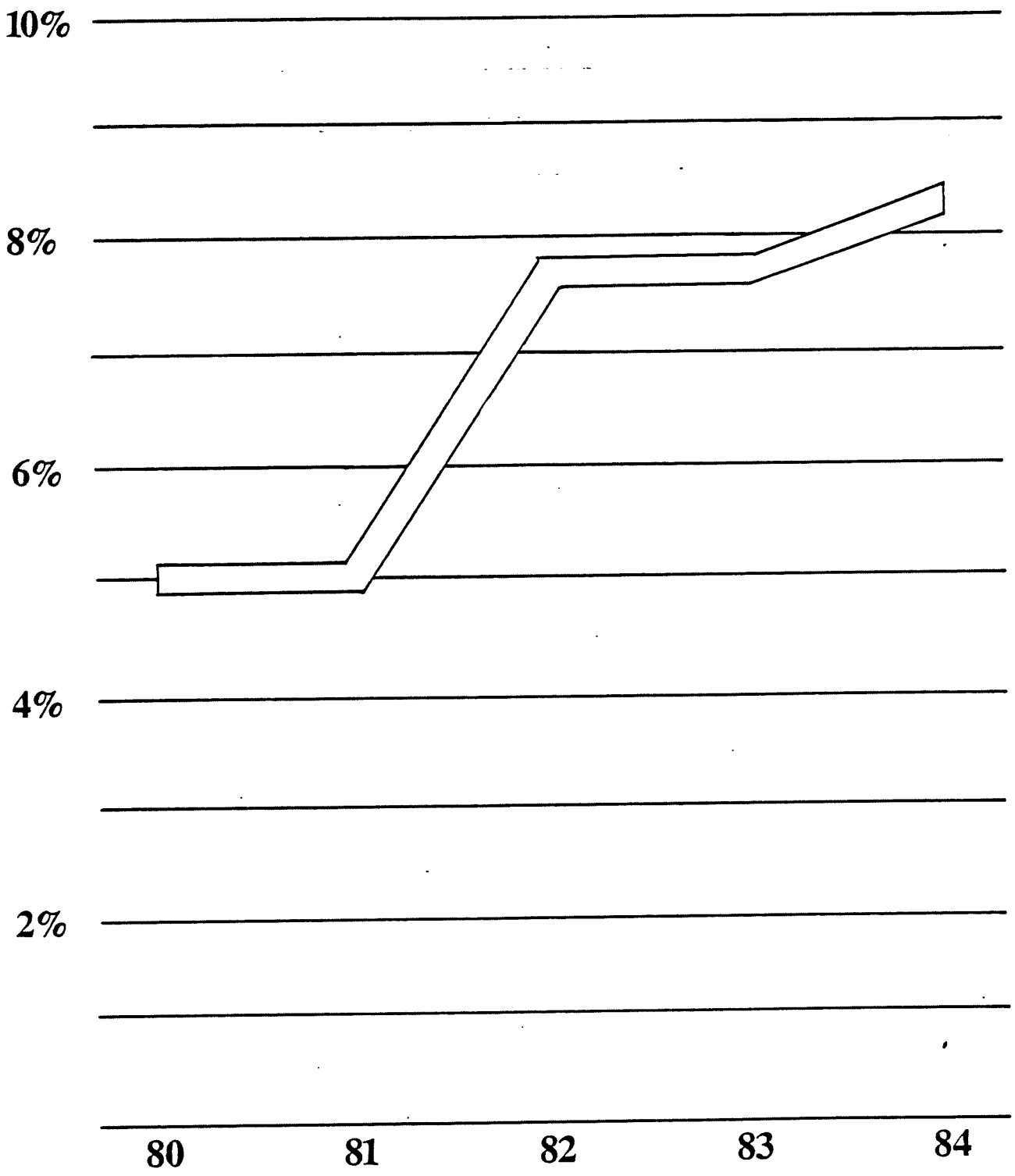


Paid Average
(in thousands)

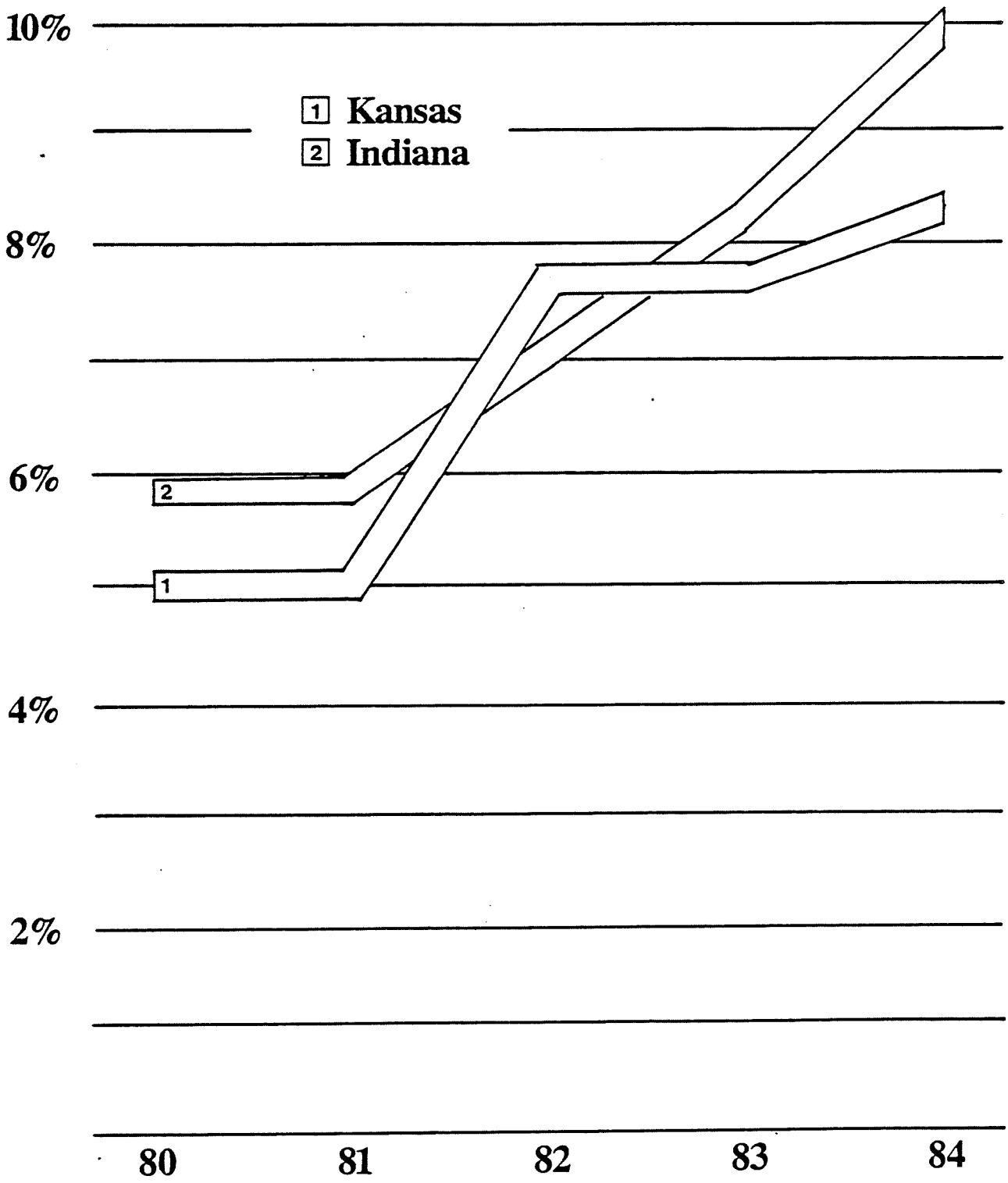
Kansas MD



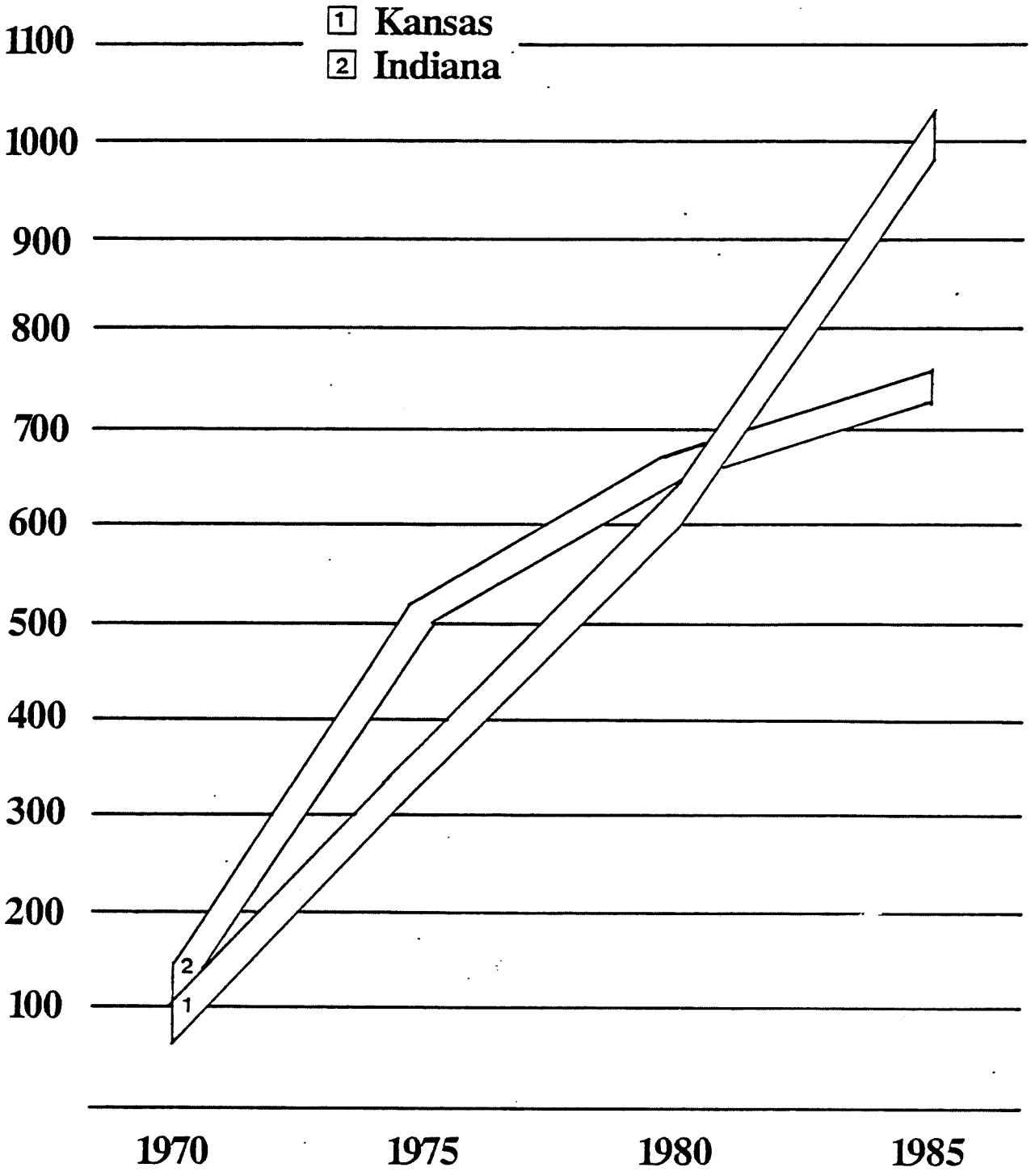
Suit Ratio
Kansas MD



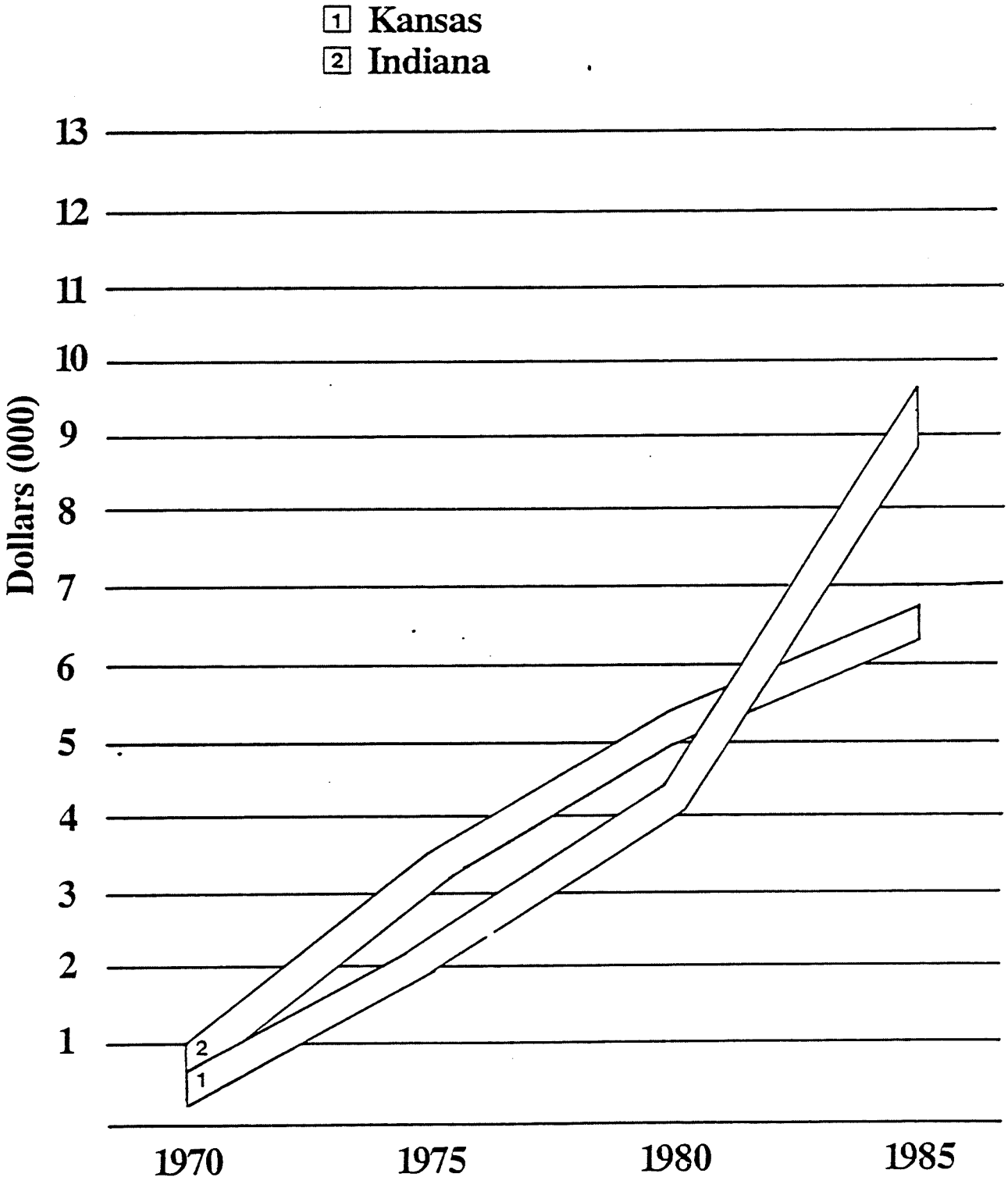
Suit Ratio
Kansas MD



$100,000 / $300,000 Rate Level
Class 1



$100,000 / $300,000 Rate Level
Class 5, 7 or 8



- Absolute Cap on Awards
- Screening Panel

Medical Malpractice
Indiana

Chapter 1

DEFINITIONS AND GENERAL APPLICATIONS

Sec.

---

§ 1. Definitions

As used in this article:

(a) "Health care provider" means:

(1) a person, partnership, corporation, professional corporation, facility or institution licensed or legally authorized by this state to provide health care or professional services as a physician, psychiatric hospital, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment;

(2) any college, university or junior college which provides health care to any student, faculty member, or employee, and the governing board, or any officer, employee or agent thereof acting in the course and scope of his employment;

(3) a blood bank, community mental health center, community mental retardation center, or community mental health clinic; or

(4) a home health agency, as defined under IC 16-102.5-1.

(b) "Physician" means a person with an unlimited license to practice medicine in this state under IC 25-22.5.

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

(d) "Hospital" means a public or private institution licensed under IC 16-10-1.

(e) "Commissioner" means the commissioner of insurance of this state.

(f) "Representative" means the spouse, parent, guardian, trustee, attorney or other legal agent of the patient.

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

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

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

(j) "Risk manager" means an insurance company admitted to make insurance and actively engaged in making in this state Class II insurance pursuant to IC 27-1-5-1, which company is appointed by the commissioner to manage the authority.

(k) "Risk" means any health care provider which shall apply for malpractice liability insurance coverage under the provisions of chapter 8 of this article.

(l) "Insurer" means the authority or an insurance company engaged on an admitted or nonadmitted basis in making in this state Class II (h) malpractice liability insurance pursuant to IC 27-1-5-1.

(m) "Authority" means the Residual Malpractice Insurance Authority established under chapter 8 of this article.

(n) "Psychiatric hospital" means a private institution licensed under IC 16-13-2-3, and public institutions under the administrative

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control of the commissioner of the department of mental health as designated by IC 16-13-1-9.

(o) "Community mental health center" means any public or private mental health center established pursuant to IC 16-16-1.

(p) "Community mental retardation center" means any public or private mental retardation center established pursuant to IC 16-16-1.

(q) "Community mental health clinic" means any public or private mental health clinic established pursuant to IC 16-16-3.

(r) "College, university, or junior college" means any institution for post secondary school education accredited by the north central association. (Source: Acts 1975, P.L. 146, § 1; as last amended by Acts 1979, P.L. 152, § 1.)

§ 2. Terms; gender and number

Wherever necessary to the context of this article [16-9.5-1-1 to 16-9.5-9-10] the masculine shall mean and include the feminine and the singular shall mean and include the plural. (Source: IC 1971, 16-9.5-1-2; as added by Acts 1975, P.L. 146, § 1.)

§ 3. Construction of certain terms

Any legal term or word of art used in this article [16-9.5-1-1 to 16-9.5-9-10], not otherwise defined, shall have such meaning as is consistent with the common law. (Source: IC 1971, 16-9.5-1-3; as added by Acts 1975, P.L. 146, § 1.)

§ 4. Liability based on contract; limitation

No liability shall be imposed upon any health care provider on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any procedure undertaken in the course of health care, unless such contract is expressly set forth in writing and signed by such health care provider or by an authorized agent of such health care provider. (Source: IC 1971, 16-9.5-1-4; as added by Acts 1975, P.L. 146, § 1.)

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§ 5. Qualification required for health care provider

A health care provider who fails to qualify under this article [16-9.5-1-1 to 16-9.5-9-10] is not covered by the provisions of this article and is subject to liability under the law without regard to the provisions of this article. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this article. (Source: IC 1971, 16-9.5-1-5; as added by Acts 1975, P.L. 146, § 1.)

§ 6. Claims—Filing complaint

Subject to chapter 9 [16-9.5-9-1 to 16-9.5-9-10], a patient or his representative having a claim under this article [16-9.5-1-1 to 16-9.5-9-10] for bodily injury or death on account of malpractice may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury. No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises. (Source: IC 1971, 16-9.5-1-6; as added by Acts 1975, P.L. 146, § 1.)

§ 7. Prospective application

The provisions of this article [16-9.5-1-1 to 16-9.5-9-10] do not apply to any act of malpractice which occurred before July 1, 1975. (Source: IC 1971, 16-9.5-1-7; as added by Acts 1975, P.L. 146, § 1.)

§ 8. Malpractice claims against governmental entity or its employee; article to govern

A claim based on an occurrence of malpractice against a governmental entity or an employee of a governmental entity, as those terms are defined in IC 34-4-16.5, shall be governed exclusively by the provisions of this article if the governmental entity or employee is qualified under the provisions of this article. (Source: Acts 1976, P.L. 65, § 2.)

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Chapter 2

LIMITATION OF RECOVERY

Sec.

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§ 1. Qualification of health care provider or the insurance carrier

(a) To be qualified under the provisions of this article [16-9.5-1-1 to 16-9.5-9-10], a health care provider or his insurance carrier shall:

(1) Cause to be filed with the commissioner proof of financial responsibility as provided by section 6 [16-9.5-2-6] of this chapter; and

(2) Pay the surcharge assessed by this article on all health care providers according to chapter 4 [16-9.5-4-1 to 16-9.5-4-3] of this article.

(b) The officers, agents or employees of a health care provider, while acting in the course and scope of their employment may be qualified under the provisions of this article if they are individually named, or are members of a named class, in the proof of financial responsibility filed by the health care provider under section 6 [16-9.5-2-6] of this chapter and if the surcharge assessed under chapter 4 [16-9.5-4-1 to 16-9.5-4-3] of this article is paid. (Source: IC 1971, 16-9.5-2-1, as added by Acts 1975, P.L. 146, § 1, p. 854; as last amended by Acts 1977, P.L. 187, § 2.)

§ 2. Limitations on recovery

(a) The total amount recoverable for any injury or death of

a patient may not exceed five hundred thousand dollars ($500,000).

(b) A health care provider qualified under this article is not liable for an amount in excess of one hundred thousand dollars ($100,000) for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers, subject to subsections (a) and (b), and (d) shall be paid from the patient's compensation fund pursuant to the provisions of IC 16-9.5-4-3.

(d) In the event a health care provider qualified under this article admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent or employee of the health care provider acting in the course and scope of his employment and qualified under this chapter, the total amount which shall be paid to the claimant on behalf of the officer, agent or employee and the health care provider by such health care provider or its insurer shall be one hundred thousand dollars ($100,000) and the balance of any adjudicated sum to which the claimant is entitled, if any, shall be paid by other liable health care providers and/or the patient's compensation fund. (Source: IC 1971, 16-9.5-2-2, as added by Acts 1975, P.L. 146, § 1, p. 854; as last amended by Acts 1977, P.L. 187, § 9.)

§ 3. Advance payments not admission of liability

Except as provided in chapter 4, section 3 [16-9.5-4-3], any advance payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice. (Source: IC 1971, 16-9.5-2-3; as added by Acts 1975, P.L. 146, § 1.)

§ 4. Evidence of advance payment inadmissible; reduction of judgment

Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it. (Source: IC 1971, 16-9.5-2-4; as added by Acts 1975, P.L. 146, § 1.)

§ 5. Claims not assignable

A patient's claim for compensation under this article [16-9.5-1-1 to 16-9.5-9-10] is not assignable. (Source: IC 1971, 16-9.5-2-5; as added by Acts 1975, P.L. 146, § 1.)

§ 6. Financial responsibility; establishment

(a) Financial responsibility of a health care provider and its officers, agents and employees while acting in the course and scope of their employment with such health care provider under this chapter may be established:

(1) by the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars ($100,000) per occurrence, and three hundred thousand dollars ($300,000) in the annual aggregate, except that if the health care provider is a hospital, as defined in this article, the annual aggregate limit shall be: for hospitals of one hundred (100) beds or less, two million dollars ($2,000,000); for hospitals of more than one hundred (100) beds, three million dollars ($3,000,000);

(2) by filing and maintaining with the commissioner cash or surety bond, approved by the commissioner in the amounts set forth in subdivision (1) of this subsection; or

(3) if the health care provider is a hospital, by submitting annually a verified financial statement which, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by it or its officers, agents and employees while acting in the course and scope of their employment up to a total of one hundred thousand dollars ($100,000) per occurrence and annual aggregates as follows: for hospitals of one hundred (100) beds or less, two million dollars ($2,000,000); for hospitals of more than one hundred (100) beds, three million dollars ($3,000,000). The commissioner may require the deposit of security to assure continued financial responsibility.

(b) Security provided pursuant to subdivision (2) of subsection (a) of this section may be held in any manner, mutually agreeable to the commissioner and the health care provider. The agreement shall provide that the principal may not be withdrawn prior to receiving the written permission of the commissioner of insurance; however, any interest earned may be withdrawn at any time by the health care provider.

(c) The bed size of a hospital for the purposes of this section shall be deemed to be the bed size published annually by the Indiana state board of health.

(d) In order to establish financial responsibility under this section, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from that partnership or professional corporation, as well as pay the surcharge required under IC 16-9.5-4-1, but this provision shall not be construed to require any health care provider to "qualify" under this article. (Source: IC 1971, 16-9.5-2-6, as added by Acts 1975, P.L. 146, § 1, p. 854; as last amended by Acts 1979, P.L. 152, § 2.)

§ 7. Payment from patient's compensation; terms and conditions

In the event an annual aggregate of insurance coverage for a health care provider qualified under this article [16-9.5-1-1 to 16-9.5-9-10] has been paid by the insurer of any such health care provider, all such sums which may thereafter become due and payable a claimant arising out of an act of malpractice of such health care provider occurring during the year in which the annual aggregate of insurance coverage was exhausted shall be paid from the patient's compensation fund under the following terms and conditions:

(a) The health care provider whose annual aggregate coverage has been exhausted shall have no right to object to or refuse permission to settle any such claim.

(b) If the health care provider or the insurance commissioner and claimant agree on a settlement the following procedure must be followed:

(1) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider or, if none is pending. in the circuit or superior court of Marion County, seeking approval of the agreed settlement.

(2) A copy of the petition shall be served on the commissioner and the health care provider at least ten [10] days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the amount of the proposed settlement.

(3) The commissioner may agree to the settlement, or the commissioner may file written objections thereto. The agreement or objections shall be filed within twenty [20] days after the petition is filed.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider and the commissioner.

(5) At the hearing the commissioner, the claimant and the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

The commissioner may promulgate rules and regulations implementing the provisions of this section. (Source: IC 16-9.5-2-7, as added by Acts 1976, P.L. 65, § 6.)

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Chapter 3

STATUTE OF LIMITATIONS

Sec.

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§ 1. Time for filing claim

No claim, whether in contract or tort, may be brought against a health care provider based upon professional services or health care rendered or which should have been rendered unless filed within two [2] years from the date of the alleged act, omission or neglect except that a minor under the full age of six [6] years shall have until his eighth birthday in which to file. This section applies to all persons regardless of minority or other legal disability. (Source: IC 1971, 16-9.5-3-1; as added by Acts 1975, P.L. 146, § 1.)

§ 2. Prior actions

Notwithstanding the provisions of IC 1971, 16-9.5-1-7, any claim by a minor or other person under legal disability against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect which occurred prior to the effective date [July 1, 1975] of this article [16-9.5-1-1 to 16-9.5-9-10], shall be brought only within the longer of:

(a) Two [2] years of the effective date of this article; or

(b) The period described in section 1 [16-9.5-3-1] of this chapter. (Source: IC 1971, 16-9.5-3-2; as added by Acts 1975, P.L. 146, § 1.)

Chapter 4

PATIENT'S COMPENSATION FUND

Sec.

---

§ 1. Creation; levy of annual surcharge; disposition of fund

(a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the commissioner pursuant to IC 27-1-13, and shall not become a part of the general fund of the state.

(b) To create the fund, an annual surcharge shall be levied on all health care providers in Indiana. The surcharge shall be determined by the commissioner based upon actuarial principles and shall not exceed ten percent (10%) of the cost to each health care provider for maintenance of financial responsibility.

(c) Notwithstanding subsection (b) of this section there is hereby imposed a minimum surcharge of five dollars ($5.00).

(d) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager or the surplus lines agents. Such surcharge shall be due and payable within thirty (30) days after the premium for malpractice liability insurance has been received by the insurer, risk manager or surplus lines agent from the health care provider in Indiana. If the surcharge is not paid as provided under this subsection, then the insurer, risk manager, or surplus lines agent responsible for the delinquency shall be liable for the surcharge plus a ten percent (10%) penalty.

(e) Receipt of proof of financial responsibility and the surcharge constitutes compliance with IC 16-9.5-2-1 as of the date of receipt thereof, or as of the effective date of the policy, provided this proof is filed with and the surcharge paid to the department not later than one hundred eighty (180) days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within one hundred eighty (180) days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid.

(f) The commissioner may promulgate rules and regulations providing for the manner in which the surcharge for health care providers establishing financial responsibility other than by a policy of malpractice liability insurance shall be determined and the manner of payment. In no event may this surcharge exceed the surcharge that would be charged by the residual authority if the health care provider electing to establish financial responsibility in this manner had applied to the residual authority for insurance.

(g) If the annual premium surcharge is not paid within the time limited above the certificate of authority of the insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

(h) All expenses of collecting, protecting and administering the fund, shall be paid from the fund.

(i) If the fund exceeds the sum of fifteen million dollars ($15,000,000) at the end of any calendar year after the payment of all claims and expenses, the commissioner shall reduce the surcharge provided in this section in order to maintain the fund at an approximate level of fifteen million dollars ($15,000,000).

(j) All claims from the patient's compensation fund shall be computed on December 31 of the year in which the claim becomes final. All claims shall be paid on or before January 15.

If the fund would be exhausted by payment in full of all claims allowed during a calendar year, then the amount paid to each claimant shall be prorated. Any amounts due and unpaid shall be paid in the following calendar year. (Source: IC 1971, 16-9.5-4-1, as added by Acts 1975, P.L. 146, § 1, p. 854; as last amended by Acts 1979, P.L. 152, § 3.)

§ 2. Warrant for claims

The auditor of Indiana shall issue a warrant in the amount of each claim submitted to him against the fund on December 31 of each year. The only claim against the fund shall be a voucher or other appropriate request by the commissioner after he receives:

(a) a certified copy of a final judgment against a health care provider; or

(b) a certified copy of a court approved settlement against a health care provider. (Source: IC 1971, 16-9.5-4-2, as added by Acts 1975, P.L. 146, § 1, p. 854; amended Acts 1976, P.L. 65, § 8.)

§ 2.5. Failure of insurance carrier or surety to pay agreed settlement or judgment; payment from patient's compensation fund

If a health care provider, his surety or liability insurance carrier fails to pay any agreed settlement or final judgment within ninety [90] days, the same shall be paid from the patient's compensation fund, and said fund shall be subrogated to any and all of claimant's rights against said health care provider, his surety and/or liability insurance carrier with interest, reasonable costs and attorney fees. (Source: IC 16-9.5-4-2.5, as added by Acts 1976, P.L. 65, § 9.)

§ 3. Settlement in excess of policy limits; procedure

If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of one hundred thousand dollars ($100,000), and claimant is demand-

ing an amount in excess thereof, then the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking (a) approval of an agreed settlement, if any, or (b) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider and his insurer, and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner, the health care provider or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached thereto.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider and the commissioner.

(5) At the hearing the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then

the court, after hearing any relevant evidence on the issue of claimant's damage, submitted by any of the parties described in this section, shall determine the amount of claimant's damages, if any, in excess of the one hundred thousand dollars ($100,000) already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties shall not bar access to the patient's compensation fund unless the release specifically provides otherwise. (Source: IC 1971, 16-9.5-4-3; as added by Acts 1975, P.L. 146, § 1; as last amended by Acts 1979, P.L. 152, § 4.)

[Page 139 follows]

Added, 1979

Chapter 5

ATTORNEY FEES

Sec.

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§ 1. Maximum fee—Fee arrangements

(a) When a plaintiff is represented by an attorney in the prosecution of his claim, the plaintiff's attorney fees from any award made from the patient's compensation fund may not exceed fifteen per cent [15%] of any recovery from the fund.

(b) A patient has the right to elect to pay for the attorney's services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment. (Source: IC 1971, 16-9.5-5-1; as added by Acts 1975, P.L. 146, § 1.)

Chapter 6

REPORTING AND REVIEW OF CLAIMS

Sec.

---

§ 1. Reporting claims settled

All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the commissioner by the plaintiff's attorney and by the health care provider or his insurer or risk manager within sixty [60] days following final disposition of the claim. The report to the commissioner shall state the following:

(a) nature of the claim;

(b) damages asserted and alleged injury;

(c) attorney's fees and expenses incurred in connection with the claim or defense; and

(d) the amount of any settlement or judgment. (Source: IC 1971, 16-9.5-6-1; as added by Acts 1975, P.L. 146, § 1.)

§ 2. Review of provider fitness—Discipline

(a) The commissioner shall forward the name of every health care provider, except a hospital, against whom a settlement is made or judgment is rendered under this article to the appropriate board of professional registration and examination for review of the fitness of the health care provider to practice his profession. In each case involving review of a health care provider's fitness to practice under this article, the board shall have the power, in appropriate cases, to take the following disciplinary action:

(1) censure;

(2) imposition of probation for a determinate period;

(3) suspension of the health care provider's license for a determinate period; or

(4) revocation of the license.

(b) Review of the health care provider's fitness to practice shall be conducted in accordance with IC 4-22-1.

(c) The board shall report to the commissioner its findings, the action taken and the final disposition of each case involving review of a health care provider's fitness to practice under this article. (Source: IC 1971, 16-9.5-6-2; as added by Acts 1975, P.L. 146, § 1; as amended by Acts 1977, P.L. 187, § 1.)

Chapter 7

MALPRACTICE COVERAGE

Sec.

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§ 1. Duration of coverage

Only while malpractice liability insurance remains in force are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this article [16-9.5-1-1 to 16-9.5-9-10]. (Source: IC 1971, 16-9.5-7-1; as added by Acts 1975, P.L. 146, § 1.)

§ 2. Insurer's acceptance

The filing of proof of financial responsibility with the commissioner shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this article [16-9.5-1-1 to 16-9.5-9-10]. (Source: IC 1971, 16-9.5-7-2; as added by Acts 1975, P.L. 146, § 1.)

§ 3. Void provisions

Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this article [16-9.5-1-1 to 16-9.5-9-10] is void. (Source: IC 1971, 16-9.5-7-3; as added by Acts 1975, P.L. 146, § 1.)

§ 4. Obligations—Cancellation

Every policy issued under this article [16-9.5-1-1 to 16-9.5-9-10] is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the general assembly of the state of Indiana as fully as if it were written therein:

(a) The insurer assumes all obligations to pay an award imposed against its insured under the provisions of this article; and

(b) Any termination of this policy by cancellation is not effective as to patients claiming against the insured covered hereby, unless at least thirty [30] days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the commissioner at their offices. (Source: IC 1971, 16-9.5-7-4; as added by Acts 1975, P.L. 146, § 1.)

§ 5. Failure of insurer to pay obligations

If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails, or refuses to comply with any provisions of this article [16-9.5-1-1 to 16-9.5-9-10], in addition to any other legal remedy, the commissioner may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this article and has resubmitted its policy form and received the approval of the commissioner. (Source: IC 1971, 16-9.5-7-5; as added by Acts 1975, P.L. 146, § 1.)

Chapter 8

RISK MANAGEMENT—AUTHORITY

Sec.

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§ 1. Purpose

The purpose of this chapter [16-9.5-8-1 to 16-9.5-8-8] is to make malpractice liability insurance available to risks as defined in this article [16-9.5-1-1 to 16-9.5-9-10]. (Source: IC 1971, 16-9.5-8-1; as added by Acts 1975, P.L. 146, § 1.)

§ 2. Residual malpractice insurance authority

There is created the residual malpractice insurance authority. The department of insurance is designated as the authority for the purposes of this article [16-9.5-1-1 to 16-9.5-9-10]. The authority is empowered to engage in making Class II(h) malpractice liability insurance in this state pursuant to IC 1971, 27-1-5-1. (Source: IC 1971, 16-9.5-8-2; as added by Acts 1975, P.L. 146, § 1.)

§ 3. Risk manager—Immunity to liability

The commissioner shall appoint a risk manager for the authority. The separate, personal or independent assets of the risk manager shall not be liable for or subject to use or expenditure for the purpose of providing insurance by the authority. (Source: IC 1971, 16-9.5-8-3; as added by Acts 1975, P.L. 146, § 1.)

§ 4. Duties of risk manager

In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

(a) be subject to all laws and regulations of this state which apply to Class II(h) insurance as provided in IC 1971, 27-1-5-1;

(b) prepare and file appropriate forms with the department of insurance;

(c) prepare and file premium rates with the department of insurance;

(d) perform the underwriting function;

(e) dispose of all claims and litigations arising out of insurance policies;

(f) maintain adequate books and records;

(g) file an annual financial statement regarding its operations under this chapter [16-9.5-8-1 to 16-9.5-8-8] with the department of insurance on forms prescribed by the commissioner;

(h) obtain private reinsurance for the authority, if necessary;

(i) prepare and file for approval of the commissioner a schedule of agent's compensation; and

(j) prepare and file a plan of operations with the commissioner for approval. (Source: IC 1971, 16-9.5-8-4; as added by Acts 1975, P.L. 146, § 1.)

§ 5. Compensation of risk manager

The risk manager shall receive as compensation for its services, a percentage of all premiums received by it under the terms of this chapter [16-9.5-8-1 to 16-9.5-8-8], as determined by the commissioner. The compensation may be adjusted by the commissioner. (Source: IC 1971, 16-9.5-8-5; as added by Acts 1975, P.L. 146, § 1.)

§ 6. Declined risks—Procedure

If a risk after diligent effort has been declined by at least two [2] insurers the risk may, together with evidence of the two [2] declinations, forward his application to the risk manager. (Source: IC 1971, 16-9.5-8-6; as added by Acts 1975, P.L. 146, § 1.)

§ 7. Unaccepted risks—Appeal

If the risk manager declines to accept the risk, notice of declination, together with the reasons, shall be sent to the

applicant and the commissioner. The applicant shall have ten [10] days from the date of notice to file an appeal for review by the commissioner. On appeal, the commissioner shall review the decision of the risk manager and enter an appropriate order. (Source: IC 1971, 16-9.5-8-7; as added by Acts 1975, P.L. 146, § 1.)

§ 8. Investment of surplus fund

All sums appropriated by the state of Indiana, and any surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the commissioner pursuant to IC 1971, 27-1-13 [27-1-13-1 to 27-1-13-13], and investment income generated shall remain in the fund. (Source: IC 1971, 16-9.5-8-8; as added by Acts 1975, P.L. 146, § 1.)

Chapter 9

MEDICAL REVIEW PANEL

Sec.

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§ 1. Establishment; proposed complaints, filing, limitations, tolling; request for review

Provision is made for the establishment of medical review panels to review all proposed malpractice complaints against health care providers covered by this article.

The filing of a proposed complaint tolls the applicable statute of limitations to and including a period of ninety (90) days following the receipt of the opinion of the medical review panel by the claimant. A proposed complaint under this chapter shall be deemed filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail to the commissioner, who shall within ten (10) days after receipt forward by registered or certified mail a copy to each health care provider named as a defendant at his last and usual place of residence or his office.

Not earlier than twenty (20) days after the filing of a proposed complaint either party may request the formation of a medical review panel by serving a request by registered or certified mail upon all parties and the commissioner. (Source: IC 1971, 16-9.5-9-1, as added by Acts 1975, P.L. 146, § 1; as amended by Acts 1977, P.L. 187, § 4.)

§ 2. Prerequisite to suit

No action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this chapter [16-9.5-9-1 to 16-9.5-9-10] and an opinion is rendered by the panel. (Source: IC 1971, 16-9.5-9-2; as added by Acts 1975, P.L. 146, § 1.)

§ 3. Members; chairman, powers and duties; selection procedures; limitations service requisite

The medical review panel shall consist of one (1) attorney and three (3) health care providers. The attorney shall act as chairman of the panel and in an advisory capacity, but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed complaint. The chairman may establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities.

The medical review panel shall be selected in the following manner:

(a) Within fifteen (15) days after filing the request for formation of a medical review panel under section 1 of this chapter, the parties shall select a panel chairman by agreement, or if no agreement can be reached, either party may request the clerk of the supreme court to draw at random a list of five (5) names of attorneys qualified to practice and presently on the roles of the supreme court and maintaining offices in the county of venue designated in the proposed complaint or in a contiguous county. The clerk shall notify the parties and the parties shall then strike names alternately with the plaintiff striking first until one (1) name remains and that remaining attorney shall be the chairman of the panel. After the striking, the plaintiff shall notify the chairman and all other parties of the name of the chairman.

If a party does not strike a name within five (5) days after notice, the clerk shall strike for that party. When one (1) name remains, the clerk shall within five (5) days notify the chairman and all other parties of the name of the chairman.

(b) (1) All health care providers in this state, whether in the teaching profession or otherwise, who hold a license to practice in their profession, shall be available for selection as members of the medical review panel.

Each party to the action shall have the right to select one (1) health care provider and upon selection, the two (2) health care providers thus selected shall select the third panelist.

When there are multiple plaintiffs or defendants, there shall be only one (1) health care provider selected per side. The plaintiff, whether single or multiple, shall have the right to select one (1) health care provider and the defendant, whether single or multiple, shall have the right to select one (1) health care provider.

If there is only one (1) party defendant, other than a hospital, two (2) of the panelists selected shall be from the same class of health care provider as the defendant.

(2) Within fifteen (15) days after the chairman is selected, both parties shall select a health care provider and they shall notify the other party and the chairman of their selection. If a party fails to make a selection within the time provided, the chairman shall make the selection and notify both parties. Within fifteen (15) days after their selection, the health care provider members shall select the third member within the time provided and notify the chairman and the parties. If they fail to make a selection, the chairman shall make the selection and notify both parties.

(3) Within ten (10) days after any selection, written challenge without cause, may be made to the panel member. Upon challenge or excuse, the party whose appointee was challenged or dismissed shall select another panelist. If the challenged or dismissed panel member was selected by the other two (2) panel members, they shall make a new selection. If two (2) such challenges are made and submitted, the chairman shall within ten (10) days appoint a panel consisting of three (3) qualified panelists and each side shall within ten (10) days after the appointment strike one (1) with the party whose appointment was challenged striking last, and the remaining member shall serve.

(4) When the medical review panel is formed, the chairman shall within five (5) days notify the commissioner and the parties by registered or certified mail of the names and ad-

dresses of the panel members and the date on which the last member was selected.

(c) A panelist selected as provided in subsection (a) or (b) of this section shall serve unless the parties by agreement excuse him or for good cause shown he may be excused as provided in this subsection.

To show good cause for relief from serving, the attorney selected as chairman must serve an affidavit upon the clerk of the supreme court. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The clerk may excuse the attorney from serving and the attorney shall notify all parties who shall then select a new chairman as provided in subsection (a) of this section.

To show good cause for relief from serving, a health care provider member must serve an affidavit upon the panel chairman. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The chairman may excuse the member from serving and notify all parties. (Source: IC 1971, 16-9.5-9-3; as added by Acts 1975, P.L. 146, § 1, p. 854; as last amended by 1977, P.L. 187, § 5.)

§ 3.5 Time limit for panel to render opinion—Effect of failure of party, attorney or panelist to act

(a) The panel shall render its expert opinion within one hundred eighty [180] days of the selection of the last member.

(b) A party, attorney or panelist who fails to act as required by this chapter [16-9.5-9-1 to 16-9.5-9-10] without good cause shown is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint as having jurisdiction. (Source: IC 16-9.5-9-3.5, as added by Acts 1976, P.L. 65, § 11, p. 287; as amended by Acts 1977, P.L. 187, § 6.)

§ 4. Form of evidence

The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only. The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties and any other form of evidence allowable by the medical review panel. Depositions of parties and witnesses

may be taken prior to the convening of the panel. The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in section 7 [16-9.5-9-7]. A copy of the evidence shall be sent to each member of the panel. (Source: IC 1971, 16-9.5-9-4; as added by Acts 1975, P.L. 146, § 1.)

§ 5. Hearing upon issues

Either party, after submission of all evidence and upon ten [10] days' notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal. (Source: IC 1971, 16-9.5-9-5; as added by Acts 1975, P.L. 146, § 1.)

§ 6. Examination of reports

The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel. (Source: IC 1971, 16-9.5-9-6; as added by Acts 1975, P.L. 146, § 1.)

§ 7. Written opinion by panel

The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty [30] days, render one or more of the following expert opinions which shall be in writing and signed by the panelists:

(a) The evidence supports the conclusion that defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(d) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered: (1) any disability and the extent and duration of the disability, and (2) any permanent impairment and the percentage of the impairment. (Source: IC 1971, 16-9.5-9-7; as added by Acts 1975, P.L. 146, § 1.)

§ 8. [Repealed.]

[History. Repealed by Acts 1977, P.L. 187, § 7.]

§ 9. Admissibility of evidence—Witnesses—Immunity of panelist

Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability from all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this article [16-9.5-1-1 to 16-9.5-9-10]. (Source: IC 1971, 16-9.5-9-9; as added by Acts 1975, P.L. 146, § 1.)

§ 10. Compensation and fees

Each health care provider member of the medical review panel shall be paid at the rate of twenty-five dollars [$25.00] per diem, not to exceed a total of two hundred fifty dollars [$250], for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in court, and in addition thereto, reasonable travel expense.

The chairman of the panel shall be paid at the rate of one hundred dollars [$100] per diem, not to exceed five hundred dollars [$500], plus reasonable travel expenses. The chairman shall keep an accurate record of the time and expenses of all the

members of the panel, and the record shall be submitted to the parties for payment with the panel's report.

Fees of the panel including travel expenses and other expenses of the review shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, then each side shall pay one-half [½] of the cost.

The chairman shall submit a copy of the panel's report to the commissioner and all parties and attorneys by registered or certified mail within five [5] days after the panel renders its opinion. (Source: IC 16-9.5-9-10, as added by Acts 1975, P.L. 146, § 1, p. 854; as amended by Acts 1977, P.L. 187, § 8.)

Chapter 10

PRELIMINARY DETERMINATION AND DISCOVERY

Sec.

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§ 1. Affirmative defenses or issues of law or fact; compelling discovery; motion; jurisdiction; limitations

A court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the commissioner under this article may, upon the filing of a copy of the proposed complaint and a written motion under this chapter, (1) preliminarily determine any affirmative defense or issue of law or fact that may be preliminarily determined under the Indiana Rules of Procedure; or (2) compel discovery in accordance with the Indiana Rules of Procedure; or (3) both. The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written opinion by the medical review panel under IC 16-9.5-9-7(a), (b) and (d). The court has jurisdiction to entertain a motion filed under this chapter only during that period of time after a proposed complaint is filed with the commissioner under this article but before the medical review panel renders its written opinion under IC 16-9.5-9-7. The failure of any party to move for a preliminary determination or to compel discovery under this chapter before the medical review panel renders its written opinion under IC 16-9.5-9-7 shall not con-

Added, 1979

stitute the waiver of any affirmative defense or issue of law or fact. (Source: Acts 1979, P.L. 162, § 5.)

§ 2. Moving parties to proceedings; limited jurisdiction; procedures

Any party to a proceeding commenced under this article, the commissioner or the chairman of any medical review panel, if any, may invoke the jurisdiction of the court by paying the statutory filing fee to the clerk and filing a copy of the proposed complaint and motion with the clerk. The filing of a copy of the proposed complaint and motion with the clerk shall confer jurisdiction upon the court over the subject matter and the parties to the proceeding for the limited purposes stated in this chapter, including the taxation and assessment of costs or the allowance of expenses, including reasonable attorney fees, or both. The moving party or his attorney shall cause as many summonses as are necessary to be issued by the clerk and served on the commissioner, each nonmoving party to the proceedings and the chairman of the medical review panel, if any, unless the commissioner or the chairman is the moving party, together with a copy of the proposed complaint and a copy of the motion pursuant to Rules 4 through 4.17 of the Indiana Rules of Trial Procedure, IC 34-5-1-1. (Source: Acts 1979, P.L. 152, § 5.)

§ 3. Nonmoving parties; appearance and response to motion; ruling; time limits

Each nonmoving party to the proceeding, including the commissioner and the chairman of the medical review panel, if any, shall have a period of twenty (20) days after service, or a period of twenty-three (23) days after service if service is by mail, to appear and file and serve his written response to the motion, unless the court, for cause shown, orders the period enlarged. The court shall enter its ruling on the motion within thirty (30) days after it is heard, or if no hearing is requested, granted or ordered, within thirty (30) days after the date on which the last written response to the motion is

Added, 1979

filed, and shall order the clerk to serve a copy of its ruling on the motion by ordinary mail on the commissioner, each party to the proceeding and the chairman of the medical review panel, if any. (Source: Acts 1979, P.L. 152, § 5.)

§ 4. Stay of medical review panel proceedings

Upon the filing of a copy of the proposed complaint and motion with the clerk of the court all further proceedings before the medical review panel shall be stayed automatically until the court has entered its ruling on the motion. (Source: Acts 1979, P.L. 152, § 5.)

§ 5. Enforcement of court's rulings

The court may enforce its ruling on any motion filed under this chapter in accordance with the Indiana Rules of Procedure, subject to the right of appeal. (Source: Acts 1979, P.L. 152, § 5.)

[Page 155 follows]

Added, 1979

G

ALL LINES - STOCK INDUSTRY PROJECTIONS
Conning & Company -- Forecasting & Modeling Service

Year	Premium Written	% Change	Loss Ratio	Expense Ratio	Comb. Ratio	Stat. Underwriting Loss	GAAP Underwriting Loss	Investment Income	% Change	Total GAAP Income Pre-Tax	Total GAAP Income After Tax	GAAP Taxes	GAAP Capital	GAAP ROE	Prem. to Surp. Ratio	Reserve to Surp. Ratio	Total Leverage Ratio
1980	$ 66,875		75.0%	28.5%	103.5%	($ 2,674)		$ 9,198					$40,568		1.76	1.82	3.58
1981	69,215	3.5%	76.8%	29.4%	106.2%	(4,579)	($ 4,254)	10,287	11.8%	6,033	5,832	201	40,763	14.3%	1.82	2.02	3.84
1982	71,834	3.8%	80.0%	30.1%	110.1%	(7,496)	(7,173)	11,845	15.1%	4,672	5,105	(434)	45,585	11.8%	1.68	1.97	3.65
1983	74,351	3.5%	82.5%	30.8%	113.3%	(10,144)	(9,825)	12,354	4.3%	2,528	3,925	(1,397)	48,629	8.3%	1.65	2.02	3.67
1984	80,865	8.8%	90.2%	30.2%	120.4%	(16,690)	(16,315)	13,353	8.1%	(2,962)	(443)	(2,519)	46,525	-0.9%	1.96	2.46	4.42
1985	92,940	14.9%	91.7%	29.1%	120.8%	(19,812)	(19,144)	14,157	6.0%	(4,987)	(3,777)	(1,210)	42,748	-8.5%	2.54	3.10	5.64
1986	113,032	21.6%	86.8%	27.2%	114.0%	(17,033)	(16,112)	15,295	8.0%	(817)	(267)	(550)	42,481	-0.6%	3.16	3.58	6.74
1987	130,189	15.2%	32.3%	26.4%	108.6%	(12,609)	(11,718)	16,961	10.9%	5,243	5,190	53	47,671	11.5%	3.24	3.57	6.81

Attachment VIII

-15-

7/18-19/85

Attachment VIII

Attachment IX
F

MAJOR REINSURERS' RESULTS

Conning & Company

COMPANY	($ Millions) PREMIUM	1984 COMBINED RATIO
General Re	$ 1,065	127.0%
North American/Swiss Re	496	129.5%
Employers Re	487	116.9%
Prudential Re	450	150.9%
American Re	441	127.5%
Munich Re	263	122.9%
Skandia American	256	133.6%
New York Insurance Exchange	218	137.3%
Kemper Re	203	120.0%
INA Re	189	132.9%
ALL REINSURERS	$ 6,610	127.1%

7/18-19/85
Attachment IX

Attachment X

E

KANSAS

	** 12/31/83		12/31/84		3/31/85	
Hospitals						
Net Earned	5,191.		114,363.		68,983.	
Incurred Loss	(970.)	18.69%	(211,393.)	184.84%	(108,150.)	156.78%
* Incurred LAE	(1,530.)	29.47%	(61,266.)	53.57%	(57,859.)	83.87%
Admin. Expense	(12,811.)	246.79%	(59,658.)	52.17%	(17,474.)	25.33%
Underwriting Gain (Loss)	(10,120.)	(194.95%)	(217,954.)	(190.58%)	(114,500.)	(165.98%)
Physicians						
Net Earned	2,802.		9,631.		2,679.	
Incurred Loss	(524.)	18.70%	(1,407.)	14.61%	(130.)	4.85%
* Incurred LAE	(813.)	29.01%	(1,064.)	11.05%	(125.)	4.67%
Admin. Expense	(6,781.)	242.01%	(4,551.)	47.25%	(679.)	25.35%
Underwriting Gain (Loss)	(5,316.)	(189.72%)	2,609.	27.09%	1,745.	65.14%
Nursing Homes						
Net Earned	862.		25,393.		5,144.	
Incurred Loss	(195.)	22.62%	(15,828.)	62.33%	(11,152.)	216.80%
* Incurred LAE	(268.)	31.09%	(6,090.)	23.98%	(4,911.)	95.47%
Admin. Expense	(2,129.)	246.98%	(11,994.)	47.23%	(1,302.)	25.31%
Underwriting Gain (Loss)	(1,730.)	(200.70%)	(8,519.)	(33.54%)	(12,221.)	(237.58%)

* Includes Unallocated

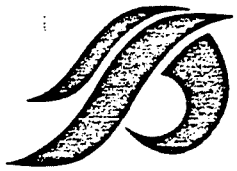
**Start-Up Expense - Not credible ratios

(149.86%) (162.72%)

Overall Underwriting

7/18-19/85

Attachment X



PROVIDERS INSURANCE COMPANY

4711 Highway 50 West • P.O. Box 1498 • Jefferson City, Missouri 65102 • 314-893-5333

Attachment XI

List of Members

and

Minutes of the

Board of Governors

of the

Kansas Health Care Stabilization Fund

* * *

July 9, 1985 minutes
not yet available

November 27, 1984

July 5, 1984

7/18-19/85
Attachment XI

BOARD OF GOVERNORS

OF THE

HEALTH CARE STABILIZATION FUND

NAME - ADDRESS	REPRESENTING
The Honorable Fletcher Bell Commissioner of Insurance	
Dr. James Lueger 201 North 6th St., Seneca, KS 66538	Doctor of Osteopathic Medicine
Dr. David Allen Jacoby 613 Market St., Osage City, KS 66523	Optometrist
Mr. Stephen Crow, Director of Pharmacy Services St. Francis Hospital & Medical Center 1700 West Seventh, Topeka, KS 66606	Pharmacist
John W. Young, M.D., P.A. 8220 Travis, Suite 115, Shawnee Mission, KS 66204	Medical Doctor
Dr. John H. Hill, II, D.C. 944 Kentucky, Lawrence, KS 66044	Chiropractor
Mr. Bradley Smoot, Petefish, Curran & Immel 9th & Louisiana, Lawrence, KS 66044	Public
Mr. James O'Connell, Executive Director Providence-St. Margaret Health Center 8929 Parallel Ave., Kansas City, KS 66112	Hospitals
Dan Roberts, M.D., Ph.D. 3333 East Central, No. 301, Wichita, KS 67208	Medical Doctor
Dr. George Learned 401 Arkansas, Lawrence, KS 66044	Medical Doctor
Mr. Curtis C. Erickson President & Chief Executive Officer Great Plains Health Alliance, 625 Third Street P. O. Box 366, Phillipsburg, KS 66761	Hospitals
Dr. Ross Shook 217 East First, Hutchinson, KS 67501	Doctor of Osteopathic Medicine
Mr. Roger Samuelson Newman Memorial Hospital 12th & Chestnut Streets, Emporia, KS 66801	Hospitals

Subsection (b)(2) of K.S.A. 40-3403

The board shall consist of 13 persons appointed by the commissioner of insurance, as follows: (A)The commissioner of insurance, or the designee of the commissioner, who shall act as chairperson; (B)one member appointed from the public at large who is not affiliated with any health care provider; (C)three members licensed to practice medicine and surgery in Kansas who are doctors of medicine; (D)three members who are representatives of Kansas hospitals; (E)two members licensed to practice medicine and surgery in Kansas who are doctors of osteopathic medicine; (F)one member licensed to practice chiropractic in Kansas; and (G)two members of other categories of health care providers. Meetings shall be called by the chairperson or by a written notice signed by three members of the board. The board, in addition to other duties imposed by this act, shall study and evaluate the operation of the fund and make such recommendations to the legislature as may be appropriate to ensure the viability of the fund.

MINUTES OF THE NOVEMBER 27, 1984 MEETING
OF THE BOARD OF GOVERNORS
OF THE
KANSAS HEALTH CARE STABILIZATION FUND

The November 27, 1984 meeting was called at the request of Commissioner Bell and nine (9) members of the Board, including the Commissioner, were in attendance. The following individuals were present at the meeting: Commissioner Fletcher Bell; Robert Hayes; Raymond Rathert; Robert B. Samuelson; James J. Lueger; George R. Learned; David Jacoby; Stephen Crow; John H. Hill; Bradley Smoot; Dan Roberts; Derenda J. Mitchell; and Pamela Sjoholm.

Introductions were made of all persons present and the minutes from the previous meeting were read and approved unanimously.

Robert Hayes of the Fire and Casualty Division of the Kansas Insurance Department presented a report on rate filings and underwriting changes in medical malpractice coverages. Mr. Hayes discussed the availability of excess insurance over the Fund's $3,000,000 per occurrence and $6,000,000 aggregate caps. Mr. Hayes reported that he had been advised that Medical Protective would not write excess over the Fund's excess unless the provider held primary coverage with Medical Protective. Robert Hayes recounted that he had received recent requests for rate changes in hospitalization rates from St. Paul and had received physicians and surgeons filings from several of the companies writing medical malpractice liability insurance coverage in Kansas. Mr. Hayes indicated that significant adjustments in rates would occur because of the new entry into the market of Pennsylvania Casualty. He indicated that Pennsylvania Casualty may be seeking a sixty-eight percent (68%) rate increase

in the near future. Medical Protective, according to his sources, did not anticipate changes until July 1, 1985. St. Paul, according to Mr. Hayes' sources, were considering a ten percent (10%) increase also around July 1, 1985.

The Commissioner reported that he was earnestly searching for a claims person to assist in handling the Fund's claims files and proposed hiring a consulting actuarial firm to assist in calculating reserves and assessments on approximately a quarterly basis. The Commissioner also reported that audits made of the Fund reflected that the Fund's administration was good, but documentation needed to be improved. The Commissioner stressed that we were going to employ outside counsel more frequently and requested questions. Dr. Roberts stated that he wanted us to make sure any claims man we hired received proper training in medical malpractice. The Commissioner responded that he would send the new employee to school.

Derenda Mitchell, newly appointed attorney for the Health Care Stabilization Fund and successor to Michael Dutton, handed out the Fund statistics current as of October 10, 1984. Ms. Mitchell recounted that the Fund had incurred the cost of three additional settlements since October 10, 1984, and that three judgments had been rendered as of the October 10 date. The three judgments which had been rendered since October 10, 1984 affected the Fund for $95,000, $1,140,000 and $4,900,000, respectively. Post trial motions and prospective appeals were pending on the two cases over $1,000,000. Ms. Mitchell added that approximately forty (40) additional claims had been opened since October 10, 1984 and she advised the Board that approximately thirteen (13) brain damaged baby cases were pending against the Fund, two of which had been filed since the October 10th figures and all of which posed significant exposure to the Fund.

Ms. Mitchell recommended to the Board the necessity of rigorous enforcement of the provisions enacted by Senate Bill No. 507 which became effective July 1, 1984.

Copies of the new law were distributed at the meeting. Ms. Mitchell cited subsection (g) of Section 3 of the law which provides:

> . . . if the board of governors determines that an individual health care provider presents a material risk of significant future liability to the fund, the board of governors is authorized. . . to terminate the liability to the fund for all claims against the health care provider.

Ms. Mitchell advised the Board that the provision was fraught with legal questions and that any action in this area would not be easily or smoothly facilitated. A provider who had its coverage cancelled by the Fund would most likely seek redress of the issue. Dr. Roberts inquired if coverage could be terminated immediately. Ms. Mitchell stated that coverage would not be cutoff on a claims basis. Persons having claims prior to the date of termination, could seek indemnity from the Fund. The Commissioner added that we must give thirty (30) days notice and that all due process issues would be and must be observed. The Commissioner suggested that a subcommittee be appointed to review claims histories of providers. The Commissioner asked Dr. Roberts, Dr. Learned and Brad Smoot if they would serve. They accepted. The formation of the subcommittee was moved, seconded and approved. Dr. Roberts added that the Fund's responsibility in this regard should be divorced and separate from that of the Board of Healing Arts. Mr. Smoot added that the Fund was more concerned with fiscal considerations.

The Commissioner closed the meeting by saying that he had tried to get health care providers and lawyers together to discuss the state of medical malpractice in Kansas. He advised that the 1985 Legislative Session would prove interesting in this regard. Dr. Roberts requested notification by telephone as well as letter prior to

future meetings. The Commissioner expressed appreciation for everyone's attendance, and the meeting was adjourned.

MINUTES OF THE MEETING
OF THE
BOARD OF GOVERNORS
OF THE
KANSAS HEALTH CARE STABILIZATION FUND
JULY 5, 1984

On July 5, 1984, at 1:30 p.m., in the Third Floor Conference Room of the Kansas Insurance Department, the newly created Board of Governors for the Health Care Stabilization Fund held their introductory meeting. In attendance at this meeting were the following members of the Board of Governors: Fletcher Bell, Chairman and Commissioner of Insurance; Dr. George Learned; Dr. John Young; Dr. Dan Roberts, representing physicians; Curtis Erickson; Roger Samuelson; James O'Connell, representing the hospitals; Dr. Ross Shook; Dr. James Luegar, representing Osteopaths and at large members; Dr. Dave Jacoby, optometrists; and Steven Crow, pharmacists. Also in attendance at the meeting were the following staff personnel of the Kansas Insurance Department: Ron Todd, Assistant Commissioner of Insurance; Dick Brock, Administrative Assistant; William W. Sneed, Chief Attorney; Michael J. Dutton, Attorney for the Kansas Health Care Stabilization Fund; Raymond Rathert, Supervisor of the Fire and Casualty Division; and Ron Nitcher, Controller and Auditor.

Chairman, Fletcher Bell, brought the meeting to order welcoming and thanking the members of the Board of Governors for agreeing to accept their appointments to serve. Introductions were made and a discussion of the duties and responsibilities of the Health Care Stabilization Fund Board of Governers was commenced.

Mike Dutton briefly outlined the implementing legislation for the Board of Governors which was 1984 Senate Bill No. 507, which became effective on July 1, 1984. He gave the Board members a handout with information regarding the Health Care Stabilization Fund. In the handout, a copy of Senate Bill No. 507 was provided. Mr. Dutton advised of the changes made to the Health Care Stabilization Fund and the Health Care Provider Insurance Availability Act by Senate Bill No. 507, specifically emphasizing the implementing authority of the Board of Governors in Section 3 of the bill. Section 3 provides that the Board of Governors shall provide (a) technical assistance with respect to the administration of the Fund; (b) expertise in the evaluation of claims or potential claims; (c) advice, information and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of health care providers; (d) recommendations to the legislature as may be appropriate to insure the viability of the Fund; and (e) the authority to terminate coverage under the Health Care Stabilization

Fund of a health care provider who presents a material or significant risk of future liability to the Fund.

A question was raised regarding tort liability for membership of the Board of Governors. It was suggested that inasmuch as the Board members are considered to be employees of the Insurance Department, they would be provided coverage under the Tort Claims Act. Commissioner Bell indicated that he would request an Attorney General Opinion so as to have that point clarified.

Ron Nitcher explained the reimbursement to be provided Board members for their travel and per diem pursuant to the requirements set forth by the State of Kansas. Such amounts are included in Section 4 of the handout that was given to the Board at the meeting. These amounts are twenty-two cents ($.22) per mile for private automobiles, thirty-four cents ($.34) per mile for private plane and a maximum of forty dollars ($40.00) per diem subsistance allowance.

Mike Dutton then directed the Board of Governors to the first section of the handout to discuss the status of the Health Care Stabilization Fund at the present time. He went through the figures that are listed in Section 1 and advised that for further background information members should read the article provided in Section III of the handout. He discussed the current claims practices of the Fund and how it works with the primary coverage. At that time, Dr. Roberts offered the opinion that it might be beneficial to explore hiring claims management person or team to evaluate the claims for the Health Care Stabilization Fund. He indicated that from his experience, oftentimes defense counsel and the primary carriers' interest are somewhat different from the Health Care Stabilization Fund. He indicated that it might be advantageous to have the Fund's interest represented at an earlier stage to determine are serious and which cases should be settled quickly and which should not. This, he indicated, would help in the relationship between the primary carrier and would prvent them from tendering their limits in to early or too late to the Fund, depending on the case.

Ray Rathert then made a presentation regarding the efforts the Department has been involved in relative to exploring reinsuring the Fund. He indicated that over the past year and one-half the Department has looked at reinsurance and has received information from four (4) reinsurers who are interested in reinsuring the Fund. At that time, Mr. Rathert was unable to provide anything definitive on what type of coverage was sought or desired, at what cost and at what levels. However, he indicated that such information should be available within the not too distant future and at the next meeting of the Board he should be able to provide a reinsurance proposal of some kind for the Board to consider.

Mr. Rathert also discussed the availability of excess coverage above the Fund's cap of $3 million. He advised that St. Paul has agreed to write coverage up to $10 million on their own insureds. He also indicated that Pennsylvania Casualty Company and Medical Defense Insurance Company were also planning to write excess insurance coverage. Mr. Rathert indicated that there will probably be others who will write this coverage but at this time there has been no confirmation. He advised that the Department is further exploring excess insurance coverage.

More indepth discussion was then had regarding the standards which should be used in determining whether a health care provider should be terminated from the Fund. Concerns were expressed as to whether this, in fact, represented an function of the Board of Healing Arts. It was explained that the fiscal impact to the Fund was what was to be considered as opposed to the type of care rendered and that the Board of Governors would have to work in concert with the Board of Healing Arts. Members were asked to consider what their thoughts would be relative to this difficult area and defer the discussion to the next meeting. The Commissioner indicated that in all likelihood, certain names would be presented to the Baord of Governors for such consideration in the not too distant future.

Commissioner Bell then advised the Board that he thinks it would be advisable to have a separate and independent claims audit of the Health Care Stabilization Fund conducted. This would be separate and apart from any claims audit conducted by a reinsurer for the purpose of determining reinsurance or any other insurance coverage. The purpose of the claims audit would help establish the status of the Fund at the present time and would help the Department in administering the Fund. A sample of the claims audit was provided in Section V of the handout as to what type of information would be provided. After a motion was made and seconded to conduct the claims audit, it was voted on and passed unanimously.

The Commissioner concluded the meeting by setting forth what should be provided at the next meeting. He indicated that by that time he would have requested and hopefully received the Attorney General opinion determining the liability exposure to the Board of Governors. Also, he indicated he hoped to have some reinsurance proposals to look at. Also, the Commissioner hoped he would be able to have the claims audit performed and received the report to go over with the Baord at the next meeting. Finally, he asked the Board members to provide him with a letter asking any questions of him or his staff about what the Board's parameters would be and offering any comments which they would like to provide.

The Commissioner indicated that the Minutes of the meetings would be prepared and submitted to the health care providers for review and signature within ten (10) days from the date of the meeting. He indicated that the next meeting would be in approxiately two (2) to three (3) months and that meetings would be held on an average of three (3) to four (4) times per year. He indicated that in the future, at least two (2) weeks notice would be given to Board members regarding the meeting if at all possible.

Inasmuch as there was no further business, the Commissioner adjourned the meeting.

The foregoing represents the Minutes of the meeting of the Health Care Stabilization Fund Board of Governors on July 5, 1984. I have reviewed and concur with the content and substance of the Minutes as recorded.

_____

Attachment XII

List of Members

and

Minutes of the

Board of Governors

of the

Kansas Health Care Provider Insurance Availability Plan

7/18-19/85

Attachment XII

KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN

Board of Governors

(7-1-85)

Names & Addresses	Representing
CHAIRMAN James L. Ketcherside President Farmers Alliance Mutual Ins. Co. 1122 North Main McPherson, KS 67460	Domestic Insurers
SECRETARY Homer H. Cowan, Jr. Vice President The Western Insurance Companies 14 East First Street Fort Scott, KS 66701	Domestic Insurers
TREASURER Paul D. Tompkins Sargent-Wanamaker Insurance P.O. Box 4266 3601 West 29th Street-Suite 106 Topeka, KS 66604	Insurance Agents
J.B. Barbee 3342 Jeanette Street Wichita, KS 67204	General Public
Mrs. Dixie Olson Rt. 1 Box 148 Lawrence, KS 66044	General Public
David Loritz, General Manager The St. Paul Insurance Companies 7600 College Blvd. P.O. Box 2954 Overland Park, KS 66201	Foreign Insurers
Clifford D. Custin Deputy Regional Vice President State Farm Insusrnce Companies 2000 1-70 Drive Columbia, MO 65201	Foreign Insurers
David W. Wilson, Vice President The Medical Protective Company 5184 Reed Road Fort Wayne, IN 46805	Foreign Insurers
M. Martin Halley, M.D. 40 Medical Arts Building 1001 Horne Topeka, KS 66604	Health Care Provider

THE WESTERN
INSURANCE COMPANIES
EAST FIRST

HOMER H. COWAN, JR.
VICE PRESIDENT -PUBLIC AFFAIRS

July 15, 1985

Mr. Bob Hayes
Kansas Insurance Department
420 S.W. 9th Street
Topeka, Kansas 66612

RE: Kansas Health Care Provider Insurance Availability Plan
Minutes - Board of Governors Meetings

Dera Mr. Hayes:

Jim Ketcherside called and stated that you needed copies of the Minutes of the Board of Governors for the past year. Attached you will find the minutes of:

July 11, 1984
September 6, 1984
October 25, 1984
March 27, 1985

Very truly yours,

HOMER H. COWAN, JR.
VICE PRESIDENT

HHC:cb
Enclosures

cc: Mr. James L. Ketcherside
Chairman - K.H.C.P.I.A.P.

MINUTES

Kansas Health Care Provider Insurance Availability Plan
Board of Governors Meeting
March 27, 1985 - 1:30 p.m.
Merchants National Bank
Topeka, Kansas

The meeting of the Board of Governors of the Kansas Health Care Provider Insurance Availability Plan was called to order by Chairman James L. Ketcherside at 1:30 p.m., March 27, 1985. The following members were recorded as being present:

Mr. James L. Ketcherside, Chairman
Mr. Paul D. Tompkins, Treasurer
Mr. Homer D. Cowan, Jr., Secretary
Mr. David W. Wilson
Mrs. Dixie Olson
Mr. David Loritz

Excused absence:

Mr. J. B. Barbee
Mr. Clifford D. Custin
Dr. M. Martin Halley

Others present:

Mr. L. M. Cornish, Legal Counsel
Mr. Robert D. Hayes, Kansas Insurance Dept.

In the absence of Mr. Custin, Mr. James L. Ketcherside was appointed recording secretary for the purpose of recording the minutes of the meeting.

Minutes

On motion by Mr. Paul Tompkins, seconded by Mr. Homer Cowan, the minutes of the Telephone Conference Meeting of the Board of Governors held October 25, 1984 and the meeting of the Board of Governors held September 6, 1984, were approved as recorded.

Treasurer's Report

Mr. Paul Tompkins then presented a Treasurer's Report for the period ending February 28, 1985. The report included the Receipts and Disbursements for the period June 30, 1984 to February 28, 1985. A copy of Mr. Tompkins' report is included as part of the minutes. Mr. Tompkins then requested permission to increase the balance at the Columbian Trust Company, Topeka, Kansas to $150,000 and reduce the authority at the Merchants National Bank, Topeka, Kansas to $100,000. He explained that there were numerous changes being made at the Merchants National Bank and he felt that it would be prudent to increase the authorization at the Columbian Trust Company and reduce the authority at the Merchants National Bank down to the F.D.I.C. insured limits. On motion by David Loritz, seconded by Homer Cowan, Mr. Tompkins treasurer's report and the recommendation to increase the balance authority at the Columbian Trust Company to $150,000 and reduce the balance authority at the Merchants National Bank, Topeka, Kansas to $100,000 were unanimously approved.

Attorney General's Opinion

Chairman Ketcherside then referred to the Attorney General's opinion on the immunity status of the Board of Governors which had been mailed out to each member and asked if there were any questions. Following discussion of the opinion, it was the consensus of the Board that Mr. L. M. Cornish, legal counsel for the PLAN, should review the opinion and report to the Board at its next meeting. Also, it was felt that a copy of the opinion should be sent to the insurance carrier providing the officers and directors insurance coverage for the PLAN.

J.U.A. Meeting

On motion by David Wilson, seconded by David Loritz, it was unanimously approved that the PLAN send one member of the Board of Governors to the National J.U.A. Meeting to be held in Florida October 9, 10, 11, 1985. Mr. Paul Tompkins was the selected representative of the Board of Governors to attend the meeting.

Amend Servicing Carrier Contract

Chairman Ketcherside explained that the present servicing carrier contract did not contain a provision for the servicing of existing claims should the contract with the current servicing carrier be cancelled or nonrenewed. Since the fee for the service provided by the servicing carrier is calculated as a percentage of written premium, in the event of cancellation or nonrenewal the contract does not provide a fee basis for the continued servicing of the outstanding claims at the time the contract is discontinued. Following discussion, it was the consensus of the Board that Mr. L. M. Cornish should draft an amendment to the servicing carrier contract that would permit the servicing of the outstanding claims by the servicing carrier retiring from the contract and provisions made for the appropriate fee for reimbursement for services rendered.

Waiver of Subrogation

Homer Cowan explained that occasionally, during the claim settlement negotiation, it may be necessary to waive subrogation in order to effect a reasonable settlement of a claim. He requested the Board of Governors either give the servicing carrier authority to waive subrogation when deemed necessary to effect a reasonable loss settlement or to advise the servicing carrier that it had no authority to waive the subrogation rights of the PLAN. Following discussion, and on motion by Dave Loritz, seconded by Paul Tompkins, it was agreed that the loss files of the PLAN are to be handled with the same claims philosophies and practices as that of the servicing carrier's loss files.

Underwriting Committee Report

Chairman Ketcherside reported that due to the concern of the Board of Governors as to the increasing underwriting losses of the PLAN, that he had requested the Underwriting Committee to meet and try to develop any feasible solutions to the adverse results of the PLAN. Mr. Ketcherside stated that the Underwriting Committee had met the morning prior to the Board of Governors' Meeting and then called on Mr. David Loritz for a report. Mr. Loritz reported that the Underwriting Committee had met at 9:30 a.m., just prior to this meeting. Those present were David Loritz, David Wilson, Homer Cowan, James L. Ketcherside, L. M. Cornish and Robert Hayes. Mr. Loritz stated that due to the reduced number of Health Care Providers insured in the PLAN, the earned premium of the PLAN was not adequate to absorb the losses now occurring in the PLAN. He said that he felt that a very small number of Health Care Providers insured in the PLAN were responsible for most of the claims. He said the Underwriting Committee discussed this problem and discussed steps that could be taken that could possibly be helpful to the PLAN. The steps recommended by the Underwriting Committee were:

1. Gather data that will enable the Medical Society to have a more clear understanding of the impact the PLAN is having on the cost of medical malpractice liability insurance in the medical profession.
2. Adjust rates to a level of 25% in excess of the St. Paul Fire and Marine medical malpractice rates being charged in Kansas and to review the surcharges to determine their appropriateness.
3. Review the Podiatrist rate structure for adequacy.
4. Determine whether or not it is possible for the PLAN to submit problem risks to the Health Care Stabilization Fund Oversight Committee for authority to cancel coverage of the risk from the PLAN. If not permissible, legislation should possibly be considered to allow this practice.

Following discussion, on motion by David Loritz, seconded by Homer Cowan, the recommendations of the Underwriting Committee were approved. Also, it was the consensus of the Board that Mr. Ketcherside should write a letter to Mr. Jerry Slaughter, Executive Director of the Kansas Medical Society, expressing the deep concern of the Board of Governors and a willingness to meet with representatives of the medical society to see if there are other steps to be considered.

Adjournment

There being no further business to come before the Board, the meeting adjourned at 4:00 p.m.

James L. Ketcherside
Recording Secretary

MINUTES

Kansas Health Care Provider Insurance Availability Plan
Board of Governors Telephone Conference Call Meeting
October 25, 1984 - 3:00 p.m.

Present were:

Mr. James L. Ketcherside, Chairman
Mr. Paul D. Tompkins, Treasurer
Mr. Homer D. Cowan, Jr., Secretary
Mr. J. B. Barbee
Mr. Clifford D. Custin
Mr. David Wilson
Mr. Dave Loritz

Excused absence:

Dr. M. Martin Halley
Mr. L. M. Cornish
Mrs. Dixie Olson

Others present:

Mr. Robert D. Hayes, Kansas Insurance Department

Before the meeting officially started by a conference call, Mr. Ketcherside mentioned that the annual statement had been sent to the Kansas Insurance Department with a request to pay the amount that was owed from the Health Care Stabilization Fund.

Directors & Officers Liability Insurance

Mr. Ketcherside called the meeting to order at 3:00 p.m. and mentioned that International Surplus Lines Insurance Company declined to renew our coverage. Mr. Ketcherside then called them directly and they agreed to quote a $2,000,000 limit at a $13,200 premium plus 4% tax. This includes a $5,000 deductible. Their concern centered around JUA's encountering financial trouble. On a motion by Mr. Homer Cowan and a second by Mr. David Loritz, a motion was made that we accept this offer of coverage. The motion carried unanimously.

Tort Claims Act

We discussed the Tort Claims Act which provides immunity for state officials. It was suggested that legislation be introduced to obtain board immunity. We need to visit with the Kansas Insurance Department to see if they will provide support for this effort. Mr. Robert Hayes mentioned that there was a new attorney general's opinion that the Tort Claims Act applies to the board of governors to the administrative fund activity. Mr. Hays will discuss this matter with the insurance commissioner.

Other Business

Mr. Homer Cowan discussed a case under the Plan that he hopefully believes can be settled for about 1.4 million. The additional insured involved is not a health care provider and, therefore, no surcharge of the premium was made. The plaintiff's attorney has made several points that are not valid including the fact that the plan should have recommended higher limits.

Adjournment

The meeting was adjourned at 3:30 p.m.

Clifford D. Custin
Recording Secretary

MINUTES

Kansas Health Care Provider Insurance Availability Plan
Board of Governors Meeting
September 6, 1984 - 9:30 a.m.
First National Bank
Topeka, Kansas

The meeting of the Board of Governors of the Kansas Health Care Provider Insurance Availability Plan was called to order by Chairman James L. Ketcherside at 9:30 a.m., September 6, 1984. The following members answered roll call and were recorded as being present:

Mr. James L. Ketcherside, Chairman
Mr. Paul D. Tompkins, Treasurer
Mr. Homer D. Cowan, Jr., Secretary
Mr. Gary Caruthers, Kansas Medical Society
(Substitute for Dr. M. Martin Halley)
Mr. David W. Wilson
Mrs. Dixie Olson
Mr. Dave Loritz
Mr. Clifford D. Custin

Excused absence:

Mr. J. B. Barbee

Others present:

Mr. L. M. Cornish, Legal Counsel
Mr. Robert D. Hayes, Kansas Insurance Department

Minutes

On a motion by Mr. Paul Tompkins and seconded by Mr. Homer Cowan, the minutes of the July 11, 1984 meeting were approved as distributed.

The balance sheet of June 30, 1984 was reviewed. Assets included bonds in the amount of $2,873,173 along with cash, interest due and the amounts to be transferred from the Kansas Health Care Stabilization Fund. The total assets were $6,013,314. Also various items of the balance sheet comparing amounts with 1983 were reviewed. It was pointed out that Western Insurance Companies, the servicing carrier, should draw more money from the bank account so that service fees can be paid on time.

Statement of Income

The net underwriting loss in 1984 was $2,538,933 compared to the underwriting loss in 1983 of $1,707,247. The net loss in 1984 is $2,181,186 compared with the net loss of $1,379,306 in 1983. The amount to be transferred from the Kansas Health Care Stabilization Fund is $2,181,186.

Financial Statement - July

We discussed the size of the checking accounts. Money is to be moved to investments as soon as the servicing carrier needs are determined; it should be around the 4th or 5th day of the following month.

Keith Mines complimented Western Casualty accounting function for their handling of loss reserves.

Discussion followed with regard to Keith Mines CPA's letter dated August 22, 1984. We discussed the problem with the professional corporations, especially the one man corporations. The charge of 20% is made for this exposure.

It was suggested that Dave Loritz draft a letter to the Kansas Insurance Department setting out the problem and the concern of the Plan board and ask for the department's response.

Paul Tompkins discussed his concern about claims made after July 1, 1984 with the $200,000 coverage limits. Premium had been collected on the $100,000 limits. A motion was made by David Wilson to approve the certified audit to be presented to the Kansas Insurance Commissioner with a request for reimbursement of the net operating loss in three installments. The second was by Dave Loritz and the motion was passed unanimously.

Selection of Independent Auditor

On a motion made by Mr. Clifford D. Custin and seconded by Mr. Paul Tompkins, it was agreed to retain Keith Mines as outside auditor for the next year.

In discussion, Mr. Custin inquired of Mr. Mines if the board was acting properly in taking care of the financial affairs. Mr. Mines stated that the board was doing "the best that we could" in view of the size of the operation. Mr. Paul Tompkins asked if any additional trails could be made for audit purposes. Mr. Mines responded that everything was being handled correctly.

The motion was passed unanimously.

Report of Servicing Carrier

Mr. Homer Cowan indicated that the allocated adjustment expense is $20,000 short. He feels that he may have to come before the board for additional payment. At the present time, he is looking to determine where the increase is coming from. Mr. Ketcherside pointed out the refunds Western has made in the past and feels that if we need to reciprocate, we should do so. We do not feel that the Western Insurance Company should suffer a loss.

Dr. Halley again requested a breakdown of claims and their nature. He would like to know what expenses are being charged to each claim. Mr. Homer Cowan indicated that he needs to get this information manually and that it will take considerable time. Discussion indicated that this information may come through the closed claim report. Mr. Cowan will investigate what his company has with regard to the closed claim report and provide to Dr. Halley.

Report of Underwriting Committee

The Underwriting Committee met on May 23 to review the rate level. The plan prefers to be 10% over the voluntary market rates. In using ISO rates, we may not reflect current activity. Therefore, as of July 1, 1984, we will use St. Paul Fire Marine and Medical Protective rates. St. Paul's rates are 40% above ISO plus the 15% surcharge. Therefore, rates have been increased 55% plus 30% increase for increased limits. Chiropractor rates went up 355% on August 1. It was disclosed that the plan will not sell excess coverage over $3,000,000 which is the Fund limit.

Insurance Department Report

There was a general discussion of market conditions by Mr. Robert Hayes. He reviewed rates by various carriers including Pennsylvania Casualty, Medical Defense, St. Paul, Medical Protective and Professional Mutual. He pointed out that there is difficulty in obtaining excess coverage over the fund. Really, no such market exists except some companies will provide excess for their own insureds.

Directors & Officers Liability Coverage Report

Mr. Paul Tompkins indicated that Alliance Administrators is quoting. Last year's quote was $11,200. We may have difficulty in obtaining coverage this year in view of the Plan's loss. The international Surplus Lines (Crum and Forrester Group) has the coverage.

Other Business

Mr. James Ketcherside reported on a constitutional referendum to be held in Florida on limiting medical malpractice losses. He feels that the limiting of this kind of loss needs to be done elsewhere.

Adjournment

The meeting adjourned at 12:00 noon.

Clifford D. Custin
Recording Secretary

MINUTES

Kansas Health Care Provider Insurance Availability Plan
Board of Governors Meeting
July 11, 1984 - 9:30 a.m.
Topeka Club Merchants National Bank
Topeka, Kansas

The meeting of the Board of Governors of the Kansas Health Care Provider Insurance Availability Plan was called to order by Chairman James L. Ketcherside at 9:30 a.m., July 11, 1984, at the Topeka Club, Merchants National Bank, Topeka, Kansas. Clifford D. Custin was appointed to be recording secretary for the meeting. The following members answered roll call and were recorded as being present:

Mr. James L. Ketcherside, Chairman
Mr. Paul D. Tompkins, Treasurer
Mr. Homer D. Cowan, Jr., Secretary
Mr. J. B. Barbee
Dr. M. Martin Halley
Mr. Clifford D. Custin

The following were excused from the meeting due to conflicting schedules:

Mr. David W. Wilson
Mrs. Dixie Olson
Mr. David Loritz

Others present:

Mr. L. M. Cornish, Legal Counsel
Mr. Robert D. Hayes, Kansas Insurance Department

Minutes — On a motion by Mr. Clifford Custin and seconded by Mr. Homer Cowan, the minutes of the meeting held August 23, 1983 were approved as recorded.

Election of Officers — Mr. Clifford D. Custin nominated Mr. James Ketcherside as President, Mr. Homer Cowan as Secretary and Mr. Paul Tompkins as Treasurer. This motion was seconded by Mr. J. B. Barbee and the slate was unanimously elected.

Servicing Carrier Report — Mr. Homer Cowan discussed possible problems with claim handling if ever the servicing carrier agreement is terminated. For example, claims on hand might take a year to be settled. There are 148 pending claims at this time. Mr. James Ketcherside suggested that if Western Casualty ever ceased being a servicing carrier, we might have to retain them to handle residue claims. Mr. Ketcherside asked Mr. Cornish to draft a three year renewal letter for the servicing carrier with a provision for annual review of

servicing carrier fees. The Western was complimented by the board for their handling of the various servicing carrier duties. The motion made by Mr. Paul Tompkins, with a second by Mr. Clifford Custin, that the servicing carrier contract be renewed with the Western Casualty as a servicing carrier was unanimously passed.

Mr. Cowan further reported that currently there are 244 risks in the Plan as of March 31, 1984. It appears that there will be less than 300 total for the 1984 year. This proves that the Plan is working. Initially, there were over 1,000 risks in the Plan. He discussed problems with chiropractic risks. Some insurers may withdraw from the market if they don't secure rate increases. This could increase substantially the number of this type of risk in the Plan.

Mr. Cowan discussed problems with punitive damages. Public policy, of course, forbids insuring willful and wanton acts. The new act (40-3412) permits vicarious liability coverage. It should be noted that the Fund by law cannot pay punitive damages. For example, in the Plan, the $200,000 limit would pay general damages and any punitive damages up to policy limits. However, the Fund could not pay any funds for punitive damages.

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eport

Mr. Paul Tompkins gave the treasury report as of June 30, 1984. Cash and investments as of this date, excluding the servicing carrier's bank account, totaled $3,559,799.08. Receipts for the past year, including interest received on investments of $295,238.56, totaled $1,688,385.72.

On motion by Mr. Custin with a second by Mr. Barbee, the treasurer's report was approved as distributed.

Mr. Paul Tompkins was complimented on his excellent work in handling the accounting responsibilities.

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Legislation passed in the last session of the legislature increased the underlying cover to 200/600 from 100/300. New rates have been filed by the Western Casualty for increased limits. Other changes brought on by this legislation include:

1. A $3,000,000 cap on the Stabilization Fund.
2. A Board of Governors was established for the fund for technical assistance.
3. A provision was made for reinsurance to be obtained by the Fund. Fund coverage can be terminated for certain health care providers. Provides for peer review, and provides for disciplinary procedures.

Mr. Ketcherside reported that the filing had been made on June 13 for a 15% increase in rates for the Plan over the St. Paul rates. At this point, the Plan is looking at a $2,000,000 loss during 1984.

JUA Meeting

On a motion made by Mr. Homer Cowan and seconded by Dr. Halley, the board authorized Mr. Paul Tompkins to attend the JUA meeting in Jacksonville, Florida on September 26, 27 and 28.

Insurance Dept. Report

Mr. Robert Hayes, from the Kansas Insurance Department, reported on various filings now pending that could have an impact on the Plan and the Fund. At this time, there are no plans to change the Fund law to pick up vicarious liability for punitive damages.

Adjournment

The meeting adjourned at 12:00 noon.

Clifford D. Custin
Recording Secretary

Attachment XIII

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07-01-76 to 06-30-80

DATE	OBJECT	VENDOR	AMOUNT
03-13-80	272	BENNETT, MARK, ATTORNEY	1,967.88
06-25-80			425.00
		Total	2,392.88
6-21-78	272	BODDINGTON & BROWN LAW OFFICE	46.40
		Total	46.40
05-30-79	272	BROWN, N. JACK, ATTORNEY	1,166.70
		Total	1,166.70
04-27-78	272	CORNISH, L. M., ATTORNEY	350.00
05-26-78			625.00
06-05-78			800.00
06-09-78			150.00
08-21-78			85.85
		Total	2,010.85
04-27-77	272	DAVIS, CHARLES, ATTORNEY	4,600.00
06-30-77			4,992.93
10-06-78			1,457.66
01-04-79			421.03
05-15-79			2,648.35
06-30-79			1,670.03
06-30-79			75.00
08-03-79			3.80
02-20-80			1,644.33
06-25-80			724.15
06-30-80			493.28
		Total	18,730.56
10-03-78	272	DEER, MONTIE, ATTORNEY	35.00
		Total	35.00
06-30-79	272	FISHER, CHARLES, ATTORNEY	518.65
04-14-80			112.50
04-22-80			100.00
		Total	731.15
10-31-78	272	FOULSTON, SIEFKIN, POWERS, EBERHART	21.00
12-03-79			2,011.00
06-30-80			3,442.91
		Total	5,474.91

7/18-19/85
Attachment XIII

04-27-78	272	HARDY, DONALD, ATTORNEY	57.21
		Total	57.21
06-13-79	272	HERNANDEZ, JAMES, ATTORNEY	2,049.60
06-30-79			18.96
08-31-79			1,389.75
02-29-80			3,676.71
04-30-80			4,115.30
06-30-80			862.30
06-30-80			1,548.42
		Total	13,661.04
03-13-80	272	HERRINGTON, ALVIN D., ATTORNEY	586.27
06-30-80			5,520.76
06-30-80			136.65
06-30-80			5,573.19
		Total	11,816.87
06-30-79	272	HOLBROOK, REID, ATTORNEY	325.00
10-17-79			471.53
04-17-80			1,170.30
04-17-80			995.41
06-30-80			572.80
06-30-85			129.00
		Total	3,664.04
06-30-80	272	HUDSON, DOUGLAS G., ATTORNEY	1,368.61
		Total	1,368.61
10-18-78	272	JOHNSON, E. EDWARD, ATTORNEY	250.00
10-18-78			177.35
10-18-78			108.44
10-18-78			125.00
10-18-78			393.70
10-18-78			1,811.30
11-27-78			79.00
11-27-78			66.67
11-27-78			222.79
11-27-78			54.00
11-27-78			1,307.17
11-27-78			882.07
03-08-79			317.00
03-08-79			79.89
03-08-79			154.88
03-08-79			122.19
03-08-79			413.60
03-08-79			404.17
04-19-79			399.92
04-19-79			244.73
04-19-79			526.95
04-19-79			25.00
04-19-79			52.70
04-19-79			395.37
12-06-79			50.00

06-29-79		JOHNSON, E. EDWARD (Continued)	80.46
06-29-79			142.37
06-29-79			79.77
06-29-79			628.30
06-29-79			325.00
08-10-79			100.00
08-10-79			25.00
08-10-79			910.18
08-10-79			150.00
08-10-79			25.00
08-10-79			50.00
08-10-79			25.00
10-17-79			125.00
10-17-79			77.40
10-17-79			1,000.14
10-17-79			219.10
10-17-79			404.60
10-17-79			50.00
10-17-79			50.00
12-06-79			86.46
12-06-79			75.00
12-06-79			50.00
12-06-79			210.27
12-06-79			289.40
02-07-80			25.00
02-07-80			387.70
02-07-80			50.00
02-07-80			50.00
02-07-80			175.00
03-13-80			75.00
04-17-80			25.00
04-17-80			218.32
04-17-80			3.80
04-17-80			309.76
04-17-80			462.45
04-17-80			50.00
04-17-80			218.33
06-11-80			75.00
06-11-80			302.84
06-11-80			287.50
06-11-80			287.50
06-11-80			50.00
06-11-80			75.00
06-30-80			75.00
06-30-80			100.00
06-30-80			75.00
06-30-80			76.65
		Total	17,297.19
08-03-79	272	KAHRS, NELSON, FANNING, HITE & KELLOGG	43.75
		Total	43.75
01-17-79	272	KELLOGG, DARRELL, ATTORNEY	116.25
		Total	116.25

02-02-79	272	LISTROM, MYRON L. ATTORNEY	266.34
06-30-79			1,510.00
		Total	1,776.34
06-30-80	272	MILLS, DAVID M., ATTORNEY	1,658.93
		Total	1,658.93
03-22-79	272	MCMULLEN, LARRY, ATTORNEY	671.75
		Total	671.75
05-31-79	272	RATNER, PAYNE, ATTORNEY	1,960.47
06-30-79			633.90
08-31-79			1,552.64
10-08-79			536.75
10-17-79			100.00
12-14-79			535.00
02-29-80			320.35
04-22-80			125.50
05-21-80			760.68
06-25-80			634.58
06-30-80			35.00
		Total	7,194.87
08-31-79	272	ROBINSON, BRETT H., ATTORNEY	849.75
09-26-79			275.00
10-15-79			300.00
11-09-79			425.00
12-06-79			430.50
01-04-80			425.00
02-06-80			438.50
03-13-80			240.00
05-21-80			150.00
06-25-80			75.00
06-30-80			508.55
		Total	4,117.30
02-15-79	272	STEINEGER, HOLBROOK & FRITZ	780.77
11-09-79			963.50
12-28-79			656.05
06-30-80			1,363.79
		Total	3,764.11
04-22-80	264 C	HERNANDEZ, JAMES, ATTORNEY	91.00
		Total	91.00
04-17-80	264 C	RAUH, THORNE, ROBINSON & CHILDS	47.50
		Total	47.50
05-26-77	264 C	WILEY, RUTH, C.S.R.	12.00
		Total	12.00

TOTALS - 272 - Attorney Fees 97,796.71
264C- Court Reporter 150.50

97,947.21

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KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
11/30/82	0279 C	AAA REPORTING COMPANY	276.08
8/16/84	0279 C	AAA REPORTING COMPANY	574.29
8/28/84	0279 C	AAA REPORTING COMPANY	75.75
5/22/85	0279 C	AAA REPORTING COMPANY	351.80
		TOTALS:	
		0279 C - COURT COPIES	1,277.92
		GRAND TOTAL:	1,277.92
3/20/85	0279 C	AK/RET REPORTING, INC.	124.45
		TOTALS:	
		0279 C - COURT COPIES	124.45
		GRAND TOTAL:	124.45
2/14/85	0279 D	ALAN LEVITON, M.D.	1,125.00
		TOTALS:	
		0279 D - DEPOSITIONS	1,125.00
		GRAND TOTAL:	1,125.00
12/10/84	0279 C	ALVIN D HERRINGTON, ATTY.	614.50
		TOTALS:	
		0279 C - COURT COPIES	614.50
		GRAND TOTAL:	614.50
11/05/81	0279 D	ALVIN D. HERRINGTON, ATTY	340.00
11/05/81	0279 D	ALVIN D. HERRINGTON, ATTY	430.00
		TOTALS:	
		0279 D - DEPOSITIONS	770.00
		GRAND TOTAL:	770.00
1/10/85	0279 C	ALVIN D.HERRINGTON, ATTY.	37.25
		TOTALS:	
		0279 C - COURT COPIES	37.25
		GRAND TOTAL:	37.25
1/22/82	0279 D	ANNE WIGGLESWORTH, M.D	403.75
		TOTALS:	
		0279 D - DEPOSITIONS	403.75
		GRAND TOTAL:	403.75
5/08/84	0279 C	ART STEIN, COURT REPORTER	32.80
6/11/84	0279 C	ART STEIN, COURT REPORTER	845.60
7/27/84	0279 C	ART STEIN, COURT REPORTER	750.00
9/27/84	0279 C	ART STEIN, COURT REPORTER	1,184.20
		TOTALS:	
		0279 C - COURT COPIES	2,812.60
		GRAND TOTAL:	2,812.60
9/21/81	0279 C	B. W. LEWIS, C. S. R	172.60
		TOTALS:	
		0279 C - COURT COPIES	172.60
		GRAND TOTAL:	172.60

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
7/27/81	0279 C	B. W. LEWIS, C.S.R	138.50
7/27/81	0279 C	B. W. LEWIS, C.S.R	138.50
9/11/81	0279 C	B. W. LEWIS, C.S.R	65.10
		TOTALS:	
		0279 C - COURT COPIES	342.10
		GRAND TOTAL:	342.10
5/22/84	0279 C	BOB LEWIS SHORTHAND REPORTERS	377.10
		TOTALS:	
		0279 C - COURT COPIES	377.10
		GRAND TOTAL:	377.10
2/21/84	0279 C	BOB LEWIS SHORTHAND REPORTING	176.40
9/27/84	0279 C	BOB LEWIS SHORTHAND REPORTING	327.30
1/10/85	0279 C	BOB LEWIS SHORTHAND REPORTING	63.90
1/16/85	0279 D	BOB LEWIS SHORTHAND REPORTING	252.10
1/30/85	0279 C	BOB LEWIS SHORTHAND REPORTING	281.10
		TOTALS:	
		0279 C - COURT COPIES	848.70
		0279 D - DEPOSITIONS	252.10
		GRAND TOTAL:	1,100.80
1/11/85	0279 D	BFM, INC.	4,556.50
		TOTALS:	
		0279 D - DEPOSITIONS	4,556.50
		GRAND TOTAL:	4,556.50
2/28/85	0279 C	CANCELLED WARRANT	423.55
		TOTALS:	
		0279 C - COURT COPIES	423.55
		GRAND TOTAL:	423.55
1/31/83	0279 C	CHARLES E. HILL, ATTY	103.00
5/24/83	0279 C	CHARLES E. HILL, ATTY	28.99
6/15/83	0279 D	CHARLES E. HILL, ATTY	15.00
		TOTALS:	
		0279 C - COURT COPIES	131.99
		0279 D - DEPOSITIONS	15.00
		GRAND TOTAL:	146.99
2/08/85	0279 D	CHARLES E. HILL, ATTY.	286.59
		TOTALS:	
		0279 D - DEPOSITIONS	286.59
		GRAND TOTAL:	286.59
4/13/83	0279 D	CHARLES S. FISHER, JR., ATTY	100.50
		TOTALS:	
		0279 D - DEPOSITIONS	100.50
		GRAND TOTAL:	100.50

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
4/25/84	0279 C	CHARLES S. FISHER, JR., ATTY.	765.80
4/25/84	0279 D	CHARLES S. FISHER, JR., ATTY.	3,000.00
		TOTALS:	
		0279 C - COURT COPIES	765.80
		0279 D - DEPOSITIONS	3,000.00
		GRAND TOTAL:	3,765.80
6/30/84	0279 D	CLARENCE L. KING, ATTY.	300.00
		TOTALS:	
		0279 D - DEPOSITIONS	300.00
		GRAND TOTAL:	300.00
8/22/83	0264 C	CLERK OF THE DIST COURT OF JOHNSON CNTY, KS	55.00
		TOTALS:	
		0264 C - COURT REPORTING	55.00
		GRAND TOTAL:	55.00
8/20/82	0264 C	CLERK OF THE DIST COURT OF SALINE COUNTY	35.00
		TOTALS:	
		0264 C - COURT REPORTING	35.00
		GRAND TOTAL:	35.00
5/24/83	0279 C	COLORADO REPORTING SERVICES, INC	408.75
		TOTALS:	
		0279 C - COURT COPIES	408.75
		GRAND TOTAL:	408.75
9/28/82	0279 C	COURT REPORTERS ASSOCIATES	57.90
		TOTALS:	
		0279 C - COURT COPIES	57.90
		GRAND TOTAL:	57.90
5/24/83	0279 C	COURT REPORTING SERVICE	530.70
2/21/84	0279 C	COURT REPORTING SERVICE	680.60
11/28/84	0279 C	COURT REPORTING SERVICE	541.10
		TOTALS:	
		0279 C - COURT COPIES	1,752.40
		GRAND TOTAL:	1,752.40
10/16/81	0279 C	CURTIS, SCHLOETZER & ASSOCIATES	287.00
		TOTALS:	
		0279 C - COURT COPIES	287.00
		GRAND TOTAL:	287.00
4/25/84	0279 C	CURTIS, SCHLOETZER, STOREY FOSTER & ASSOCIATE	82.50
		TOTALS:	
		0279 C - COURT COPIES	82.50
		GRAND TOTAL:	82.50

DATE	OBJECT	VENDOR	AMOUNT
6/02/83	0279 D	D. BERNARD FOSTER, M.D	300.00
		TOTALS:	
		0279 D - DEPOSITIONS	300.00
		GRAND TOTAL:	300.00
5/30/85	0279 D	D. C. MOORE, M.D.	1,247.05
		TOTALS:	
		0279 D - DEPOSITIONS	1,247.05
		GRAND TOTAL:	1,247.05
4/27/83	0279 D	D. GARY HUNTER, ATTY	50.00
		TOTALS:	
		0279 D - DEPOSITIONS	50.00
		GRAND TOTAL:	50.00
9/08/82	0279 C	DARRELL D KELLOGG, ATTY	152.23
		TOTALS:	
		0279 C - COURT COPIES	152.23
		GRAND TOTAL:	152.23
2/15/83	0279 D	DARRELL D. KELLOGG, ATTY	98.20
5/31/83	0279 C	DARRELL D. KELLOGG, ATTY	442.88
12/19/83	0279 C	DARRELL D. KELLOGG, ATTY	310.85
		TOTALS:	
		0279 C - COURT COPIES	753.73
		0279 D - DEPOSITIONS	98.20
		GRAND TOTAL:	851.93
4/25/84	0279 C	DARRELL D. KELLOGG, ATTY.	154.50
6/11/84	0279 C	DARRELL D. KELLOGG, ATTY.	562.75
7/27/84	0279 C	DARRELL D. KELLOGG, ATTY.	499.50
8/28/84	0279 C	DARRELL D. KELLOGG, ATTY.	237.25
9/21/84	0279 D	DARRELL D. KELLOGG, ATTY.	513.75
9/27/84	0279 C	DARRELL D. KELLOGG, ATTY.	51.25
9/27/84	0279 C	DARRELL D. KELLOGG, ATTY.	183.21
10/17/84	0279 C	DARRELL D. KELLOGG, ATTY.	103.43
		TOTALS:	
		0279 C - COURT COPIES	1,791.89
		0279 D - DEPOSITIONS	513.75
		GRAND TOTAL:	2,305.64
4/12/83	0279 C	DEPOSITION SERVICES	18.47
		TOTALS:	
		0279 C - COURT COPIES	18.47
		GRAND TOTAL:	18.47
6/23/82	0279 C	DON K. SMITH AND ASSOCIATES	281.25
		TOTALS:	
		0279 C - COURT COPIES	281.25
		GRAND TOTAL:	281.25

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
9/21/84	0279 D	DR. KENNETH KIMMEL	600.00
		TOTALS:	600.00
		0279 D - DEPOSITIONS	600.00
		GRAND TOTAL:	600.00
1/10/85	0264 C	EDWARD J. CHAPMAN, JR., ATTY.	1,325.07
		TOTALS:	1,325.07
		0264 C - COURT REPORTING	1,325.07
		GRAND TOTAL:	1,325.07
5/05/82	0279 D	ERNEST D. KOVARIK, M.D., F.A.C.S	187.00
		TOTALS:	187.00
		0279 D - DEPOSITIONS	187.00
		GRAND TOTAL:	187.00
1/10/85	0279 C	EUGENE DOLGINOFF & ASSOCIATES, LTD	423.55
		TOTALS:	423.55
		0279 C - COURT COPIES	423.55
		GRAND TOTAL:	423.55
8/27/82	0279 C	EUGENE L. DOLGINOFF	232.40
		TOTALS:	232.40
		0279 C - COURT COPIES	232.40
		GRAND TOTAL:	232.40
1/27/83	0279 C	FISHER, OCHS AND HECK, P.A	341.98
3/30/83	0279 C	FISHER, OCHS AND HECK, P.A	973.01
		TOTALS:	1,314.99
		0279 C - COURT COPIES	1,314.99
		GRAND TOTAL:	1,314.99
8/28/84	0279 D	FRANK SAUNDERS, JR. ATTY.	2,283.00
		TOTALS:	2,283.00
		0279 D - DEPOSITIONS	2,283.00
		GRAND TOTAL:	2,283.00
12/13/84	0279 D	FRANK SAUNDERS, JR., ATTY.	1,325.00
		TOTALS:	1,325.00
		0279 D - DEPOSITIONS	1,325.00
		GRAND TOTAL:	1,325.00
11/17/83	0279 C	FRED SPIGARELLI, ATTY	1,445.00
		TOTALS:	1,445.00
		0279 C - COURT COPIES	1,445.00
		GRAND TOTAL:	1,445.00
11/05/81	0279 C	GENE E SHROER, ATTY	36.00
		TOTALS:	36.00
		0279 C - COURT COPIES	36.00
		GRAND TOTAL:	36.00

9/30/84 ... 0279 C ... GRAND TOTAL:

DATE	OBJECT	VENDOR	AMOUNT
6/21/82	0279 D	GEORGE H. MCCRACKEN, JR., M.D	200.00
		TOTALS:	
		0279 D - DEPOSITIONS	200.00
		GRAND TOTAL:	200.00
8/16/84	0279 C	GOODELL, STRATTON, EDMONDS & PALMER	74.25
8/16/84	0279 D	GOODELL, STRATTON, EDMONDS & PALMER	150.00
		TOTALS:	
		0279 C - COURT COPIES	74.25
		0279 D - DEPOSITIONS	150.00
		GRAND TOTAL:	224.25
6/09/83	0279 C	HARKER E. RUSSELL, ATTY	750.00
		TOTALS:	
		0279 C - COURT COPIES	750.00
		GRAND TOTAL:	750.00
11/17/81	0279 D	HOLBROOK AND ELLIS, P.A	841.00
6/30/83	0279 C	HOLBROOK AND ELLIS, P.A	91.84
6/30/83	0279 D	HOLBROOK AND ELLIS, P.A	1,975.00
		TOTALS:	
		0279 C - COURT COPIES	91.84
		0279 D - DEPOSITIONS	2,816.00
		GRAND TOTAL:	2,907.84
3/24/81	0279 C	HOLBROOK AND ELLIS, P.A.	212.50
3/24/81	0279 C	HOLBROOK AND ELLIS, P.A.	78.20
		TOTALS:	
		0279 C - COURT COPIES	290.70
		GRAND TOTAL:	290.70
2/05/85	0279 C	HOSTETLER & ASSOCIATES, INC.	182.12
5/10/85	0279 C	HOSTETLER & ASSOCIATES, INC.	561.20
		TOTALS:	
		0279 C - COURT COPIES	743.32
		GRAND TOTAL:	743.32
8/20/80	0264 C	HOSTETLER AND ASSOCIATES	52.55
		TOTALS:	
		0264 C - COURT REPORTING	52.55
		GRAND TOTAL:	52.55
5/24/82	0279 C	HOSTETLER AND ASSOCIATES, INC	393.75
8/12/83	0279 C	HOSTETLER AND ASSOCIATES, INC	251.20
		TOTALS:	
		0279 C - COURT COPIES	644.95
		GRAND TOTAL:	644.95
3/14/83	0279 C	HOSTETTLER AND ASSOCIATES, INC	196.85
		TOTALS:	
		0279 C - COURT COPIES	196.85
		GRAND TOTAL:	196.85

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
9/18/80	0279 D	HOWARD N. WARD, M.D	
		TOTALS:	400.00
		0279 D - DEPOSITIONS	
		GRAND TOTAL:	400.00
			400.00
11/05/81	0279 D	INTERNAL MEDICINE, P.A	
12/22/81	0279 D	INTERNAL MEDICINE, P.A	800.00
8/12/83	0279 D	INTERNAL MEDICINE, P.A	200.00
		TOTALS:	2,500.00
		0279 D - DEPOSITIONS	
		GRAND TOTAL:	3,500.00
			3,500.00
8/18/81	0279 C	INTERNAL MEDICINE, P.A.	
		TOTALS:	804.60
		0279 C - COURT COPIES	
		GRAND TOTAL:	804.60
			804.60
12/04/80	0279 C	IRELAND AND BARBER	
2/11/81	0279 C	IRELAND AND BARBER	64.80
3/17/81	0279 C	IRELAND AND BARBER	68.30
5/18/81	0279 C	IRELAND AND BARBER	231.00
4/28/82	0279 C	IRELAND AND BARBER	39.20
4/28/82	0279 C	IRELAND AND BARBER	27.35
		TOTALS:	27.35
		0279 C - COURT COPIES	
		GRAND TOTAL:	458.00
			458.00
1/23/85	0279 D	J. A. GLEASON, M.D.	
		TOTALS:	800.00
		0279 D - DEPOSITIONS	
		GRAND TOTAL:	800.00
			800.00
3/12/85	0279 D	JAMES Z. HERNANDEZ, ATTY.	
		TOTALS:	3,000.00
		0279 D - DEPOSITIONS	
		GRAND TOTAL:	3,000.00
			3,000.00
5/29/84	0279 C	JAY E. SUDDRETH & ASSOCIATES, INC.	
		TOTALS:	218.00
		0279 C - COURT COPIES	
		GRAND TOTAL:	218.00
			218.00
9/21/84	0279 D	JOHN G. ATHERTON, ATTY.	
		TOTALS:	1,094.15
		0279 D - DEPOSITIONS	
		GRAND TOTAL:	1,094.15
			1,094.15
4/30/84	0279 C	JOHN M. BOWEN & ASSOCIATES	
9/30/84	0279 C	JOHN M. BOWEN & ASSOCIATES	175.32
		TOTALS:	170.80
		0279 C - COURT COPIES	
		GRAND TOTAL:	346.12
			346.12

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
2/26/82	0279 D	JOSEPH W HUME, M.D., F.A.C.O.G	428.00
		TOTALS:	
		0279 D - DEPOSITIONS	428.00
		GRAND TOTAL:	428.00
9/21/81	0279 C	KAHRS, NELSON, FANNING, HITE AND KELLOGG	30.60
12/22/81	0279 C	KAHRS, NELSON, FANNING, HITE AND KELLOGG	30.60
		TOTALS:	
		0279 C - COURT COPIES	61.20
		GRAND TOTAL:	61.20
4/02/85	0279 C	KAREN STARKEY, C.S.R.	36.40
5/24/85	0279 C	KAREN STARKEY, C.S.R.	284.70
		TOTALS:	
		0279 C - COURT COPIES	321.10
		GRAND TOTAL:	321.10
4/20/83	0279 C	KENNETH E. HOLM, ATTY	74.11
5/05/83	0279 C	KENNETH E. HOLM, ATTY	2,013.50
5/05/83	0279 D	KENNETH E. HOLM, ATTY	500.00
5/12/83	0279 D	KENNETH E. HOLM, ATTY	203.67
6/15/83	0279 D	KENNETH E. HOLM, ATTY	1,085.00
12/15/83	0279 C	KENNETH E. HOLM, ATTY	91.36
		TOTALS:	
		0279 C - COURT COPIES	2,178.97
		0279 D - DEPOSITIONS	1,788.67
		GRAND TOTAL:	3,967.64
4/09/84	0279 C	KENNETH E. HOLM, ATTY.	112.85
4/25/84	0279 D	KENNETH E. HOLM, ATTY.	300.00
4/25/84	0279 D	KENNETH E. HOLM, ATTY.	200.00
9/27/84	0279 D	KENNETH E. HOLM, ATTY.	150.00
10/23/84	0279 C	KENNETH E. HOLM, ATTY.	33.00
5/10/85	0279 D	KENNETH E. HOLM, ATTY.	500.00
		TOTALS:	
		0279 C - COURT COPIES	145.85
		0279 D - DEPOSITIONS	1,150.00
		GRAND TOTAL:	1,295.85
1/23/85	0279 D	KENNETH R. NISWANDER, M.D.	1,400.00
		TOTALS:	
		0279 D - DEPOSITIONS	1,400.00
		GRAND TOTAL:	1,400.00
9/20/84	0279 C	LARRY D. SHOAF, ATTY.	184.50
		TOTALS:	
		0279 C - COURT COPIES	184.50
		GRAND TOTAL:	184.50

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
11/17/81	0279 C	LARRY L MCMULLEN, ATTY.	202.64
		TOTALS:	
		0279 C - COURT COPIES	202.64
		GRAND TOTAL:	202.64
10/18/83	0279 D	LARRY L. MCMULLEN, ATTY	250.00
		TOTALS:	
		0279 D - DEPOSITIONS	250.00
		GRAND TOTAL:	250.00
6/11/84	0279 D	LARRY L. MCMULLEN, ATTY.	350.00
6/22/84	0279 D	LARRY L. MCMULLEN, ATTY.	300.00
6/30/84	0279 D	LARRY L. MCMULLEN, ATTY.	975.00
10/24/84	0279 C	LARRY L. MCMULLEN, ATTY.	86.00
1/16/85	0279 C	LARRY L. MCMULLEN, ATTY.	76.52
4/02/85	0279 D	LARRY L. MCMULLEN, ATTY.	1,000.00
		TOTALS:	
		0279 C - COURT COPIES	162.52
		0279 D - DEPOSITIONS	2,625.00
		GRAND TOTAL:	2,787.52
5/10/85	0279 D	LAURENCE R. TUCKER, ATTY.	475.00
		TOTALS:	
		0279 D - DEPOSITIONS	475.00
		GRAND TOTAL:	475.00
1/31/85	0279 D	LEONARD R. RUBIN, M.D.	500.00
		TOTALS:	
		0279 D - DEPOSITIONS	500.00
		GRAND TOTAL:	500.00
2/28/83	0279 C	LUANNE RUPP	289.00
		TOTALS:	
		0279 C - COURT COPIES	289.00
		GRAND TOTAL:	289.00
3/12/84	0279 C	M WARREN MCCAMISH, ATTY.	950.00
9/30/84	0279 C	M WARREN MCCAMISH, ATTY.	32.85
		TOTALS:	
		0279 C - COURT COPIES	982.85
		GRAND TOTAL:	982.85
6/15/83	0279 D	M. WARREN MCCAMISH, ATTY	750.00
10/26/83	0279 C	M. WARREN MCCAMISH, ATTY	122.53
		TOTALS:	
		0279 C - COURT COPIES	122.53
		0279 D - DEPOSITIONS	750.00
		GRAND TOTAL:	872.53

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
2/08/84	0279 C	M. WARREN MCCAMISH, ATTY.	200.55
3/12/84	0279 D	M. WARREN MCCAMISH, ATTY.	50.00
3/30/84	0279 D	M. WARREN MCCAMISH, ATTY.	718.75
4/09/84	0279 C	M. WARREN MCCAMISH, ATTY.	526.30
6/11/84	0279 D	M. WARREN MCCAMISH, ATTY.	893.70
		TOTALS:	
		0279 C - COURT COPIES	726.85
		0279 D - DEPOSITIONS	1,662.45
		GRAND TOTAL:	2,389.30
8/28/84	0279 D	MARSHALL A HAVENHILL, II, M.D.	150.00
		TOTALS:	
		0279 D - DEPOSITIONS	150.00
		GRAND TOTAL:	150.00
1/27/83	0279 C	MARTHA L. STAPLETON, C.S.R	214.50
		TOTALS:	
		0279 C - COURT COPIES	214.50
		GRAND TOTAL:	214.50
2/28/85	0279 C	MCDONALD, TINKER, SKAER, QUINN & HERRINGTON	572.75
		TOTALS:	
		0279 C - COURT COPIES	572.75
		GRAND TOTAL:	572.75
4/21/82	0279 C	MICHELLE D. JANUARY	694.50
		TOTALS:	
		0279 C - COURT COPIES	694.50
		GRAND TOTAL:	694.50
4/13/83	0279 D	MYROM L. LISTROM, ATTY	375.00
		TOTALS:	
		0279 D - DEPOSITIONS	375.00
		GRAND TOTAL:	375.00
3/30/83	0279 D	MYRON L. LISTROM, ATTY	500.00
5/12/83	0279 C	MYRON L. LISTROM, ATTY	520.80
5/24/83	0279 D	MYRON L. LISTROM, ATTY	850.00
6/29/83	0279 D	MYRON L. LISTROM, ATTY	150.00
8/12/83	0279 C	MYRON L. LISTROM, ATTY	417.60
9/16/83	0279 C	MYRON L. LISTROM, ATTY	84.65
		TOTALS:	
		0279 C - COURT COPIES	1,023.05
		0279 D - DEPOSITIONS	1,500.00
		GRAND TOTAL:	2,523.05
5/24/85	0279 C	MYRON L. LISTROM, ATTY.	40.00
		TOTALS:	
		0279 C - COURT COPIES	40.00
		GRAND TOTAL:	40.00

DATE	OBJECT	VENDOR	AMOUNT
4/13/83	0279 C	NORA LYON & ASSOCIATES	10.76
5/12/83	0279 C	NORA LYON & ASSOCIATES	235.00
9/16/83	0279 C	NORA LYON & ASSOCIATES	394.50
10/19/83	0279 C	NORA LYON & ASSOCIATES	213.75
5/22/84	0279 C	NORA LYON & ASSOCIATES	150.65
9/21/84	0279 C	NORA LYON & ASSOCIATES	370.00
		TOTALS:	
		0279 C - COURT COPIES	1,374.66
		GRAND TOTAL:	1,374.66
5/06/82	0279 D	OLATHE COMMUNITY HOSPITAL	87.00
		TOTALS:	
		0279 D - DEPOSITIONS	87.00
		GRAND TOTAL:	87.00
11/28/84	0279 D	ORTHOPAEDICS & RECONSTRUCTIVE SURGERY, P.A.	100.00
		TOTALS:	
		0279 D - DEPOSITIONS	100.00
		GRAND TOTAL:	100.00
6/30/84	0279 D	ORTHOPEDIC & SPORTS MEDICINE OF WICHITA, INC.	75.00
		TOTALS:	
		0279 D - DEPOSITIONS	75.00
		GRAND TOTAL:	75.00
9/16/81	0279 D	ORTHOPEDIC ASSOCIATES, P.A	200.00
10/16/81	0279 D	ORTHOPEDIC ASSOCIATES, P.A	200.00
		TOTALS:	
		0279 D - DEPOSITIONS	400.00
		GRAND TOTAL:	400.00
6/14/82	0279 C	OWENS, BRAKE AND ASSOCIATES	391.60
		TOTALS:	
		0279 C - COURT COPIES	391.60
		GRAND TOTAL:	391.60
5/22/84	0279 D	R. A. RAWCLIFFE, JR., M.D.	225.00
		TOTALS:	
		0279 D - DEPOSITIONS	225.00
		GRAND TOTAL:	225.00
10/13/82	0279 D	RADIOLOGY AND NUCLEAR MEDICINE	275.00
		TOTALS:	
		0279 D - DEPOSITIONS	275.00
		GRAND TOTAL:	275.00
9/06/84	0279 C	RANDALL D. PALMER, ATTY.	25.00
		TOTALS:	
		0279 C - COURT COPIES	25.00
		GRAND TOTAL:	25.00

DATE	OBJECT	VENDOR	AMOUNT
9/27/82	0279 C	RICHARD T. WATERS, C.S.R	397.50
		TOTALS:	
		0279 C - COURT COPIES	397.50
		GRAND TOTAL:	397.50
9/12/80	0264 C	ROBERT M. SIEFKIN, ATTY.	368.98
		TOTALS:	
		0264 C - COURT REPORTING	368.98
		GRAND TOTAL:	368.98
3/26/84	0279 D	ROBERT T. HALL, M.D.	200.00
		TOTALS:	
		0279 D - DEPOSITIONS	200.00
		GRAND TOTAL:	200.00
1/23/85	0279 D	ROGER K. FREEMAN, M.D., INC.	1,500.00
		TOTALS:	
		0279 D - DEPOSITIONS	1,500.00
		GRAND TOTAL:	1,500.00
1/10/85	0279 C	ROY A LARSON, ATTY.	416.87
		TOTALS:	
		0279 C - COURT COPIES	416.87
		GRAND TOTAL:	416.87
3/19/85	0279 C	ROY A. LARSON, ATTY.	234.38
		TOTALS:	
		0279 C - COURT COPIES	234.38
		GRAND TOTAL:	234.38
6/02/83	0279 C	SANDERS, GALE AND RUSSELL	92.35
		TOTALS:	
		0279 C - COURT COPIES	92.35
		GRAND TOTAL:	92.35
10/17/84	0279 C	SLOAN, LISTROM, EISENBARTH, SLOAN & GLASSMAN	120.35
		TOTALS:	
		0279 C - COURT COPIES	120.35
		GRAND TOTAL:	120.35
11/28/84	0279 C	SLOAN,LISTROM,EISENBARTH, SLOAN AND GLASSMAN	225.00
		TOTALS:	
		0279 C - COURT COPIES	225.00
		GRAND TOTAL:	225.00
3/17/81	0279 C	SPALDING REPORTING	205.03
1/15/82	0279 C	SPALDING REPORTING	117.35
5/06/82	0279 C	SPALDING REPORTING	50.70
		TOTALS:	
		0279 C - COURT COPIES	373.08
		GRAND TOTAL:	373.08

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
6/30/81	0279 C	STOREY-FOSTER REPORTING	123.50
6/30/81	0279 C	STOREY-FOSTER REPORTING	65.00
7/27/81	0279 C	STOREY-FOSTER REPORTING	128.05
5/05/82	0279 C	STOREY-FOSTER REPORTING	348.00
		TOTALS:	
		0279 C - COURT COPIES	664.55
		GRAND TOTAL:	664.55
3/31/82	0279 C	THE CHILDREN'S MERCY HOSPITAL	659.50
		TOTALS:	
		0279 C - COURT COPIES	659.50
		GRAND TOTAL:	659.50
4/25/84	0279 D	THE WICHITA CLINIC	150.00
		TOTALS:	
		0279 D - DEPOSITIONS	150.00
		GRAND TOTAL:	150.00
5/29/84	0279 D	THOMAS L. THEIS, ATTY.	450.00
5/31/84	0279 D	THOMAS L. THEIS, ATTY.	300.00
		TOTALS:	
		0279 D - DEPOSITIONS	750.00
		GRAND TOTAL:	750.00
2/26/82	0279 C	THOMAS W WAGSTAFF, ATTY	32.80
		TOTALS:	
		0279 C - COURT COPIES	32.80
		GRAND TOTAL:	32.80
2/28/83	0279 D	TYRONE D. ARTZ, M.D	12.50
		TOTALS:	
		0279 D - DEPOSITIONS	12.50
		GRAND TOTAL:	12.50
8/16/84	0279 C	VIDEO ASSOCIATES	100.00
9/21/84	0279 C	VIDEO ASSOCIATES	182.25
		TOTALS:	
		0279 C - COURT COPIES	282.25
		GRAND TOTAL:	282.25
6/29/83	0279 C	WAYNE T. STRATTON, ATTY	159.50
6/29/83	0279 D	WAYNE T. STRATTON, ATTY	3,506.25
12/20/83	0279 C	WAYNE T. STRATTON, ATTY	413.25
12/20/83	0279 D	WAYNE T. STRATTON, ATTY	600.00
		TOTALS:	
		0279 C - COURT COPIES	572.75
		0279 D - DEPOSITIONS	4,106.25
		GRAND TOTAL:	4,679.00

DATE	OBJECT	VENDOR	AMOUNT
2/28/83	0279 D	WILLIAM R. JEWELL, M.D	300.00
		TOTALS:	
		0279 D - DEPOSITIONS	300.00
		GRAND TOTAL:	300.00
8/03/83	0279 C	WM. DIRK VANDEVER, ATTY	61.00
8/12/83	0279 D	WM. DIRK VANDEVER, ATTY	450.00
		TOTALS:	
		0279 C - COURT COPIES	61.00
		0279 D - DEPOSITIONS	450.00
		GRAND TOTAL:	511.00
6/27/84	0279 D	GERALD L. GOODELL, ATTY.	750.00
		TOTALS:	
		0279 D - DEPOSITIONS	750.00
		GRAND TOTAL:	750.00
6/30/84	0279 C	OWENS, BRAKE AND ASSOCIATES	359.15
		TOTALS:	
		0279 C - COURT COPIES	359.15
		GRAND TOTAL:	359.15
11/18/82	0272 M	HILL, CHARLES E.	101.77
11/30/82	0272 E	HILL, CHARLES E.	65.12
1/10/83	0272 F	HILL, CHARLES E.	442.66
8/03/83	0272 E	HILL, CHARLES E.	176.32
8/03/83	0272 E	HILL, CHARLES E.	97.00
8/03/83	0272 F	HILL, CHARLES E.	1,238.75
8/03/83	0272 F	HILL, CHARLES E.	686.88
8/03/83	0272 M	HILL, CHARLES E.	84.73
8/03/83	0272 M	HILL, CHARLES E.	133.80
1/31/84	0272 E	HILL, CHARLES E.	196.10
1/31/84	0272 F	HILL, CHARLES E.	300.00
1/31/84	0272 M	HILL, CHARLES E.	128.29
4/30/85	0272 E	HILL, CHARLES E.	190.40
4/30/85	0272 F	HILL, CHARLES E.	2,410.00
4/30/85	0272 M	HILL, CHARLES E.	269.67
5/08/85	0272 E	HILL, CHARLES E.	307.00
5/08/85	0272 F	HILL, CHARLES E.	2,096.25
5/08/85	0272 M	HILL, CHARLES E.	204.60
		TOTALS:	
		0272 F - ATTORNEY FEES	7,174.54
		0272 E - ATTORNEY TRAVEL EXPENSE	1,031.94
		0272 M - ATTORNEY MISCELLANEOUS	922.86
		GRAND TOTAL:	9,129.34
9/12/80	0272 F	ROBINSON, BRETT H.	1,110.00
9/12/80	0272 M	ROBINSON, BRETT H.	525.68
10/24/80	0272 F	ROBINSON, BRETT H.	150.00

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
1/27/81	0272 F	ROBINSON, BRETT H.	700.00
3/03/81	0272 F	ROBINSON, BRETT H.	175.00
4/15/81	0272 F	ROBINSON, BRETT H.	675.00
4/15/81	0272 M	ROBINSON, BRETT H.	28.50
5/31/81	0272 E	ROBINSON, BRETT H.	28.50
5/31/81	0272 F	ROBINSON, BRETT H.	325.00
6/30/81	0272 F	ROBINSON, BRETT H.	125.00
8/18/81	0272 E	ROBINSON, BRETT H.	33.00
8/18/81	0272 F	ROBINSON, BRETT H.	915.00
9/15/81	0272 F	ROBINSON, BRETT H.	540.00
10/14/81	0272 F	ROBINSON, BRETT H.	180.00
11/10/81	0272 F	ROBINSON, BRETT H.	150.00
12/29/81	0272 F	ROBINSON, BRETT H.	570.00
2/15/82	0272 F	ROBINSON, BRETT H.	240.00
3/19/82	0272 E	ROBINSON, BRETT H.	33.00
3/19/82	0272 F	ROBINSON, BRETT H.	1,290.00
4/14/82	0272 F	ROBINSON, BRETT H.	1,470.00
4/14/82	0272 M	ROBINSON, BRETT H.	62.25
5/05/82	0272 F	ROBINSON, BRETT H.	675.00
5/05/82	0272 M	ROBINSON, BRETT H.	56.05
6/14/82	0272 E	ROBINSON, BRETT H.	33.00
6/14/82	0272 F	ROBINSON, BRETT H.	930.00
6/14/82	0272 M	ROBINSON, BRETT H.	16.88
6/30/82	0272 E	ROBINSON, BRETT H.	165.00
6/30/82	0272 F	ROBINSON, BRETT H.	4,046.25
8/12/82	0272 F	ROBINSON, BRETT H.	510.00
8/12/82	0272 M	ROBINSON, BRETT H.	495.49
11/10/82	0272 F	ROBINSON, BRETT H.	120.00
11/30/82	0272 F	ROBINSON, BRETT H.	360.00
1/10/83	0272 F	ROBINSON, BRETT H.	450.00
2/09/83	0272 F	ROBINSON, BRETT H.	210.00
		TOTALS:	
		0272 F - ATTORNEY FEES	15,916.25
		0272 E - ATTORNEY TRAVEL EXPENSE	292.50
		0272 M - ATTORNEY MISCELLANEOUS	1,184.85
		GRAND TOTAL:	17,393.60
9/12/80	0272 F	RATNER, PAYNE H., JR.	200.00
9/12/80	0272 M	RATNER, PAYNE H., JR.	10.00
10/02/80	0272 E	RATNER, PAYNE H., JR.	216.99
10/02/80	0272 F	RATNER, PAYNE H., JR.	2,725.00
10/02/80	0272 M	RATNER, PAYNE H., JR.	195.37
10/23/80	0272 E	RATNER, PAYNE H., JR.	197.27
10/23/80	0272 F	RATNER, PAYNE H., JR.	3,775.00
10/23/80	0272 M	RATNER, PAYNE H., JR.	118.33
12/15/80	0272 F	RATNER, PAYNE H., JR.	715.00
12/15/80	0272 M	RATNER, PAYNE H., JR.	10.00
12/17/80	0272 F	RATNER, PAYNE H., JR.	380.00
12/17/80	0272 M	RATNER, PAYNE H., JR.	90.26

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
1/26/81	0272 F	RATNER, PAYNE H., JR.	25.00
2/05/81	0272 F	RATNER, PAYNE H., JR.	430.00
2/05/81	0272 M	RATNER, PAYNE H., JR.	3.90
2/11/81	0272 E	RATNER, PAYNE H., JR.	903.78
2/11/81	0272 F	RATNER, PAYNE H., JR.	10,590.00
2/11/81	0272 M	RATNER, PAYNE H., JR.	30.98
3/16/81	0272 F	RATNER, PAYNE H., JR.	90.00
3/23/81	0272 E	RATNER, PAYNE H., JR.	223.05
3/23/81	0272 F	RATNER, PAYNE H., JR.	425.00
6/30/81	0272 F	RATNER, PAYNE H., JR.	600.00
6/30/81	0272 M	RATNER, PAYNE H., JR.	56.27
9/11/81	0272 F	RATNER, PAYNE H., JR.	39.00
9/11/81	0272 M	RATNER, PAYNE H., JR.	4.57
9/18/81	0272 F	RATNER, PAYNE H., JR.	636.00
9/18/81	0272 M	RATNER, PAYNE H., JR.	94.64
10/16/81	0272 F	RATNER, PAYNE H., JR.	260.00
10/16/81	0272 M	RATNER, PAYNE H., JR.	36.52
1/15/82	0272 F	RATNER, PAYNE H., JR.	1,475.50
1/15/82	0272 F	RATNER, PAYNE H., JR.	84.50
1/15/82	0272 M	RATNER, PAYNE H., JR.	83.98
1/15/82	0272 M	RATNER, PAYNE H., JR.	2.82
2/26/82	0272 F	RATNER, PAYNE H., JR.	552.50
2/26/82	0272 M	RATNER, PAYNE H., JR.	15.33
6/21/82	0272 F	RATNER, PAYNE H., JR.	1,644.50
		TOTALS:	
		0272 F - ATTORNEY FEES	24,647.00
		0272 E - ATTORNEY TRAVEL EXPENSE	1,541.09
		0272 M - ATTORNEY MISCELLANEOUS	752.97
		GRAND TOTAL:	26,941.06
11/21/80	0272 E	SIEFKIN, ROBERT M.	455.40
11/21/80	0272 F	SIEFKIN, ROBERT M.	1,580.00
11/21/80	0272 M	SIEFKIN, ROBERT M.	17.22
5/31/81	0272 F	SIEFKIN, ROBERT M.	600.00
6/30/81	0272 F	SIEFKIN, ROBERT M.	415.00
		TOTALS:	
		0272 F - ATTORNEY FEES	2,595.00
		0272 E - ATTORNEY TRAVEL EXPENSE	455.40
		0272 M - ATTORNEY MISCELLANEOUS	17.22
		GRAND TOTAL:	3,067.62
3/03/81	0272 E	MILLS, DAVID M.	70.80
3/03/81	0272 F	MILLS, DAVID M.	4,700.00
3/03/81	0272 M	MILLS, DAVID M.	196.78
6/30/81	0272 E	MILLS, DAVID M.	68.83
6/30/81	0272 F	MILLS, DAVID M.	1,862.50
6/30/81	0272 M	MILLS, DAVID M.	1.96
1/15/82	0272 E	MILLS, DAVID M.	179.28
1/15/82	0272 F	MILLS, DAVID M.	3,315.00

DATE	OBJECT	VENDOR	AMOUNT
1/15/82	0272 M	MILLS, DAVID M.	154.12
6/08/82	0272 E	MILLS, DAVID M.	109.39
6/08/82	0272 F	MILLS, DAVID M.	2,957.50
6/08/82	0272 M	MILLS, DAVID M.	79.84
6/30/82	0272 F	MILLS, DAVID M.	617.50
6/30/82	0272 M	MILLS, DAVID M.	7.56
2/15/83	0272 E	MILLS, DAVID M.	28.06
2/15/83	0272 F	MILLS, DAVID M.	1,852.50
2/15/83	0272 M	MILLS, DAVID M.	21.22
9/20/84	0272 E	MILLS, DAVID M.	24.20
9/20/84	0272 F	MILLS, DAVID M.	585.00
9/20/84	0272 M	MILLS, DAVID M.	7.53
		TOTALS:	
		0272 F - ATTORNEY FEES	15,890.00
		0272 E - ATTORNEY TRAVEL EXPENSE	480.56
		0272 M - ATTORNEY MISCELLANEOUS	469.03
		GRAND TOTAL:	16,839.59
8/05/80	0272 E	JOHNSON, E. EDWARD	655.74
8/20/80	0272 F	JOHNSON, E. EDWARD	1,375.00
8/20/80	0272 M	JOHNSON, E. EDWARD	137.28
10/02/80	0272 E	JOHNSON, E. EDWARD	295.50
10/02/80	0272 F	JOHNSON, E. EDWARD	475.00
10/02/80	0272 M	JOHNSON, E. EDWARD	90.31
11/12/80	0272 F	JOHNSON, E. EDWARD	600.00
11/12/80	0272 M	JOHNSON, E. EDWARD	239.26
12/19/80	0272 F	JOHNSON, E. EDWARD	100.00
12/19/80	0272 F	JOHNSON, E. EDWARD	475.00
12/19/80	0272 F	JOHNSON, E. EDWARD	100.00
12/19/80	0272 F	JOHNSON, E. EDWARD	100.00
12/19/80	0272 F	JOHNSON, E. EDWARD	50.00
12/19/80	0272 F	JOHNSON, E. EDWARD	50.00
12/19/80	0272 M	JOHNSON, E. EDWARD	3.15
12/19/80	0272 M	JOHNSON, E. EDWARD	5.18
12/19/80	0272 M	JOHNSON, E. EDWARD	5.18
3/16/81	0272 F	JOHNSON, E. EDWARD	50.00
3/16/81	0272 F	JOHNSON, E. EDWARD	237.50
3/16/81	0272 F	JOHNSON, E. EDWARD	237.50
3/16/81	0272 M	JOHNSON, E. EDWARD	8.85
3/16/81	0272 M	JOHNSON, E. EDWARD	8.85
3/17/81	0272 F	JOHNSON, E. EDWARD	250.00
3/17/81	0272 F	JOHNSON, E. EDWARD	50.00
3/17/81	0272 F	JOHNSON, E. EDWARD	100.00
3/17/81	0272 M	JOHNSON, E. EDWARD	7.98
5/18/81	0272 F	JOHNSON, E. EDWARD	100.00
5/18/81	0272 F	JOHNSON, E. EDWARD	75.00
5/18/81	0272 F	JOHNSON, E. EDWARD	225.00
5/18/81	0272 F	JOHNSON, E. EDWARD	75.00
5/18/81	0272 F	JOHNSON, E. EDWARD	550.00

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
5/18/81	0272 M	JOHNSON, E. EDWARD	2.59
5/18/81	0272 M	JOHNSON, E. EDWARD	7.97
6/30/81	0272 F	JOHNSON, E. EDWARD	275.00
6/30/81	0272 F	JOHNSON, E. EDWARD	225.00
6/30/81	0272 F	JOHNSON, E. EDWARD	100.00
6/30/81	0272 F	JOHNSON, E. EDWARD	25.00
6/30/81	0272 F	JOHNSON, E. EDWARD	25.00
6/30/81	0272 M	JOHNSON, E. EDWARD	218.39
6/30/81	0272 M	JOHNSON, E. EDWARD	1.78
6/30/81	0272 M	JOHNSON, E. EDWARD	4.97
6/30/81	0272 M	JOHNSON, E. EDWARD	1.77
7/17/81	0272 F	JOHNSON, E. EDWARD	25.00
8/18/81	0272 F	JOHNSON, E. EDWARD	536.25
8/18/81	0272 F	JOHNSON, E. EDWARD	536.25
8/18/81	0272 F	JOHNSON, E. EDWARD	162.50
8/18/81	0272 M	JOHNSON, E. EDWARD	84.87
8/18/81	0272 M	JOHNSON, E. EDWARD	84.88
8/18/81	0272 M	JOHNSON, E. EDWARD	3.98
9/11/81	0272 F	JOHNSON, E. EDWARD	135.00
9/11/81	0272 F	JOHNSON, E. EDWARD	65.00
9/11/81	0272 M	JOHNSON, E. EDWARD	487.50
9/11/81	0272 M	JOHNSON, E. EDWARD	226.25
9/15/81	0272 F	JOHNSON, E. EDWARD	4.25
9/15/81	0272 M	JOHNSON, E. EDWARD	65.00
11/05/81	0272 E	JOHNSON, E. EDWARD	11.12
11/05/81	0272 F	JOHNSON, E. EDWARD	35.20
11/05/81	0272 F	JOHNSON, E. EDWARD	877.50
11/05/81	0272 F	JOHNSON, E. EDWARD	32.50
11/05/81	0272 M	JOHNSON, E. EDWARD	97.50
11/10/81	0272 F	JOHNSON, E. EDWARD	119.40
11/10/81	0272 F	JOHNSON, E. EDWARD	552.50
11/10/81	0272 M	JOHNSON, E. EDWARD	552.50
11/10/81	0272 M	JOHNSON, E. EDWARD	46.48
11/30/81	0272 F	JOHNSON, E. EDWARD	46.47
11/30/81	0272 F	JOHNSON, E. EDWARD	32.50
11/30/81	0272 M	JOHNSON, E. EDWARD	32.50
11/30/81	0272 M	JOHNSON, E. EDWARD	1.44
1/15/82	0272 F	JOHNSON, E. EDWARD	1.45
1/15/82	0272 F	JOHNSON, E. EDWARD	455.00
1/15/82	0272 F	JOHNSON, E. EDWARD	828.75
1/15/82	0272 M	JOHNSON, E. EDWARD	487.50
1/15/82	0272 M	JOHNSON, E. EDWARD	3.64
3/19/82	0272 E	JOHNSON, E. EDWARD	11.10
3/19/82	0272 F	JOHNSON, E. EDWARD	35.40
4/08/82	0272 F	JOHNSON, E. EDWARD	390.00
4/08/82	0272 F	JOHNSON, E. EDWARD	65.00
4/08/82	0272 M	JOHNSON, E. EDWARD	162.50
4/08/82	0272 M	JOHNSON, E. EDWARD	7.32
			8.74

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
5/05/82	0272 E	JOHNSON, E. EDWARD	72.50
5/05/82	0272 F	JOHNSON, E. EDWARD	1,072.50
5/05/82	0272 M	JOHNSON, E. EDWARD	93.71
5/25/82	0272 F	JOHNSON, E. EDWARD	227.50
5/25/82	0272 M	JOHNSON, E. EDWARD	277.08
6/30/82	0272 F	JOHNSON, E. EDWARD	357.50
6/30/82	0272 M	JOHNSON, E. EDWARD	8.66
8/20/82	0272 F	JOHNSON, E. EDWARD	666.25
8/20/82	0272 M	JOHNSON, E. EDWARD	3.50
9/28/82	0272 M	JOHNSON, E. EDWARD	17.35
		TOTALS:	
		0272 F - ATTORNEY FEES	14,692.50
		0272 E - ATTORNEY TRAVEL EXPENSE	1,094.34
		0272 M - ATTORNEY MISCELLANEOUS	1,940.20
		GRAND TOTAL:	17,727.04
10/02/80	0272 F	HERRINGTON, ALVIN D.	147.50
10/02/80	0272 M	HERRINGTON, ALVIN D.	2.40
12/31/80	0272 E	HERRINGTON, ALVIN D.	452.09
12/31/80	0272 F	HERRINGTON, ALVIN D.	15,528.00
12/31/80	0272 M	HERRINGTON, ALVIN D.	532.98
6/12/81	0272 F	HERRINGTON, ALVIN D.	10,093.00
6/12/81	0272 M	HERRINGTON, ALVIN D.	664.50
6/30/81	0272 E	HERRINGTON, ALVIN D.	95.40
6/30/81	0272 F	HERRINGTON, ALVIN D.	1,972.00
6/30/81	0272 F	HERRINGTON, ALVIN D.	4,892.50
6/30/81	0272 F	HERRINGTON, ALVIN D.	1,734.50
6/30/81	0272 M	HERRINGTON, ALVIN D.	204.48
6/30/81	0272 M	HERRINGTON, ALVIN D.	148.25
6/30/81	0272 M	HERRINGTON, ALVIN D.	49.97
7/17/81	0272 M	HERRINGTON, ALVIN D.	74.05
7/17/81	0272 M	HERRINGTON, ALVIN D.	350.00
9/11/81	0272 E	HERRINGTON, ALVIN D.	833.00
9/11/81	0272 E	HERRINGTON, ALVIN D.	1,589.00
9/11/81	0272 M	HERRINGTON, ALVIN D.	223.07
9/11/81	0272 M	HERRINGTON, ALVIN D.	57.90
9/16/81	0272 E	HERRINGTON, ALVIN D.	94.15
9/16/81	0272 F	HERRINGTON, ALVIN D.	2,059.00
9/16/81	0272 F	HERRINGTON, ALVIN D.	3,144.00
9/16/81	0272 F	HERRINGTON, ALVIN D.	4,510.00
9/16/81	0272 M	HERRINGTON, ALVIN D.	180.36
4/28/82	0272 E	HERRINGTON, ALVIN D.	50.00
4/28/82	0272 F	HERRINGTON, ALVIN D.	5,020.20
4/28/82	0272 F	HERRINGTON, ALVIN D.	1,200.00
4/28/82	0272 M	HERRINGTON, ALVIN D.	524.95
4/28/82	0272 M	HERRINGTON, ALVIN D.	378.79
6/30/82	0272 F	HERRINGTON, ALVIN D.	933.00
6/30/82	0272 F	HERRINGTON, ALVIN D.	270.00
6/30/82	0272 M	HERRINGTON, ALVIN D.	12.21

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
11/03/82	0272 E	HERRINGTON, ALVIN D.	1,165.63
11/03/82	0272 M	HERRINGTON, ALVIN D.	801.50
11/10/82	0272 F	HERRINGTON, ALVIN D.	855.00
11/10/82	0272 M	HERRINGTON, ALVIN D.	8.61
11/30/82	0272 E	HERRINGTON, ALVIN D.	1,538.64
11/30/82	0272 F	HERRINGTON, ALVIN D.	4,014.50
11/30/82	0272 M	HERRINGTON, ALVIN D.	2,023.51
3/16/83	0272 F	HERRINGTON, ALVIN D.	14,033.88
3/16/83	0272 M	HERRINGTON, ALVIN D.	3,166.28
6/29/83	0272 E	HERRINGTON, ALVIN D.	1,087.65
6/29/83	0272 F	HERRINGTON, ALVIN D.	10,886.36
6/29/83	0272 M	HERRINGTON, ALVIN D.	584.86
6/30/83	0272 F	HERRINGTON, ALVIN D.	7,596.08
6/30/83	0272 M	HERRINGTON, ALVIN D.	150.65
8/29/83	0272 M	HERRINGTON, ALVIN D.	2,722.35
9/16/83	0272 E	HERRINGTON, ALVIN D.	2,372.00
9/16/83	0272 M	HERRINGTON, ALVIN D.	3,947.72
9/29/83	0272 M	HERRINGTON, ALVIN D.	8,190.79
11/03/83	0272 E	HERRINGTON, ALVIN D.	2,803.86
11/03/83	0272 M	HERRINGTON, ALVIN D.	6,561.26
11/17/83	0272 E	HERRINGTON, ALVIN D.	2,241.07
11/17/83	0272 M	HERRINGTON, ALVIN D.	4,271.64
12/20/83	0272 F	HERRINGTON, ALVIN D.	48,146.38
12/20/83	0272 M	HERRINGTON, ALVIN D.	7,284.82
1/31/84	0272 F	HERRINGTON, ALVIN D.	34,299.66
1/31/84	0272 M	HERRINGTON, ALVIN D.	364.21
		TOTALS:	171,335.56
		0272 F - ATTORNEY FEES	14,322.49
		0272 E - ATTORNEY TRAVEL EXPENSE	43,482.11
		0272 M - ATTORNEY MISCELLANEOUS	229,140.16
		GRAND TOTAL:	
10/15/84	0272 F	BENNETT, MARK L.	4,030.00
10/15/84	0272 M	BENNETT, MARK L.	327.15
		TOTALS:	4,030.00
		0272 F - ATTORNEY FEES	327.15
		0272 M - ATTORNEY MISCELLANEOUS	4,357.15
		GRAND TOTAL:	
9/12/80	0272 F	DAVIS, CHARLES L., JR.	210.00
9/12/80	0272 M	DAVIS, CHARLES L., JR.	74.30
9/18/80	0272 E	DAVIS, CHARLES L., JR.	113.23
9/18/80	0272 F	DAVIS, CHARLES L., JR.	1,295.00
9/18/80	0272 M	DAVIS, CHARLES L., JR.	123.79
5/18/81	0272 E	DAVIS, CHARLES L., JR.	49.02
5/18/81	0272 F	DAVIS, CHARLES L., JR.	1,280.00
5/18/81	0272 M	DAVIS, CHARLES L., JR.	74.63
6/30/81	0272 E	DAVIS, CHARLES L., JR.	876.53
6/30/81	0272 F	DAVIS, CHARLES L., JR.	3,275.00

DATE	OBJECT	VENDOR	AMOUNT
6/30/81	0272 M	DAVIS, CHARLES L., JR.	34.75
10/13/81	0272 E	DAVIS, CHARLES L., JR.	34.10
10/13/81	0272 F	DAVIS, CHARLES L., JR.	2,000.00
10/13/81	0272 M	DAVIS, CHARLES L., JR.	9.64
12/11/81	0272 F	DAVIS, CHARLES L., JR.	2,100.00
12/11/81	0272 M	DAVIS, CHARLES L., JR.	3.60
4/08/85	0272 E	DAVIS, CHARLES L., JR.	157.61
4/08/85	0272 F	DAVIS, CHARLES L., JR.	2,736.50
4/08/85	0272 M	DAVIS, CHARLES L., JR.	125.95
		TOTALS:	
		0272 F - ATTORNEY FEES	12,896.50
		0272 E - ATTORNEY TRAVEL EXPENSE	1,230.49
		0272 M - ATTORNEY MISCELLANEOUS	446.66
		GRAND TOTAL:	14,573.65
0/00/00	0272 M	HOLBROOK AND ELLIS	8,190.79
10/23/80	0272 F	HOLBROOK AND ELLIS	761.00
10/23/80	0272 F	HOLBROOK AND ELLIS	169.00
10/23/80	0272 F	HOLBROOK AND ELLIS	435.00
10/23/80	0272 F	HOLBROOK AND ELLIS	350.00
10/23/80	0272 M	HOLBROOK AND ELLIS	199.65
10/23/80	0272 M	HOLBROOK AND ELLIS	50.00
10/23/80	0272 M	HOLBROOK AND ELLIS	207.35
10/23/80	0272 M	HOLBROOK AND ELLIS	27.30
12/15/80	0272 F	HOLBROOK AND ELLIS	475.00
12/15/80	0272 F	HOLBROOK AND ELLIS	325.00
12/15/80	0272 F	HOLBROOK AND ELLIS	92.00
12/15/80	0272 M	HOLBROOK AND ELLIS	60.00
12/15/80	0272 M	HOLBROOK AND ELLIS	66.81
12/15/80	0272 M	HOLBROOK AND ELLIS	172.50
2/05/81	0272 F	HOLBROOK AND ELLIS	50.00
2/06/81	0272 F	HOLBROOK AND ELLIS	75.00
2/06/81	0272 M	HOLBROOK AND ELLIS	4.98
3/24/81	0272 F	HOLBROOK AND ELLIS	525.00
3/24/81	0272 F	HOLBROOK AND ELLIS	200.00
3/24/81	0272 F	HOLBROOK AND ELLIS	1,345.00
3/24/81	0272 M	HOLBROOK AND ELLIS	230.55
3/24/81	0272 M	HOLBROOK AND ELLIS	125.54
4/27/81	0272 F	HOLBROOK AND ELLIS	625.00
5/18/81	0272 E	HOLBROOK AND ELLIS	619.35
5/18/81	0272 F	HOLBROOK AND ELLIS	787.50
5/18/81	0272 F	HOLBROOK AND ELLIS	460.00
5/18/81	0272 F	HOLBROOK AND ELLIS	890.00
5/18/81	0272 M	HOLBROOK AND ELLIS	2.64
5/18/81	0272 M	HOLBROOK AND ELLIS	242.05
6/24/81	0272 F	HOLBROOK AND ELLIS	550.00
6/24/81	0272 M	HOLBROOK AND ELLIS	116.05
7/27/81	0272 E	HOLBROOK AND ELLIS	983.88
7/27/81	0272 F	HOLBROOK AND ELLIS	1,152.50

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
7/27/81	0272 F	HOLBROOK AND ELLIS	25.00
7/27/81	0272 M	HOLBROOK AND ELLIS	61.50
7/27/81	0272 M	HOLBROOK AND ELLIS	137.35
9/11/81	0272 F	HOLBROOK AND ELLIS	60.00
9/11/81	0272 F	HOLBROOK AND ELLIS	426.00
9/11/81	0272 F	HOLBROOK AND ELLIS	1,450.00
9/11/81	0272 F	HOLBROOK AND ELLIS	60.00
9/11/81	0272 M	HOLBROOK AND ELLIS	214.69
9/16/81	0272 F	HOLBROOK AND ELLIS	90.00
9/16/81	0272 F	HOLBROOK AND ELLIS	90.00
9/16/81	0272 F	HOLBROOK AND ELLIS	120.00
9/16/81	0272 M	HOLBROOK AND ELLIS	95.00
11/17/81	0272 F	HOLBROOK AND ELLIS	360.00
11/17/81	0272 M	HOLBROOK AND ELLIS	263.03
12/11/81	0272 F	HOLBROOK AND ELLIS	1,788.00
12/11/81	0272 F	HOLBROOK AND ELLIS	1,137.50
12/11/81	0272 F	HOLBROOK AND ELLIS	137.50
12/11/81	0272 M	HOLBROOK AND ELLIS	274.29
12/11/81	0272 M	HOLBROOK AND ELLIS	49.89
1/15/82	0272 F	HOLBROOK AND ELLIS	90.00
1/15/82	0272 F	HOLBROOK AND ELLIS	405.00
1/15/82	0272 F	HOLBROOK AND ELLIS	270.00
1/15/82	0272 M	HOLBROOK AND ELLIS	902.72
1/15/82	0272 M	HOLBROOK AND ELLIS	25.69
2/26/82	0272 F	HOLBROOK AND ELLIS	113.75
2/26/82	0272 F	HOLBROOK AND ELLIS	81.25
2/26/82	0272 M	HOLBROOK AND ELLIS	141.11
2/26/82	0272 M	HOLBROOK AND ELLIS	3.45
3/10/82	0272 F	HOLBROOK AND ELLIS	955.50
3/10/82	0272 M	HOLBROOK AND ELLIS	12.94
5/05/82	0272 F	HOLBROOK AND ELLIS	75.00
5/05/82	0272 M	HOLBROOK AND ELLIS	5.34
6/23/82	0272 F	HOLBROOK AND ELLIS	225.00
6/23/82	0272 M	HOLBROOK AND ELLIS	3,021.00
10/27/82	0272 E	HOLBROOK AND ELLIS	194.50
10/27/82	0272 F	HOLBROOK AND ELLIS	1,140.00
10/27/82	0272 M	HOLBROOK AND ELLIS	84.08
12/23/82	0272 E	HOLBROOK AND ELLIS	228.50
12/23/82	0272 F	HOLBROOK AND ELLIS	1,343.25
12/23/82	0272 M	HOLBROOK AND ELLIS	439.77
1/10/83	0272 F	HOLBROOK AND ELLIS	357.00
1/10/83	0272 M	HOLBROOK AND ELLIS	276.45
3/10/83	0272 E	HOLBROOK AND ELLIS	587.22
3/10/83	0272 F	HOLBROOK AND ELLIS	3,041.50
3/10/83	0272 F	HOLBROOK AND ELLIS	945.00
3/10/83	0272 M	HOLBROOK AND ELLIS	246.50
4/30/83	0272 E	HOLBROOK AND ELLIS	1,048.54
4/30/83	0272 F	HOLBROOK AND ELLIS	5,039.30
4/30/83	0272 M	HOLBROOK AND ELLIS	1,527.51

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
5/19/83	0272 E	HOLBROOK AND ELLIS	296.00
5/19/83	0272 F	HOLBROOK AND ELLIS	1,543.75
5/19/83	0272 F	HOLBROOK AND ELLIS	180.00
5/19/83	0272 M	HOLBROOK AND ELLIS	1,649.62
5/31/83	0272 F	HOLBROOK AND ELLIS	1,923.00
5/31/83	0272 M	HOLBROOK AND ELLIS	645.93
6/15/83	0272 F	HOLBROOK AND ELLIS	162.50
6/15/83	0272 F	HOLBROOK AND ELLIS	586.50
6/15/83	0272 M	HOLBROOK AND ELLIS	703.00
6/29/83	0272 E	HOLBROOK AND ELLIS	623.97
6/29/83	0272 F	HOLBROOK AND ELLIS	1,605.00
6/29/83	0272 F	HOLBROOK AND ELLIS	65.00
8/19/83	0272 F	HOLBROOK AND ELLIS	498.00
8/19/83	0272 M	HOLBROOK AND ELLIS	172.60
9/29/83	0272 E	HOLBROOK AND ELLIS	581.73
9/29/83	0272 F	HOLBROOK AND ELLIS	1,217.50
9/29/83	0272 M	HOLBROOK AND ELLIS	8,190.79
10/31/83	0272 F	HOLBROOK AND ELLIS	1,931.00
10/31/83	0272 M	HOLBROOK AND ELLIS	1,299.11
11/30/83	0272 E	HOLBROOK AND ELLIS	5.74
11/30/83	0272 F	HOLBROOK AND ELLIS	2,252.50
11/30/83	0272 M	HOLBROOK AND ELLIS	1,312.71
12/15/83	0272 F	HOLBROOK AND ELLIS	66.00
12/15/83	0272 M	HOLBROOK AND ELLIS	856.47
3/26/84	0272 E	HOLBROOK AND ELLIS	458.80
3/26/84	0272 F	HOLBROOK AND ELLIS	1,479.75
3/26/84	0272 M	HOLBROOK AND ELLIS	20.00
4/12/84	0272 F	HOLBROOK AND ELLIS	1,013.50
4/12/84	0272 M	HOLBROOK AND ELLIS	326.99
6/11/84	0272 E	HOLBROOK AND ELLIS	216.00
6/11/84	0272 F	HOLBROOK AND ELLIS	2,063.75
6/11/84	0272 M	HOLBROOK AND ELLIS	850.19
6/27/84	0272 F	HOLBROOK AND ELLIS	860.50
6/27/84	0272 M	HOLBROOK AND ELLIS	100.43
6/30/84	0272 F	HOLBROOK AND ELLIS	763.00
7/27/84	0272 E	HOLBROOK AND ELLIS	45.64
7/27/84	0272 F	HOLBROOK AND ELLIS	1,052.00
7/27/84	0272 M	HOLBROOK AND ELLIS	65.47
9/06/84	0272 E	HOLBROOK AND ELLIS	637.67
9/06/84	0272 M	HOLBROOK AND ELLIS	632.95
9/06/84	0272 M	HOLBROOK AND ELLIS	299.82
9/20/84	0272 F	HOLBROOK AND ELLIS	7,420.74
10/15/84	0272 F	HOLBROOK AND ELLIS	644.00
10/15/84	0272 M	HOLBROOK AND ELLIS	575.13
10/23/84	0272 E	HOLBROOK AND ELLIS	4.18
10/23/84	0272 F	HOLBROOK AND ELLIS	150.00
1/16/85	0272 F	HOLBROOK AND ELLIS	1,551.37
1/16/85	0272 M	HOLBROOK AND ELLIS	102.41
3/12/85	0272 E	HOLBROOK AND ELLIS	112.73

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
3/12/85	0272 F	HOLBROOK AND ELLIS	5,666.00
3/12/85	0272 M	HOLBROOK AND ELLIS	617.49
4/30/85	0272 E	HOLBROOK AND ELLIS	1,510.91
4/30/85	0272 F	HOLBROOK AND ELLIS	7,212.00
4/30/85	0272 M	HOLBROOK AND ELLIS	3,753.90
		TOTALS:	70,999.91
		0272 F - ATTORNEY FEES	8,155.36
		0272 E - ATTORNEY TRAVEL EXPENSE	39,653.53
		0272 M - ATTORNEY MISCELLANEOUS	118,808.80
		GRAND TOTAL:	
8/20/80	0272 F	HERNANDEZ, JAMES Z.	2,417.50
8/20/80	0272 M	HERNANDEZ, JAMES Z.	232.95
10/23/80	0272 E	HERNANDEZ, JAMES Z.	95.80
10/23/80	0272 F	HERNANDEZ, JAMES Z.	2,620.00
10/23/80	0272 M	HERNANDEZ, JAMES Z.	274.05
11/29/80	0272 F	HERNANDEZ, JAMES Z.	227.50
2/11/81	0272 E	HERNANDEZ, JAMES Z.	622.35
2/11/81	0272 F	HERNANDEZ, JAMES Z.	7,377.50
2/11/81	0272 M	HERNANDEZ, JAMES Z.	89.09
5/05/81	0272 F	HERNANDEZ, JAMES Z.	1,370.00
5/05/81	0272 M	HERNANDEZ, JAMES Z.	221.70
7/27/81	0272 F	HERNANDEZ, JAMES Z.	305.00
7/27/81	0272 M	HERNANDEZ, JAMES Z.	14.20
9/11/81	0272 E	HERNANDEZ, JAMES Z.	666.35
9/11/81	0272 F	HERNANDEZ, JAMES Z.	6,608.25
9/11/81	0272 M	HERNANDEZ, JAMES Z.	115.20
11/10/81	0272 F	HERNANDEZ, JAMES Z.	1,127.75
11/10/81	0272 M	HERNANDEZ, JAMES Z.	750.35
12/11/81	0272 E	HERNANDEZ, JAMES Z.	569.45
12/11/81	0272 F	HERNANDEZ, JAMES Z.	2,219.00
12/11/81	0272 M	HERNANDEZ, JAMES Z.	107.88
2/10/82	0272 F	HERNANDEZ, JAMES Z.	1,228.50
2/10/82	0272 M	HERNANDEZ, JAMES Z.	73.50
2/26/82	0272 F	HERNANDEZ, JAMES Z.	273.00
2/26/82	0272 M	HERNANDEZ, JAMES Z.	32.59
4/21/82	0272 M	HERNANDEZ, JAMES Z.	252.20
4/21/82	0272 M	HERNANDEZ, JAMES Z.	110.07
4/21/82	0272 M	HERNANDEZ, JAMES Z.	167.92
5/05/82	0272 E	HERNANDEZ, JAMES Z.	553.40
5/05/82	0272 F	HERNANDEZ, JAMES Z.	3,044.25
5/05/82	0272 M	HERNANDEZ, JAMES Z.	221.02
6/21/82	0272 F	HERNANDEZ, JAMES Z.	1,496.00
6/21/82	0272 F	HERNANDEZ, JAMES Z.	1,222.00
6/21/82	0272 M	HERNANDEZ, JAMES Z.	99.66
6/21/82	0272 M	HERNANDEZ, JAMES Z.	113.95
6/28/82	0272 F	HERNANDEZ, JAMES Z.	2,468.50
6/28/82	0272 M	HERNANDEZ, JAMES Z.	61.82
6/30/82	0272 E	HERNANDEZ, JAMES Z.	401.98

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
6/30/82	0272 E	HERNANDEZ, JAMES Z.	401.96
6/30/82	0272 F	HERNANDEZ, JAMES Z.	1,849.25
6/30/82	0272 F	HERNANDEZ, JAMES Z.	1,972.25
6/30/82	0272 F	HERNANDEZ, JAMES Z.	422.50
6/30/82	0272 M	HERNANDEZ, JAMES Z.	44.72
6/30/82	0272 M	HERNANDEZ, JAMES Z.	8.49
6/30/82	0272 M	HERNANDEZ, JAMES Z.	11.13
7/29/82	0272 E	HERNANDEZ, JAMES Z.	26.10
7/29/82	0272 F	HERNANDEZ, JAMES Z.	780.50
7/29/82	0272 M	HERNANDEZ, JAMES Z.	959.55
8/12/82	0272 F	HERNANDEZ, JAMES Z.	536.25
8/12/82	0272 M	HERNANDEZ, JAMES Z.	438.77
9/10/82	0272 E	HERNANDEZ, JAMES Z.	545.12
9/10/82	0272 F	HERNANDEZ, JAMES Z.	1,789.25
9/10/82	0272 M	HERNANDEZ, JAMES Z.	74.76
9/30/82	0272 E	HERNANDEZ, JAMES Z.	140.65
9/30/82	0272 F	HERNANDEZ, JAMES Z.	2,987.25
9/30/82	0272 M	HERNANDEZ, JAMES Z.	120.75
10/26/82	0272 E	HERNANDEZ, JAMES Z.	574.07
10/26/82	0272 F	HERNANDEZ, JAMES Z.	522.75
10/26/82	0272 F	HERNANDEZ, JAMES Z.	2,977.50
10/26/82	0272 F	HERNANDEZ, JAMES Z.	937.25
10/26/82	0272 M	HERNANDEZ, JAMES Z.	1,361.42
10/26/82	0272 M	HERNANDEZ, JAMES Z.	195.75
10/26/82	0272 M	HERNANDEZ, JAMES Z.	1,095.27
11/30/82	0272 M	HERNANDEZ, JAMES Z.	65.00
12/06/82	0272 M	HERNANDEZ, JAMES Z.	231.11
1/10/83	0272 F	HERNANDEZ, JAMES Z.	253.50
1/10/83	0272 F	HERNANDEZ, JAMES Z.	1,133.50
1/10/83	0272 F	HERNANDEZ, JAMES Z.	726.25
1/10/83	0272 M	HERNANDEZ, JAMES Z.	209.07
1/10/83	0272 M	HERNANDEZ, JAMES Z.	797.52
1/10/83	0272 M	HERNANDEZ, JAMES Z.	69.64
3/10/83	0272 E	HERNANDEZ, JAMES Z.	846.63
3/10/83	0272 F	HERNANDEZ, JAMES Z.	2,531.00
3/10/83	0272 M	HERNANDEZ, JAMES Z.	1,719.62
4/20/83	0272 E	HERNANDEZ, JAMES Z.	345.57
4/20/83	0272 F	HERNANDEZ, JAMES Z.	3,941.50
4/20/83	0272 F	HERNANDEZ, JAMES Z.	765.00
4/20/83	0272 M	HERNANDEZ, JAMES Z.	82.32
4/20/83	0272 M	HERNANDEZ, JAMES Z.	374.37
6/10/83	0272 E	HERNANDEZ, JAMES Z.	78.40
6/10/83	0272 F	HERNANDEZ, JAMES Z.	1,687.50
6/10/83	0272 F	HERNANDEZ, JAMES Z.	1,120.25
6/10/83	0272 F	HERNANDEZ, JAMES Z.	1,006.50
6/10/83	0272 F	HERNANDEZ, JAMES Z.	1,059.50
6/10/83	0272 M	HERNANDEZ, JAMES Z.	341.80
6/10/83	0272 M	HERNANDEZ, JAMES Z.	770.49
6/10/83	0272 M	HERNANDEZ, JAMES Z.	2,328.19

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

07/01/80 TO 05/31/85

DATE	OBJECT	VENDOR	AMOUNT
6/10/83	0272 M	HERNANDEZ, JAMES Z.	64.65
6/30/83	0272 F	HERNANDEZ, JAMES Z.	1,069.25
6/30/83	0272 F	HERNANDEZ, JAMES Z.	531.00
6/30/83	0272 F	HERNANDEZ, JAMES Z.	372.25
6/30/83	0272 F	HERNANDEZ, JAMES Z.	154.00
6/30/83	0272 F	HERNANDEZ, JAMES Z.	304.50
6/30/83	0272 F	HERNANDEZ, JAMES Z.	2,297.25
6/30/83	0272 M	HERNANDEZ, JAMES Z.	17.50
6/30/83	0272 M	HERNANDEZ, JAMES Z.	126.53
6/30/83	0272 M	HERNANDEZ, JAMES Z.	9.16
6/30/83	0272 M	HERNANDEZ, JAMES Z.	18.18
6/30/83	0272 M	HERNANDEZ, JAMES Z.	617.85
6/30/83	0272 M	HERNANDEZ, JAMES Z.	53.29
8/12/83	0272 E	HERNANDEZ, JAMES Z.	719.17
8/12/83	0272 E	HERNANDEZ, JAMES Z.	102.87
8/12/83	0272 F	HERNANDEZ, JAMES Z.	1,389.00
8/12/83	0272 F	HERNANDEZ, JAMES Z.	2,417.00
8/12/83	0272 F	HERNANDEZ, JAMES Z.	203.50
8/12/83	0272 F	HERNANDEZ, JAMES Z.	233.87
8/12/83	0272 F	HERNANDEZ, JAMES Z.	175.50
8/12/83	0272 M	HERNANDEZ, JAMES Z.	5.40
8/12/83	0272 M	HERNANDEZ, JAMES Z.	900.43
8/12/83	0272 M	HERNANDEZ, JAMES Z.	50.10
8/12/83	0272 M	HERNANDEZ, JAMES Z.	439.43
8/12/83	0272 M	HERNANDEZ, JAMES Z.	228.90
9/16/83	0272 F	HERNANDEZ, JAMES Z.	277.00
9/16/83	0272 F	HERNANDEZ, JAMES Z.	1,490.50
9/16/83	0272 F	HERNANDEZ, JAMES Z.	651.75
9/16/83	0272 F	HERNANDEZ, JAMES Z.	182.00
9/16/83	0272 F	HERNANDEZ, JAMES Z.	365.50
9/16/83	0272 F	HERNANDEZ, JAMES Z.	568.75
9/16/83	0272 M	HERNANDEZ, JAMES Z.	4,422.15
9/16/83	0272 M	HERNANDEZ, JAMES Z.	16.92
9/16/83	0272 M	HERNANDEZ, JAMES Z.	18.88
9/16/83	0272 M	HERNANDEZ, JAMES Z.	44.19
9/16/83	0272 M	HERNANDEZ, JAMES Z.	554.86
9/16/83	0272 M	HERNANDEZ, JAMES Z.	3.00
10/19/83	0272 E	HERNANDEZ, JAMES Z.	248.70
10/19/83	0272 F	HERNANDEZ, JAMES Z.	250.25
10/19/83	0272 F	HERNANDEZ, JAMES Z.	504.50
10/19/83	0272 F	HERNANDEZ, JAMES Z.	524.25
10/19/83	0272 F	HERNANDEZ, JAMES Z.	761.00
10/19/83	0272 F	HERNANDEZ, JAMES Z.	578.50
10/19/83	0272 F	HERNANDEZ, JAMES Z.	344.50
10/19/83	0272 M	HERNANDEZ, JAMES Z.	140.33
10/19/83	0272 M	HERNANDEZ, JAMES Z.	8.36
10/19/83	0272 M	HERNANDEZ, JAMES Z.	237.82
10/19/83	0272 M	HERNANDEZ, JAMES Z.	5.75
10/19/83	0272 M	HERNANDEZ, JAMES Z.	92.83

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
10/19/83	0272 M	HERNANDEZ, JAMES Z.	10.50
10/26/83	0272 E	HERNANDEZ, JAMES Z.	33.25
10/26/83	0272 F	HERNANDEZ, JAMES Z.	1,058.25
10/26/83	0272 M	HERNANDEZ, JAMES Z.	283.32
11/17/83	0272 F	HERNANDEZ, JAMES Z.	625.75
11/17/83	0272 F	HERNANDEZ, JAMES Z.	1,416.63
11/17/83	0272 F	HERNANDEZ, JAMES Z.	1,158.75
11/17/83	0272 M	HERNANDEZ, JAMES Z.	107.04
11/17/83	0272 M	HERNANDEZ, JAMES Z.	330.56
11/17/83	0272 M	HERNANDEZ, JAMES Z.	256.85
12/30/83	0272 F	HERNANDEZ, JAMES Z.	324.75
12/30/83	0272 F	HERNANDEZ, JAMES Z.	334.50
12/30/83	0272 F	HERNANDEZ, JAMES Z.	422.25
12/30/83	0272 F	HERNANDEZ, JAMES Z.	916.50
12/30/83	0272 F	HERNANDEZ, JAMES Z.	916.50
12/30/83	0272 F	HERNANDEZ, JAMES Z.	224.25
12/30/83	0272 M	HERNANDEZ, JAMES Z.	78.87
12/30/83	0272 M	HERNANDEZ, JAMES Z.	451.80
12/30/83	0272 M	HERNANDEZ, JAMES Z.	451.80
12/30/83	0272 M	HERNANDEZ, JAMES Z.	106.96
12/30/83	0272 M	HERNANDEZ, JAMES Z.	6.13
12/30/83	0272 M	HERNANDEZ, JAMES Z.	43.33
1/31/84	0272 F	HERNANDEZ, JAMES Z.	680.75
1/31/84	0272 M	HERNANDEZ, JAMES Z.	31.27
2/14/84	0272 E	HERNANDEZ, JAMES Z.	102.48
2/14/84	0272 E	HERNANDEZ, JAMES Z.	44.24
2/14/84	0272 F	HERNANDEZ, JAMES Z.	366.50
2/14/84	0272 F	HERNANDEZ, JAMES Z.	423.75
2/14/84	0272 F	HERNANDEZ, JAMES Z.	1,230.75
2/14/84	0272 F	HERNANDEZ, JAMES Z.	737.75
2/14/84	0272 F	HERNANDEZ, JAMES Z.	798.75
2/14/84	0272 M	HERNANDEZ, JAMES Z.	624.38
2/14/84	0272 M	HERNANDEZ, JAMES Z.	3.73
2/14/84	0272 M	HERNANDEZ, JAMES Z.	212.54
2/14/84	0272 M	HERNANDEZ, JAMES Z.	615.34
2/15/84	0272 F	HERNANDEZ, JAMES Z.	487.00
2/15/84	0272 M	HERNANDEZ, JAMES Z.	6.40
3/23/84	0272 E	HERNANDEZ, JAMES Z.	194.39
3/23/84	0272 F	HERNANDEZ, JAMES Z.	127.88
3/23/84	0272 F	HERNANDEZ, JAMES Z.	478.50
3/23/84	0272 F	HERNANDEZ, JAMES Z.	684.75
3/23/84	0272 F	HERNANDEZ, JAMES Z.	81.25
3/23/84	0272 F	HERNANDEZ, JAMES Z.	495.25
3/23/84	0272 F	HERNANDEZ, JAMES Z.	1,227.00
3/23/84	0272 M	HERNANDEZ, JAMES Z.	154.50
3/23/84	0272 M	HERNANDEZ, JAMES Z.	940.83
3/23/84	0272 M	HERNANDEZ, JAMES Z.	933.69
3/23/84	0272 M	HERNANDEZ, JAMES Z.	72.20
5/10/84	0272 E	HERNANDEZ, JAMES Z.	51.50

DATE	OBJECT	VENDOR	AMOUNT
5/10/84	0272 E	HERNANDEZ, JAMES Z.	175.70
5/10/84	0272 E	HERNANDEZ, JAMES Z.	395.25
5/10/84	0272 F	HERNANDEZ, JAMES Z.	1,202.25
5/10/84	0272 F	HERNANDEZ, JAMES Z.	387.50
5/10/84	0272 F	HERNANDEZ, JAMES Z.	1,846.25
5/10/84	0272 F	HERNANDEZ, JAMES Z.	1,069.25
5/10/84	0272 F	HERNANDEZ, JAMES Z.	273.00
5/10/84	0272 F	HERNANDEZ, JAMES Z.	929.62
5/10/84	0272 M	HERNANDEZ, JAMES Z.	63.83
5/10/84	0272 M	HERNANDEZ, JAMES Z.	426.62
5/10/84	0272 M	HERNANDEZ, JAMES Z.	36.55
5/10/84	0272 M	HERNANDEZ, JAMES Z.	488.28
5/10/84	0272 M	HERNANDEZ, JAMES Z.	24.73
5/10/84	0272 M	HERNANDEZ, JAMES Z.	35.88
6/22/84	0272 F	HERNANDEZ, JAMES Z.	1,256.97
6/30/84	0272 F	HERNANDEZ, JAMES Z.	436.00
6/30/84	0272 F	HERNANDEZ, JAMES Z.	943.63
6/30/84	0272 F	HERNANDEZ, JAMES Z.	583.75
6/30/84	0272 F	HERNANDEZ, JAMES Z.	634.25
6/30/84	0272 F	HERNANDEZ, JAMES Z.	276.25
6/30/84	0272 F	HERNANDEZ, JAMES Z.	266.75
6/30/84	0272 F	HERNANDEZ, JAMES Z.	700.00
6/30/84	0272 M	HERNANDEZ, JAMES Z.	207.83
6/30/84	0272 M	HERNANDEZ, JAMES Z.	104.50
6/30/84	0272 M	HERNANDEZ, JAMES Z.	22.75
6/30/84	0272 M	HERNANDEZ, JAMES Z.	105.00
8/28/84	0272 F	HERNANDEZ, JAMES Z.	637.75
8/28/84	0272 F	HERNANDEZ, JAMES Z.	217.50
8/28/84	0272 F	HERNANDEZ, JAMES Z.	557.25
8/28/84	0272 M	HERNANDEZ, JAMES Z.	1,356.90
8/28/84	0272 M	HERNANDEZ, JAMES Z.	43.50
8/28/84	0272 M	HERNANDEZ, JAMES Z.	21.00
10/15/84	0272 E	HERNANDEZ, JAMES Z.	219.00
10/15/84	0272 F	HERNANDEZ, JAMES Z.	26.00
10/15/84	0272 F	HERNANDEZ, JAMES Z.	146.25
10/15/84	0272 F	HERNANDEZ, JAMES Z.	222.50
10/15/84	0272 F	HERNANDEZ, JAMES Z.	1,852.25
10/15/84	0272 F	HERNANDEZ, JAMES Z.	734.50
10/15/84	0272 F	HERNANDEZ, JAMES Z.	617.88
10/15/84	0272 F	HERNANDEZ, JAMES Z.	1,083.75
10/15/84	0272 M	HERNANDEZ, JAMES Z.	12.57
10/15/84	0272 M	HERNANDEZ, JAMES Z.	.75
10/15/84	0272 M	HERNANDEZ, JAMES Z.	9.62
10/15/84	0272 M	HERNANDEZ, JAMES Z.	32.65
10/15/84	0272 M	HERNANDEZ, JAMES Z.	61.84
10/15/84	0272 M	HERNANDEZ, JAMES Z.	25.21
10/15/84	0272 M	HERNANDEZ, JAMES Z.	4.28
1/10/85	0272 F	HERNANDEZ, JAMES Z.	1,967.50
1/10/85	0272 M	HERNANDEZ, JAMES Z.	150.66

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
1/16/85	0272 E	HERNANDEZ, JAMES Z.	395.00
1/16/85	0272 E	HERNANDEZ, JAMES Z.	337.65
1/16/85	0272 F	HERNANDEZ, JAMES Z.	3,600.75
1/16/85	0272 F	HERNANDEZ, JAMES Z.	4,274.25
1/16/85	0272 F	HERNANDEZ, JAMES Z.	1,302.75
1/16/85	0272 M	HERNANDEZ, JAMES Z.	1,963.60
1/16/85	0272 M	HERNANDEZ, JAMES Z.	324.29
1/16/85	0272 M	HERNANDEZ, JAMES Z.	150.80
1/31/85	0272 F	HERNANDEZ, JAMES Z.	516.75
1/31/85	0272 F	HERNANDEZ, JAMES Z.	314.00
1/31/85	0272 F	HERNANDEZ, JAMES Z.	149.50
1/31/85	0272 M	HERNANDEZ, JAMES Z.	20.94
1/31/85	0272 M	HERNANDEZ, JAMES Z.	142.31
1/31/85	0272 M	HERNANDEZ, JAMES Z.	253.84
4/02/85	0272 F	HERNANDEZ, JAMES Z.	1,033.50
4/02/85	0272 M	HERNANDEZ, JAMES Z.	48.60
4/08/85	0272 E	HERNANDEZ, JAMES Z.	175.73
4/08/85	0272 F	HERNANDEZ, JAMES Z.	1,483.50
4/08/85	0272 M	HERNANDEZ, JAMES Z.	212.59
4/29/85	0272 E	HERNANDEZ, JAMES Z.	296.00
4/29/85	0272 F	HERNANDEZ, JAMES Z.	159.25
4/29/85	0272 F	HERNANDEZ, JAMES Z.	4,022.00
4/29/85	0272 M	HERNANDEZ, JAMES Z.	173.99
5/22/85	0272 E	HERNANDEZ, JAMES Z.	599.39
5/22/85	0272 F	HERNANDEZ, JAMES Z.	933.50
5/22/85	0272 F	HERNANDEZ, JAMES Z.	71.50
5/22/85	0272 F	HERNANDEZ, JAMES Z.	143.00
5/22/85	0272 F	HERNANDEZ, JAMES Z.	5,334.00
5/22/85	0272 F	HERNANDEZ, JAMES Z.	673.00
5/22/85	0272 M	HERNANDEZ, JAMES Z.	2.75
5/22/85	0272 M	HERNANDEZ, JAMES Z.	557.63
5/22/85	0272 M	HERNANDEZ, JAMES Z.	225.45
5/22/85	0272 M	HERNANDEZ, JAMES Z.	81.34
5/22/85	0272 M	HERNANDEZ, JAMES Z.	4.00
		TOTALS:	
		0272 F - ATTORNEY FEES	136,747.48
		0272 E - ATTORNEY TRAVEL EXPENSE	9,958.15
		0272 M - ATTORNEY MISCELLANEOUS	35,433.52
		GRAND TOTAL:	182,139.15
2/05/81	0272 M	MCMULLEN, LARRY L.	219.80
5/13/81	0272 F	MCMULLEN, LARRY L.	777.49
5/13/81	0272 M	MCMULLEN, LARRY L.	1.05
5/18/81	0272 F	MCMULLEN, LARRY L.	25.00
5/18/81	0272 M	MCMULLEN, LARRY L.	2.57
6/30/81	0272 F	MCMULLEN, LARRY L.	25.00
6/30/81	0272 F	MCMULLEN, LARRY L.	17.00
10/31/81	0272 F	MCMULLEN, LARRY L.	135.00
10/31/81	0272 M	MCMULLEN, LARRY L.	10.50

DATE	OBJECT	VENDOR	AMOUNT
11/05/81	0272 F	MCMULLEN, LARRY L.	365.83
12/11/81	0272 F	MCMULLEN, LARRY L.	373.88
12/11/81	0272 M	MCMULLEN, LARRY L.	17.49
2/26/82	0272 M	MCMULLEN, LARRY L.	57.87
4/21/82	0272 F	MCMULLEN, LARRY L.	220.20
4/21/82	0272 M	MCMULLEN, LARRY L.	23.85
6/30/82	0272 F	MCMULLEN, LARRY L.	363.75
6/30/82	0272 M	MCMULLEN, LARRY L.	179.62
10/13/82	0272 F	MCMULLEN, LARRY L.	292.49
5/12/83	0272 E	MCMULLEN, LARRY L.	646.87
5/12/83	0272 M	MCMULLEN, LARRY L.	796.99
12/08/83	0272 F	MCMULLEN, LARRY L.	2,498.60
12/08/83	0272 M	MCMULLEN, LARRY L.	57.10
12/19/83	0272 F	MCMULLEN, LARRY L.	623.35
12/19/83	0272 M	MCMULLEN, LARRY L.	22.38
3/26/84	0272 M	MCMULLEN, LARRY L.	66.90
4/24/84	0272 F	MCMULLEN, LARRY L.	2,822.20
4/24/84	0272 F	MCMULLEN, LARRY L.	525.20
4/24/84	0272 M	MCMULLEN, LARRY L.	5.67
4/24/84	0272 M	MCMULLEN, LARRY L.	368.58
5/29/84	0272 M	MCMULLEN, LARRY L.	2,486.02
6/30/84	0272 M	MCMULLEN, LARRY L.	1,204.81
7/17/84	0272 M	MCMULLEN, LARRY L.	83.69
7/17/84	0272 M	MCMULLEN, LARRY L.	486.68
9/06/84	0272 E	MCMULLEN, LARRY L.	1,408.35
9/06/84	0272 M	MCMULLEN, LARRY L.	5.20
9/06/84	0272 M	MCMULLEN, LARRY L.	147.37
12/14/84	0272 E	MCMULLEN, LARRY L.	2,960.87
12/14/84	0272 F	MCMULLEN, LARRY L.	17,733.99
12/14/84	0272 M	MCMULLEN, LARRY L.	589.19
1/18/85	0272 F	MCMULLEN, LARRY L.	4,449.30
1/18/85	0272 M	MCMULLEN, LARRY L.	247.60
3/12/85	0272 E	MCMULLEN, LARRY L.	29.00
3/12/85	0272 F	MCMULLEN, LARRY L.	4,708.60
3/12/85	0272 M	MCMULLEN, LARRY L.	138.79
5/08/85	0272 F	MCMULLEN, LARRY L.	901.50
5/08/85	0272 M	MCMULLEN, LARRY L.	44.80
5/28/85	0272 E	MCMULLEN, LARRY L.	22.00
5/28/85	0272 M	MCMULLEN, LARRY L.	709.88
5/31/85	0272 E	MCMULLEN, LARRY L.	466.55
5/31/85	0272 F	MCMULLEN, LARRY L.	3,427.30
5/31/85	0272 M	MCMULLEN, LARRY L.	774.81
		TOTALS:	
		0272 F - ATTORNEY FEES	40,285.68
		0272 E - ATTORNEY TRAVEL EXPENSE	5,533.64
		0272 M - ATTORNEY MISCELLANEOUS	8,749.21
		GRAND TOTAL:	54,568.53
12/15/80	0272 F	LYNCH, WILLIAM A.	579.92

DATE	OBJECT	VENDOR	AMOUNT
3/23/81	0272 M	LYNCH, WILLIAM A.	26.28
3/31/82	0272 E	LYNCH, WILLIAM A.	579.25
3/31/82	0272 M	LYNCH, WILLIAM A.	6.93
5/12/82	0272 F	LYNCH, WILLIAM A.	2,139.51
5/12/82	0272 M	LYNCH, WILLIAM A.	287.94
7/29/82	0272 E	LYNCH, WILLIAM A.	156.00
7/29/82	0272 F	LYNCH, WILLIAM A.	1,242.09
7/29/82	0272 M	LYNCH, WILLIAM A.	186.78
10/14/82	0272 F	LYNCH, WILLIAM A.	417.08
10/14/82	0272 M	LYNCH, WILLIAM A.	36.15
8/12/83	0272 F	LYNCH, WILLIAM A.	447.85
10/18/83	0272 E	LYNCH, WILLIAM A.	118.76
10/18/83	0272 M	LYNCH, WILLIAM A.	137.21
10/26/83	0272 E	LYNCH, WILLIAM A.	598.80
10/26/83	0272 F	LYNCH, WILLIAM A.	1,306.50
10/26/83	0272 M	LYNCH, WILLIAM A.	19.95
12/30/83	0272 F	LYNCH, WILLIAM A.	430.30
12/30/83	0272 M	LYNCH, WILLIAM A.	71.55
		TOTALS:	
		0272 F - ATTORNEY FEES	6,563.25
		0272 E - ATTORNEY TRAVEL EXPENSE	1,452.81
		0272 M - ATTORNEY MISCELLANEOUS	772.79
		GRAND TOTAL:	8,788.85
12/15/80	0272 F	RALSTON, EUGENE B.	1,587.50
12/15/80	0272 M	RALSTON, EUGENE B.	123.63
5/31/81	0272 E	RALSTON, EUGENE B.	1,350.27
5/31/81	0272 F	RALSTON, EUGENE B.	8,695.00
5/31/81	0272 M	RALSTON, EUGENE B.	620.70
9/11/81	0272 E	RALSTON, EUGENE B.	76.18
9/11/81	0272 F	RALSTON, EUGENE B.	280.00
9/11/81	0272 M	RALSTON, EUGENE B.	948.25
		TOTALS:	
		0272 F - ATTORNEY FEES	10,562.50
		0272 E - ATTORNEY TRAVEL EXPENSE	1,426.45
		0272 M - ATTORNEY MISCELLANEOUS	1,692.58
		GRAND TOTAL:	13,681.53
2/05/81	0272 E	FANNING, H. W.	51.05
2/05/81	0272 F	FANNING, H. W.	625.00
2/05/81	0272 M	FANNING, H. W.	92.90
5/12/82	0272 F	FANNING, H. W.	936.25
5/12/82	0272 M	FANNING, H. W.	61.80
8/03/83	0272 E	FANNING, H. W.	263.50
8/03/83	0272 F	FANNING, H. W.	3,298.75
8/03/83	0272 M	FANNING, H. W.	75.20
12/30/83	0272 F	FANNING, H. W.	406.25
12/30/83	0272 M	FANNING, H. W.	9.18
		TOTALS:	
		0272 F - ATTORNEY FEES	5,266.25
		0272 E - ATTORNEY TRAVEL EXPENSE	314.55
		0272 M - ATTORNEY MISCELLANEOUS	239.08
		GRAND TOTAL:	5,819.88

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DATE	OBJECT	VENDOR	AMOUNT
6/30/81	0272 F	LISTROM, MYRON L.	1,250.00
6/30/81	0272 M	LISTROM, MYRON L.	87.50
1/15/82	0272 F	LISTROM, MYRON L.	612.00
1/15/82	0272 M	LISTROM, MYRON L.	99.28
5/24/82	0272 F	LISTROM, MYRON L.	432.00
5/24/82	0272 M	LISTROM, MYRON L.	138.50
6/30/82	0272 F	LISTROM, MYRON L.	271.00
6/30/82	0272 M	LISTROM, MYRON L.	10.25
4/20/83	0272 E	LISTROM, MYRON L.	97.20
4/20/83	0272 E	LISTROM, MYRON L.	430.68
4/20/83	0272 F	LISTROM, MYRON L.	2,881.00
4/20/83	0272 F	LISTROM, MYRON L.	3,288.00
4/20/83	0272 M	LISTROM, MYRON L.	439.35
4/20/83	0272 M	LISTROM, MYRON L.	582.10
6/08/83	0272 E	LISTROM, MYRON L.	217.29
6/08/83	0272 F	LISTROM, MYRON L.	18,141.00
6/08/83	0272 M	LISTROM, MYRON L.	660.25
6/24/83	0272 E	LISTROM, MYRON L.	290.54
6/24/83	0272 F	LISTROM, MYRON L.	13,313.50
6/24/83	0272 M	LISTROM, MYRON L.	998.75
6/30/83	0272 E	LISTROM, MYRON L.	812.56
6/30/83	0272 F	LISTROM, MYRON L.	1,967.50
6/30/83	0272 F	LISTROM, MYRON L.	833.50
6/30/83	0272 M	LISTROM, MYRON L.	919.65
6/30/83	0272 M	LISTROM, MYRON L.	9.90
10/19/83	0272 F	LISTROM, MYRON L.	1,029.00
10/19/83	0272 F	LISTROM, MYRON L.	669.50
10/19/83	0272 M	LISTROM, MYRON L.	6.05
10/19/83	0272 M	LISTROM, MYRON L.	117.75
1/31/84	0272 F	LISTROM, MYRON L.	445.00
3/26/84	0272 F	LISTROM, MYRON L.	3,808.50
3/26/84	0272 M	LISTROM, MYRON L.	201.27
7/27/84	0272 E	LISTROM, MYRON L.	1,358.05
7/27/84	0272 F	LISTROM, MYRON L.	13,543.00
7/27/84	0272 M	LISTROM, MYRON L.	7,162.45
8/16/84	0272 F	LISTROM, MYRON L.	1,953.50
8/16/84	0272 M	LISTROM, MYRON L.	238.03
10/23/84	0272 F	LISTROM, MYRON L.	5,279.50
10/23/84	0272 M	LISTROM, MYRON L.	168.16
11/28/84	0272 E	LISTROM, MYRON L.	18.80
11/28/84	0272 F	LISTROM, MYRON L.	4,685.00
11/28/84	0272 F	LISTROM, MYRON L.	175.50
11/28/84	0272 M	LISTROM, MYRON L.	374.81
11/28/84	0272 M	LISTROM, MYRON L.	1,136.21
3/28/85	0272 E	LISTROM, MYRON L.	111.36
3/28/85	0272 F	LISTROM, MYRON L.	7,852.00
3/28/85	0272 M	LISTROM, MYRON L.	1,559.85
4/29/85	0272 E	LISTROM, MYRON L.	65.81
4/29/85	0272 F	LISTROM, MYRON L.	734.00

DATE	OBJECT	VENDOR	AMOUNT
4/29/85	0272 M	LISTROM, MYRON L.	8.50
5/28/85	0272 F	LISTROM, MYRON L.	3,142.50
5/28/85	0272 M	LISTROM, MYRON L.	11.52
		TOTALS:	
		0272 F - ATTORNEY FEES	86,306.50
		0272 E - ATTORNEY TRAVEL EXPENSE	3,402.29
		0272 M - ATTORNEY MISCELLANEOUS	14,930.13
		GRAND TOTAL:	104,638.92
7/27/81	0272 E	CONNELL, O. J., JR.	36.75
7/27/81	0272 F	CONNELL, O. J., JR.	1,350.00
7/27/81	0272 M	CONNELL, O. J., JR.	234.76
5/05/82	0272 E	CONNELL, O. J., JR.	29.00
5/05/82	0272 F	CONNELL, O. J., JR.	2,437.50
5/05/82	0272 M	CONNELL, O. J., JR.	219.32
		TOTALS:	
		0272 F - ATTORNEY FEES	3,787.50
		0272 E - ATTORNEY TRAVEL EXPENSE	65.75
		0272 M - ATTORNEY MISCELLANEOUS	454.08
		GRAND TOTAL:	4,307.33
3/16/81	0272 F	THEIS, THOMAS L.	450.00
3/16/81	0272 M	THEIS, THOMAS L.	17.05
6/30/81	0272 F	THEIS, THOMAS L.	975.00
6/30/81	0272 M	THEIS, THOMAS L.	7.95
1/22/82	0272 E	THEIS, THOMAS L.	977.07
1/22/82	0272 F	THEIS, THOMAS L.	4,264.00
1/22/82	0272 M	THEIS, THOMAS L.	105.25
3/10/82	0272 F	THEIS, THOMAS L.	1,283.50
3/10/82	0272 M	THEIS, THOMAS L.	60.28
3/19/82	0272 F	THEIS, THOMAS L.	1,385.00
3/19/82	0272 M	THEIS, THOMAS L.	1,980.72
4/14/82	0272 F	THEIS, THOMAS L.	198.00
4/14/82	0272 M	THEIS, THOMAS L.	41.85
6/14/82	0272 F	THEIS, THOMAS L.	1,215.50
6/14/82	0272 M	THEIS, THOMAS L.	44.10
6/21/82	0272 E	THEIS, THOMAS L.	37.35
6/21/82	0272 F	THEIS, THOMAS L.	1,648.50
6/21/82	0272 M	THEIS, THOMAS L.	651.17
6/30/82	0272 F	THEIS, THOMAS L.	533.50
6/30/82	0272 F	THEIS, THOMAS L.	786.00
6/30/82	0272 M	THEIS, THOMAS L.	274.50
6/30/82	0272 M	THEIS, THOMAS L.	41.10
8/12/82	0272 E	THEIS, THOMAS L.	484.00
8/12/82	0272 F	THEIS, THOMAS L.	1,897.50
8/12/82	0272 F	THEIS, THOMAS L.	2,998.50
8/12/82	0272 M	THEIS, THOMAS L.	530.21
8/12/82	0272 M	THEIS, THOMAS L.	16.75
10/13/82	0272 F	THEIS, THOMAS L.	6,267.50

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DATE	OBJECT	VENDOR	AMOUNT
10/13/82	0272 M	THEIS, THOMAS L.	4,527.14
10/26/82	0272 F	THEIS, THOMAS L.	140.00
10/26/82	0272 M	THEIS, THOMAS L.	3,050.94
4/13/83	0272 E	THEIS, THOMAS L.	1,026.28
4/13/83	0272 F	THEIS, THOMAS L.	2,964.50
4/13/83	0272 M	THEIS, THOMAS L.	508.42
6/08/83	0272 F	THEIS, THOMAS L.	396.50
6/08/83	0272 M	THEIS, THOMAS L.	20.40
6/10/83	0272 F	THEIS, THOMAS L.	39.00
6/30/83	0272 E	THEIS, THOMAS L.	77.25
6/30/83	0272 F	THEIS, THOMAS L.	1,613.00
6/30/83	0272 M	THEIS, THOMAS L.	8.20
8/26/83	0272 M	THEIS, THOMAS L.	1,966.98
10/26/83	0272 E	THEIS, THOMAS L.	276.50
10/26/83	0272 F	THEIS, THOMAS L.	2,320.00
10/26/83	0272 M	THEIS, THOMAS L.	2,950.90
12/19/83	0272 E	THEIS, THOMAS L.	886.85
12/19/83	0272 F	THEIS, THOMAS L.	4,516.50
12/19/83	0272 M	THEIS, THOMAS L.	1,031.24
1/31/84	0272 F	THEIS, THOMAS L.	9,587.00
1/31/84	0272 M	THEIS, THOMAS L.	2,403.20
2/29/84	0272 E	THEIS, THOMAS L.	552.00
2/29/84	0272 M	THEIS, THOMAS L.	34.00
3/13/84	0272 E	THEIS, THOMAS L.	46.10
3/13/84	0272 F	THEIS, THOMAS L.	1,695.55
3/13/84	0272 M	THEIS, THOMAS L.	740.35
9/30/84	0272 F	THEIS, THOMAS L.	253.50
9/30/84	0272 F	THEIS, THOMAS L.	268.00
9/30/84	0272 F	THEIS, THOMAS L.	1,524.50
9/30/84	0272 F	THEIS, THOMAS L.	1,066.00
9/30/84	0272 M	THEIS, THOMAS L.	3.80
9/30/84	0272 M	THEIS, THOMAS L.	120.23
9/30/84	0272 M	THEIS, THOMAS L.	34.30
9/30/84	0272 M	THEIS, THOMAS L.	22.30
10/08/84	0272 F	THEIS, THOMAS L.	537.00
10/08/84	0272 M	THEIS, THOMAS L.	110.30
1/10/85	0272 E	THEIS, THOMAS L.	657.91
1/10/85	0272 F	THEIS, THOMAS L.	5,388.50
1/10/85	0272 M	THEIS, THOMAS L.	1,044.50
5/28/85	0272 F	THEIS, THOMAS L.	284.00
5/28/85	0272 M	THEIS, THOMAS L.	6.65
		TOTALS:	
		0272 F - ATTORNEY FEES	56,496.05
		0272 E - ATTORNEY TRAVEL EXPENSE	5,021.31
		0272 M - ATTORNEY MISCELLANEOUS	22,354.78
		GRAND TOTAL:	83,872.14
6/17/81	0272 F	HAWVER IRA DENNIS	681.25
		TOTALS:	
		0272 F - ATTORNEY FEES	681.25
		GRAND TOTAL:	681.25

DATE	OBJECT	VENDOR	AMOUNT
6/30/81	0272 F	STRATTON, WAYNE T.	317.50
6/30/81	0272 M	STRATTON, WAYNE T.	8.57
7/17/81	0272 F	STRATTON, WAYNE T.	10.00
12/29/81	0272 E	STRATTON, WAYNE T.	2,155.60
12/29/81	0272 F	STRATTON, WAYNE T.	7,854.00
12/29/81	0272 M	STRATTON, WAYNE T.	2,246.49
5/12/82	0272 F	STRATTON, WAYNE T.	4,950.00
5/12/82	0272 M	STRATTON, WAYNE T.	2,592.97
6/30/82	0272 F	STRATTON, WAYNE T.	468.00
6/30/82	0272 M	STRATTON, WAYNE T.	2.23
8/09/82	0272 F	STRATTON, WAYNE T.	2,021.25
8/09/82	0272 M	STRATTON, WAYNE T.	582.05
12/23/82	0272 F	STRATTON, WAYNE T.	91.00
12/23/82	0272 M	STRATTON, WAYNE T.	103.82
3/30/83	0272 E	STRATTON, WAYNE T.	151.21
3/30/83	0272 F	STRATTON, WAYNE T.	1,542.50
3/30/83	0272 M	STRATTON, WAYNE T.	202.43
6/30/83	0272 E	STRATTON, WAYNE T.	242.00
6/30/83	0272 F	STRATTON, WAYNE T.	1,623.50
6/30/83	0272 F	STRATTON, WAYNE T.	117.00
6/30/83	0272 M	STRATTON, WAYNE T.	180.20
6/30/83	0272 M	STRATTON, WAYNE T.	27.00
10/12/83	0272 F	STRATTON, WAYNE T.	2,511.75
10/12/83	0272 M	STRATTON, WAYNE T.	343.25
1/04/84	0272 F	STRATTON, WAYNE T.	1,516.13
1/04/84	0272 M	STRATTON, WAYNE T.	519.90
1/31/84	0272 E	STRATTON, WAYNE T.	1,068.38
1/31/84	0272 F	STRATTON, WAYNE T.	7,096.88
1/31/84	0272 M	STRATTON, WAYNE T.	1,721.31
3/30/84	0272 F	STRATTON, WAYNE T.	331.50
3/30/84	0272 M	STRATTON, WAYNE T.	10.15
7/21/84	0272 E	STRATTON, WAYNE T.	171.10
7/21/84	0272 F	STRATTON, WAYNE T.	6,234.38
7/21/84	0272 M	STRATTON, WAYNE T.	1,447.09
		TOTALS:	
		0272 F - ATTORNEY FEES	36,685.39
		0272 E - ATTORNEY TRAVEL EXPENSE	3,788.29
		0272 M - ATTORNEY MISCELLANEOUS	9,987.46
		GRAND TOTAL:	50,461.14
6/30/82	0272 F	SHOAF, LARRY,	1,494.00
6/30/82	0272 F	SHOAF, LARRY,	1,020.00
6/30/82	0272 M	SHOAF, LARRY,	372.89
6/30/82	0272 M	SHOAF, LARRY,	115.46
1/10/83	0272 F	SHOAF, LARRY,	528.00
5/24/83	0272 E	SHOAF, LARRY,	368.41
5/24/83	0272 M	SHOAF, LARRY,	380.80
8/03/83	0272 F	SHOAF, LARRY,	220.59
8/03/83	0272 F	SHOAF, LARRY,	1,852.25

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DATE	OBJECT	VENDOR	AMOUNT
8/03/83	0272 F	SHOAF, LARRY,	4,635.00
8/03/83	0272 M	SHOAF, LARRY,	118.08
8/03/83	0272 M	SHOAF, LARRY,	7.00
10/26/83	0272 E	SHOAF, LARRY,	206.83
10/26/83	0272 M	SHOAF, LARRY,	150.00
2/21/84	0272 E	SHOAF, LARRY,	275.11
2/21/84	0272 M	SHOAF, LARRY,	395.10
5/23/84	0272 E	SHOAF, LARRY,	516.95
5/23/84	0272 F	SHOAF, LARRY,	3,489.13
5/23/84	0272 M	SHOAF, LARRY,	1,201.68
5/29/84	0272 E	SHOAF, LARRY,	311.24
5/29/84	0272 M	SHOAF, LARRY,	227.36
8/07/84	0272 E	SHOAF, LARRY,	148.99
8/07/84	0272 F	SHOAF, LARRY,	3,064.75
8/07/84	0272 M	SHOAF, LARRY,	593.69
9/06/84	0272 F	SHOAF, LARRY,	8,324.50
9/06/84	0272 M	SHOAF, LARRY,	2,662.88
11/28/84	0272 E	SHOAF, LARRY,	639.45
11/28/84	0272 M	SHOAF, LARRY,	167.91
4/18/85	0272 E	SHOAF, LARRY,	62.80
4/18/85	0272 F	SHOAF, LARRY,	3,495.50
4/18/85	0272 M	SHOAF, LARRY,	328.09
		TOTALS:	
		0272 F - ATTORNEY FEES	28,123.72
		0272 E - ATTORNEY TRAVEL EXPENSE	2,529.78
		0272 M - ATTORNEY MISCELLANEOUS	6,720.94
		GRAND TOTAL:	37,374.44
6/30/82	0272 F	KELLOGG, DARRELL D.	507.26
6/30/82	0272 F	KELLOGG, DARRELL D.	466.25
6/30/82	0272 M	KELLOGG, DARRELL D.	62.88
11/03/82	0272 M	KELLOGG, DARRELL D.	55.20
5/12/83	0272 F	KELLOGG, DARRELL D.	1,193.75
5/12/83	0272 M	KELLOGG, DARRELL D.	69.02
5/13/83	0272 F	KELLOGG, DARRELL D.	841.25
5/13/83	0272 F	KELLOGG, DARRELL D.	832.50
5/13/83	0272 M	KELLOGG, DARRELL D.	443.40
5/13/83	0272 M	KELLOGG, DARRELL D.	11.70
6/30/83	0272 F	KELLOGG, DARRELL D.	2,140.00
6/30/83	0272 F	KELLOGG, DARRELL D.	122.50
6/30/83	0272 M	KELLOGG, DARRELL D.	8.00
6/30/83	0272 M	KELLOGG, DARRELL D.	60.30
6/30/84	0272 F	KELLOGG, DARRELL D.	991.25
6/30/84	0272 F	KELLOGG, DARRELL D.	3,910.00
6/30/84	0272 M	KELLOGG, DARRELL D.	69.92
6/30/84	0272 M	KELLOGG, DARRELL D.	478.95
9/27/84	0272 M	KELLOGG, DARRELL D.	66.25
		TOTALS:	
		0272 F - ATTORNEY FEES	11,004.76
		0272 M - ATTORNEY MISCELLANEOUS	1,325.62
		GRAND TOTAL:	12,330.38

DATE	OBJECT	VENDOR	AMOUNT
6/24/82	0272 F	HOLM, KENNETH E.	1,273.75
6/24/82	0272 F	HOLM, KENNETH E.	1,462.50
6/24/82	0272 M	HOLM, KENNETH E.	432.61
6/24/82	0272 M	HOLM, KENNETH E.	81.15
10/26/82	0272 M	HOLM, KENNETH E.	1,599.20
10/26/82	0272 M	HOLM, KENNETH E.	508.04
11/30/82	0272 E	HOLM, KENNETH E.	35.75
11/30/82	0272 F	HOLM, KENNETH E.	3,977.50
11/30/82	0272 F	HOLM, KENNETH E.	3,677.50
11/30/82	0272 M	HOLM, KENNETH E.	590.34
11/30/82	0272 M	HOLM, KENNETH E.	169.58
12/06/82	0272 M	HOLM, KENNETH E.	67.10
3/10/83	0272 E	HOLM, KENNETH E.	4,252.11
3/10/83	0272 F	HOLM, KENNETH E.	27,356.25
3/10/83	0272 M	HOLM, KENNETH E.	703.59
4/27/83	0272 M	HOLM, KENNETH E.	709.34
4/30/83	0272 E	HOLM, KENNETH E.	10.00
4/30/83	0272 F	HOLM, KENNETH E.	3,653.75
4/30/83	0272 M	HOLM, KENNETH E.	153.47
6/08/83	0272 F	HOLM, KENNETH E.	892.50
6/08/83	0272 M	HOLM, KENNETH E.	38.73
6/30/83	0272 F	HOLM, KENNETH E.	1,698.75
6/30/83	0272 M	HOLM, KENNETH E.	1,020.42
12/15/83	0272 E	HOLM, KENNETH E.	12.50
12/15/83	0272 F	HOLM, KENNETH E.	1,192.50
12/15/83	0272 M	HOLM, KENNETH E.	27.98
12/19/83	0272 E	HOLM, KENNETH E.	41.10
12/19/83	0272 F	HOLM, KENNETH E.	2,175.00
12/19/83	0272 M	HOLM, KENNETH E.	511.49
1/11/84	0272 F	HOLM, KENNETH E.	7,912.50
1/11/84	0272 M	HOLM, KENNETH E.	366.11
1/31/84	0272 F	HOLM, KENNETH E.	60.00
1/31/84	0272 M	HOLM, KENNETH E.	5.00
2/29/84	0272 E	HOLM, KENNETH E.	4.50
2/29/84	0272 F	HOLM, KENNETH E.	1,008.75
2/29/84	0272 M	HOLM, KENNETH E.	471.27
4/12/84	0272 F	HOLM, KENNETH E.	750.00
4/12/84	0272 M	HOLM, KENNETH E.	207.40
5/07/84	0272 E	HOLM, KENNETH E.	1,223.20
5/07/84	0272 M	HOLM, KENNETH E.	1,221.32
6/26/84	0272 E	HOLM, KENNETH E.	49.10
6/26/84	0272 F	HOLM, KENNETH E.	3,161.25
6/26/84	0272 M	HOLM, KENNETH E.	2,393.23
6/30/84	0272 E	HOLM, KENNETH E.	3,629.70
6/30/84	0272 F	HOLM, KENNETH E.	6,857.50
6/30/84	0272 M	HOLM, KENNETH E.	2,378.72
9/20/84	0272 E	HOLM, KENNETH E.	647.79
9/20/84	0272 F	HOLM, KENNETH E.	12,737.50
9/20/84	0272 M	HOLM, KENNETH E.	5,133.67

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
1/16/85	0272 E	HOLM, KENNETH E.	112.00
1/16/85	0272 F	HOLM, KENNETH E.	7,442.50
1/16/85	0272 M	HOLM, KENNETH E.	2,801.34
2/28/85	0272 F	HOLM, KENNETH E.	255.00
2/28/85	0272 M	HOLM, KENNETH E.	165.25
4/29/85	0272 E	HOLM, KENNETH E.	824.10
4/29/85	0272 F	HOLM, KENNETH E.	768.75
4/29/85	0272 F	HOLM, KENNETH E.	162.50
4/29/85	0272 F	HOLM, KENNETH E.	1,263.75
4/29/85	0272 M	HOLM, KENNETH E.	150.00
4/29/85	0272 M	HOLM, KENNETH E.	678.85
5/24/85	0272 F	HOLM, KENNETH E.	835.00
5/24/85	0272 M	HOLM, KENNETH E.	303.31
5/28/85	0272 F	HOLM, KENNETH E.	306.25
		TOTALS:	
		0272 F - ATTORNEY FEES	90,881.25
		0272 E - ATTORNEY TRAVEL EXPENSE	10,841.85
		0272 M - ATTORNEY MISCELLANEOUS	22,888.51
		GRAND TOTAL:	124,611.61
3/17/82	0272 F	WILLIAMS, RON	357.50
3/17/82	0272 M	WILLIAMS, RON	7.27
		TOTALS:	
		0272 F - ATTORNEY FEES	357.50
		0272 M - ATTORNEY MISCELLANEOUS	7.27
		GRAND TOTAL:	364.77
5/18/82	0272 E	RANDALL, CHRISTOPHER	110.00
5/18/82	0272 E	RANDALL, CHRISTOPHER	110.00
		TOTALS:	
		0272 E - ATTORNEY TRAVEL EXPENSE	220.00
		GRAND TOTAL:	220.00
6/30/82	0272 F	WAGSTAFF, THOMAS	3,943.67
8/20/82	0272 F	WAGSTAFF, THOMAS	109.16
1/27/83	0272 E	WAGSTAFF, THOMAS	765.24
1/27/83	0272 M	WAGSTAFF, THOMAS	1,349.72
5/19/83	0272 F	WAGSTAFF, THOMAS	5,474.30
5/19/83	0272 M	WAGSTAFF, THOMAS	594.15
6/15/83	0272 E	WAGSTAFF, THOMAS	913.06
6/15/83	0272 M	WAGSTAFF, THOMAS	307.82
10/06/83	0272 F	WAGSTAFF, THOMAS	2,838.55
10/06/83	0272 M	WAGSTAFF, THOMAS	85.49
12/15/83	0272 F	WAGSTAFF, THOMAS	4,682.60
12/15/83	0272 M	WAGSTAFF, THOMAS	27.51
		TOTALS:	
		0272 F - ATTORNEY FEES	17,048.28
		0272 E - ATTORNEY TRAVEL EXPENSE	1,678.30
		0272 M - ATTORNEY MISCELLANEOUS	2,364.69
		GRAND TOTAL:	21,091.27

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
6/22/82	0272 M	PALMER, RANDALL D.	24.20
8/03/83	0272 E	PALMER, RANDALL D.	618.30
8/03/83	0272 M	PALMER, RANDALL D.	7,493.17
8/26/83	0272 F	PALMER, RANDALL D.	29,592.00
8/26/83	0272 M	PALMER, RANDALL D.	2,133.81
4/25/84	0272 E	PALMER, RANDALL D.	718.04
4/25/84	0272 F	PALMER, RANDALL D.	6,822.00
4/25/84	0272 M	PALMER, RANDALL D.	2,696.13
8/27/84	0272 F	PALMER, RANDALL D.	3,456.00
8/27/84	0272 M	PALMER, RANDALL D.	3,657.39
2/05/85	0272 E	PALMER, RANDALL D.	124.15
2/05/85	0272 F	PALMER, RANDALL D.	1,753.50
2/05/85	0272 M	PALMER, RANDALL D.	50.79
2/28/85	0272 E	PALMER, RANDALL D.	228.30
2/28/85	0272 F	PALMER, RANDALL D.	6,113.00
2/28/85	0272 M	PALMER, RANDALL D.	862.56
		TOTALS:	
		0272 F - ATTORNEY FEES	47,736.50
		0272 E - ATTORNEY TRAVEL EXPENSE	1,688.79
		0272 M - ATTORNEY MISCELLANEOUS	16,918.05
		GRAND TOTAL:	66,343.34
8/09/82	0272 F	GREEN, CHARLES D.	2,096.25
8/09/82	0272 M	GREEN, CHARLES D.	177.39
		TOTALS:	
		0272 F - ATTORNEY FEES	2,096.25
		0272 M - ATTORNEY MISCELLANEOUS	177.39
		GRAND TOTAL:	2,273.64
9/08/82	0272 F	HUNTER, GARY D.	3,627.00
9/08/82	0272 M	HUNTER, GARY D.	4,889.21
4/12/83	0272 F	HUNTER, GARY D.	669.50
4/12/83	0272 M	HUNTER, GARY D.	63.90
6/30/83	0272 F	HUNTER, GARY D.	2,795.00
6/30/83	0272 F	HUNTER, GARY D.	3,839.50
6/30/83	0272 F	HUNTER, GARY D.	1,043.25
6/30/83	0272 F	HUNTER, GARY D.	1,043.25
6/30/83	0272 M	HUNTER, GARY D.	3.80
6/30/83	0272 M	HUNTER, GARY D.	3.80
6/30/83	0272 M	HUNTER, GARY D.	487.95
6/30/83	0272 M	HUNTER, GARY D.	423.95
8/12/83	0272 F	HUNTER, GARY D.	377.00
8/12/83	0272 M	HUNTER, GARY D.	138.10
9/16/83	0272 F	HUNTER, GARY D.	617.50
9/16/83	0272 M	HUNTER, GARY D.	5,513.95
		TOTALS:	
		0272 F - ATTORNEY FEES	14,012.00
		0272 M - ATTORNEY MISCELLANEOUS	11,524.66
		GRAND TOTAL:	25,536.66

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
9/27/82	0272 F	KING, CLARENCE L., JR.	2,446.50
9/27/82	0272 M	KING, CLARENCE L., JR.	74.65
6/27/84	0272 E	KING, CLARENCE L., JR.	67.95
6/27/84	0272 F	KING, CLARENCE L., JR.	824.00
6/27/84	0272 M	KING, CLARENCE L., JR.	11.83
9/06/84	0272 F	KING, CLARENCE L., JR.	2,706.00
9/06/84	0272 M	KING, CLARENCE L., JR.	216.23
		TOTALS:	
		0272 F - ATTORNEY FEES	5,976.50
		0272 E - ATTORNEY TRAVEL EXPENSE	67.95
		0272 M - ATTORNEY MISCELLANEOUS	302.71
		GRAND TOTAL:	6,347.16
10/25/82	0272 E	HAVNER, KENNETH C.	1,104.91
11/03/82	0272 M	HAVNER, KENNETH C.	440.47
12/06/82	0272 E	HAVNER, KENNETH C.	96.00
12/06/82	0272 F	HAVNER, KENNETH C.	3,450.00
12/06/82	0272 M	HAVNER, KENNETH C.	109.19
		TOTALS:	
		0272 F - ATTORNEY FEES	3,450.00
		0272 E - ATTORNEY TRAVEL EXPENSE	1,200.91
		0272 M - ATTORNEY MISCELLANEOUS	549.66
		GRAND TOTAL:	5,200.57
4/14/83	0272 E	TUCKER, LAURENCE R.	398.06
4/14/83	0272 F	TUCKER, LAURENCE R.	3,006.25
4/14/83	0272 M	TUCKER, LAURENCE R.	1,351.83
1/30/85	0272 E	TUCKER, LAURENCE R.	10.20
1/30/85	0272 F	TUCKER, LAURENCE R.	2,401.25
1/30/85	0272 M	TUCKER, LAURENCE R.	102.49
2/21/85	0272 E	TUCKER, LAURENCE R.	38.35
2/21/85	0272 F	TUCKER, LAURENCE R.	4,657.50
2/21/85	0272 M	TUCKER, LAURENCE R.	256.43
		TOTALS:	
		0272 F - ATTORNEY FEES	10,065.00
		0272 E - ATTORNEY TRAVEL EXPENSE	446.61
		0272 M - ATTORNEY MISCELLANEOUS	1,710.75
		GRAND TOTAL:	12,222.36
3/16/83	0272 F	STRAUSBAUGH, DANIEL J.	7,663.50
3/16/83	0272 M	STRAUSBAUGH, DANIEL J.	2,854.86
		TOTALS:	
		0272 F - ATTORNEY FEES	7,663.50
		0272 M - ATTORNEY MISCELLANEOUS	2,854.86
		GRAND TOTAL:	10,518.36
4/30/83	0272 F	MCCAMISH, M. WARREN,	773.50
4/30/83	0272 M	MCCAMISH, M. WARREN,	16.89
6/15/83	0272 E	MCCAMISH, M. WARREN,	164.00

DATE	OBJECT	VENDOR	AMOUNT
6/15/83	0272 F	MCCAMISH, M. WARREN,	1,501.50
6/15/83	0272 M	MCCAMISH, M. WARREN,	982.79
6/30/83	0272 F	MCCAMISH, M. WARREN,	1,826.50
6/30/83	0272 M	MCCAMISH, M. WARREN,	124.38
8/03/83	0272 M	MCCAMISH, M. WARREN,	1,033.13
12/08/83	0272 E	MCCAMISH, M. WARREN,	1,238.71
12/08/83	0272 M	MCCAMISH, M. WARREN,	1,089.60
12/19/83	0272 E	MCCAMISH, M. WARREN,	856.13
12/19/83	0272 F	MCCAMISH, M. WARREN,	6,266.00
12/19/83	0272 M	MCCAMISH, M. WARREN,	1,112.47
10/16/84	0272 E	MCCAMISH, M. WARREN,	205.00
10/16/84	0272 F	MCCAMISH, M. WARREN,	1,001.00
10/16/84	0272 M	MCCAMISH, M. WARREN,	970.20
10/23/84	0272 E	MCCAMISH, M. WARREN,	161.65
10/23/84	0272 M	MCCAMISH, M. WARREN,	402.18
5/08/85	0272 F	MCCAMISH, M. WARREN,	2,411.50
5/08/85	0272 M	MCCAMISH, M. WARREN,	123.06
		TOTALS:	
		0272 F - ATTORNEY FEES	13,780.00
		0272 E - ATTORNEY TRAVEL EXPENSE	2,625.49
		0272 M - ATTORNEY MISCELLANEOUS	5,854.70
		GRAND TOTAL:	22,260.19
5/05/83	0272 F	LARSON, BYRON G.	1,254.50
		TOTALS:	
		0272 F - ATTORNEY FEES	1,254.50
		GRAND TOTAL:	1,254.50
6/30/83	0272 F	VANDEVER, WM. DIRK	3,201.25
6/30/83	0272 F	VANDEVER, WM. DIRK	5,053.75
6/30/83	0272 M	VANDEVER, WM. DIRK	2,337.12
6/30/83	0272 M	VANDEVER, WM. DIRK	206.05
10/18/83	0272 E	VANDEVER, WM. DIRK	1,178.58
10/18/83	0272 M	VANDEVER, WM. DIRK	1,175.00
12/15/83	0272 F	VANDEVER, WM. DIRK	2,210.00
12/15/83	0272 M	VANDEVER, WM. DIRK	238.80
12/19/83	0272 F	VANDEVER, WM. DIRK	1,088.75
12/19/83	0272 M	VANDEVER, WM. DIRK	278.65
5/29/85	0272 F	VANDEVER, WM. DIRK	1,833.00
5/29/85	0272 M	VANDEVER, WM. DIRK	218.75
		TOTALS:	
		0272 F - ATTORNEY FEES	13,386.75
		0272 E - ATTORNEY TRAVEL EXPENSE	1,178.58
		0272 M - ATTORNEY MISCELLANEOUS	4,454.37
		GRAND TOTAL:	19,019.70
6/30/83	0272 E	NEWMAN, RONALD C.	58.45
6/30/83	0272 F	NEWMAN, RONALD C.	982.00
6/30/83	0272 F	NEWMAN, RONALD C.	5,651.00

DATE	OBJECT	VENDOR	AMOUNT
6/30/83	0272 M	NEWMAN, RONALD C.	22.62
6/30/83	0272 M	NEWMAN, RONALD C.	1,298.33
10/26/83	0272 F	NEWMAN, RONALD C.	492.00
10/26/83	0272 M	NEWMAN, RONALD C.	49.82
2/29/84	0272 E	NEWMAN, RONALD C.	440.38
2/29/84	0272 F	NEWMAN, RONALD C.	11,882.00
2/29/84	0272 M	NEWMAN, RONALD C.	5,702.82
4/25/84	0272 F	NEWMAN, RONALD C.	876.00
4/25/84	0272 M	NEWMAN, RONALD C.	88.19
6/30/84	0272 F	NEWMAN, RONALD C.	5,207.31
8/07/84	0272 E	NEWMAN, RONALD C.	102.52
8/07/84	0272 F	NEWMAN, RONALD C.	12,428.00
8/07/84	0272 M	NEWMAN, RONALD C.	2,921.10
		TOTALS:	
		0272 F - ATTORNEY FEES	37,518.31
		0272 E - ATTORNEY TRAVEL EXPENSE	601.35
		0272 M - ATTORNEY MISCELLANEOUS	10,082.88
		GRAND TOTAL:	48,202.54
10/26/83	0272 E	DEARTH, RICHARD	733.65
10/26/83	0272 F	DEARTH, RICHARD	3,666.00
10/26/83	0272 M	DEARTH, RICHARD	686.82
12/08/83	0272 E	DEARTH, RICHARD	380.42
12/08/83	0272 F	DEARTH, RICHARD	90.00
12/08/83	0272 M	DEARTH, RICHARD	1,670.03
2/08/84	0272 F	DEARTH, RICHARD	2,748.37
2/21/84	0272 E	DEARTH, RICHARD	135.71
2/21/84	0272 F	DEARTH, RICHARD	1,521.00
2/21/84	0272 M	DEARTH, RICHARD	2,161.82
4/17/84	0272 F	DEARTH, RICHARD	1,050.18
5/31/84	0272 E	DEARTH, RICHARD	95.48
5/31/84	0272 F	DEARTH, RICHARD	414.00
5/31/84	0272 M	DEARTH, RICHARD	1.16
2/07/85	0272 E	DEARTH, RICHARD	53.78
2/07/85	0272 F	DEARTH, RICHARD	1,029.00
2/07/85	0272 M	DEARTH, RICHARD	10.03
		TOTALS:	
		0272 F - ATTORNEY FEES	10,518.55
		0272 E - ATTORNEY TRAVEL EXPENSE	1,399.04
		0272 M - ATTORNEY MISCELLANEOUS	4,529.86
		GRAND TOTAL:	16,447.45
3/23/84	0272 E	LARSON, ROY A.	379.56
3/23/84	0272 F	LARSON, ROY A.	13,462.50
3/23/84	0272 M	LARSON, ROY A.	149.96
4/26/84	0272 E	LARSON, ROY A.	34.10
4/26/84	0272 F	LARSON, ROY A.	12,165.00
4/26/84	0272 M	LARSON, ROY A.	494.40
1/08/85	0272 F	LARSON, ROY A.	24,559.20

DATE	OBJECT	VENDOR		AMOUNT
1/30/85	0272 E	LARSON, ROY A.		293.34
1/30/85	0272 F	LARSON, ROY A.		5,788.91
1/30/85	0272 M	LARSON, ROY A.		214.58
		TOTALS:		
		0272 F -	ATTORNEY FEES	55,975.61
		0272 E -	ATTORNEY TRAVEL EXPENSE	707.00
		0272 M -	ATTORNEY MISCELLANEOUS	858.94
			GRAND TOTAL:	57,541.55
6/30/84	0272 E	GOODELL, GERALD L.		871.13
6/30/84	0272 F	GOODELL, GERALD L.		7,249.63
6/30/84	0272 M	GOODELL, GERALD L.		310.21
1/10/85	0272 F	GOODELL, GERALD L.		9,410.75
1/10/85	0272 M	GOODELL, GERALD L.		784.38
4/02/85	0272 E	GOODELL, GERALD L.		583.50
4/02/85	0272 F	GOODELL, GERALD L.		2,187.25
4/02/85	0272 M	GOODELL, GERALD L.		60.87
		TOTALS:		
		0272 F -	ATTORNEY FEES	18,847.63
		0272 E -	ATTORNEY TRAVEL EXPENSE	1,454.63
		0272 M -	ATTORNEY MISCELLANEOUS	1,155.46
			GRAND TOTAL:	21,457.72
7/27/84	0272 E	SMITH, EDWIN D.		4.00
7/27/84	0272 F	SMITH, EDWIN D.		4,940.00
7/27/84	0272 M	SMITH, EDWIN D.		2,960.71
		TOTALS:		
		0272 F -	ATTORNEY FEES	4,940.00
		0272 E -	ATTORNEY TRAVEL EXPENSE	4.00
		0272 M -	ATTORNEY MISCELLANEOUS	2,960.71
			GRAND TOTAL:	7,904.71
8/16/84	0272 E	SAUNDERS, JR., FRANK		2.32
8/16/84	0272 F	SAUNDERS, JR., FRANK		495.62
8/16/84	0272 M	SAUNDERS, JR., FRANK		29.38
8/29/84	0272 E	SAUNDERS, JR., FRANK		36.30
8/29/84	0272 F	SAUNDERS, JR., FRANK		3,828.75
8/29/84	0272 M	SAUNDERS, JR., FRANK		315.27
9/20/84	0272 E	SAUNDERS, JR., FRANK		1,365.02
9/20/84	0272 F	SAUNDERS, JR., FRANK		12,910.00
9/20/84	0272 M	SAUNDERS, JR., FRANK		653.12
1/10/85	0272 E	SAUNDERS, JR., FRANK		156.20
1/10/85	0272 F	SAUNDERS, JR., FRANK		287.50
1/10/85	0272 M	SAUNDERS, JR., FRANK		3.28
1/29/85	0272 E	SAUNDERS, JR., FRANK		1,191.98
1/29/85	0272 F	SAUNDERS, JR., FRANK		14,420.00
1/29/85	0272 M	SAUNDERS, JR., FRANK		1,611.67
2/05/85	0272 E	SAUNDERS, JR., FRANK		8.37
2/05/85	0272 F	SAUNDERS, JR., FRANK		1,804.38

KANSAS INSURANCE DEPARTMENT
HEALTH CARE STABILIZATION FUND
DEFENSE COSTS

DATE	OBJECT	VENDOR	AMOUNT
2/05/85	0272 F	SAUNDERS, JR., FRANK	828.75
2/05/85	0272 M	SAUNDERS, JR., FRANK	242.98
2/05/85	0272 M	SAUNDERS, JR., FRANK	48.48
3/22/85	0272 E	SAUNDERS, JR., FRANK	178.36
3/22/85	0272 F	SAUNDERS, JR., FRANK	2,963.75
3/22/85	0272 M	SAUNDERS, JR., FRANK	388.09
4/29/85	0272 F	SAUNDERS, JR., FRANK	1,821.25
4/29/85	0272 M	SAUNDERS, JR., FRANK	36.83
		TOTALS:	
		0272 F - ATTORNEY FEES	39,360.00
		0272 E - ATTORNEY TRAVEL EXPENSE	2,938.55
		0272 M - ATTORNEY MISCELLANEOUS	3,329.10
		GRAND TOTAL:	45,627.65
9/27/84	0272 E	ATHERTON, JOHN G.	128.89
9/27/84	0272 F	ATHERTON, JOHN G.	2,543.67
9/27/84	0272 M	ATHERTON, JOHN G.	55.25
		TOTALS:	
		0272 F - ATTORNEY FEES	2,543.67
		0272 E - ATTORNEY TRAVEL EXPENSE	128.89
		0272 M - ATTORNEY MISCELLANEOUS	55.25
		GRAND TOTAL:	2,727.81
12/14/84	0272 F	EISENBRANDT, JAMES L.	9,256.00
12/14/84	0272 M	EISENBRANDT, JAMES L.	3.60
3/19/85	0272 F	EISENBRANDT, JAMES L.	1,792.50
3/19/85	0272 M	EISENBRANDT, JAMES L.	1.50
5/24/85	0272 F	EISENBRANDT, JAMES L.	182.00
5/24/85	0272 M	EISENBRANDT, JAMES L.	4.00
		TOTALS:	
		0272 F - ATTORNEY FEES	11,230.50
		0272 M - ATTORNEY MISCELLANEOUS	9.10
		GRAND TOTAL:	11,239.60
1/30/85	0272 F	PETERSON, JOHN L.	1,001.00
1/30/85	0272 M	PETERSON, JOHN L.	119.58
		TOTALS:	
		0272 F - ATTORNEY FEES	1,001.00
		0272 M - ATTORNEY MISCELLANEOUS	119.58
		GRAND TOTAL:	1,120.58
2/21/85	0272 E	WHITE, ROBERT L.	41.25
2/21/85	0272 F	WHITE, ROBERT L.	3,672.50
2/21/85	0272 M	WHITE, ROBERT L.	87.62
		TOTALS:	
		0272 F - ATTORNEY FEES	3,672.50
		0272 E - ATTORNEY TRAVEL EXPENSE	41.25
		0272 M - ATTORNEY MISCELLANEOUS	87.62
		GRAND TOTAL:	3,801.37

DATE	OBJECT	VENDOR		AMOUNT
3/06/85	0272 F	VANPARYS, DAVID C.		221.00
		TOTALS:		
			0272 F - ATTORNEY FEES	221.00
			GRAND TOTAL:	221.00
5/24/85	0272 F	RUSE, STEVEN D.		130.00
5/28/85	0272 F	RUSE, STEVEN D.		1,365.00
5/28/85	0272 M	RUSE, STEVEN D.		119.13
		TOTALS:		
			0272 F - ATTORNEY FEES	1,495.00
			0272 M - ATTORNEY MISCELLANEOUS	119.13
			GRAND TOTAL:	1,614.13
		TOTALS:	0272 F - ATTORNEY FEES	1,177,719.39
			0272 E - ATTORNEY TRAVEL EXPENSE	89,320.38
			0272 M - ATTORNEY MISCELLANEOUS	284,772.02
			0279 C - COURT COPIES	35,790.85
			0279 D - DEPOSITIONS	51,808.46
			0264 C - COURT REPORTING	1,836.60
			GRAND TOTAL:	1,641,247.70

Attachment XIV

DEFENSE OF THE HEALTH CARE STABILIZATION FUND

The defense of the Health Care Stabilization Fund begins immediately upon notification to the Fund of a medical malpractice claim under K.S.A. 40-3409. An attorney for the Fund is always and immediately appointed to defend the Fund in a case where the circumstances warrant it. This determination is made upon notification from the primary carrier as to whom was appointed to defend the provider by the primary carrier and is made early in the first few weeks of litigation or of initiation of a claim if no lawsuit has been filed. The attorney defining the provider is instructed to advise the Fund immediately if the exposure against the provider encroaches on the Fund's limits and if the Fund's best interests would be better served if independent counsel were appointed. The files are reviewed every thirty days by the Fund, and the attorneys are asked to report the Fund with an ongoing evaluation of the case every thirty days.

The facts of each particular claim or case will dictate the appropriate attorney to appoint. Each case will present unique aspects requiring the consideration of factors in making the choice of an attorney.

One of the single most important considerations is the expertise of the attorney being considered for appointment. The attorney will have experience in trial defense work, preferably medical malpractice defense work, and will have familiarity with the Health Care Stabilization Fund and the statutes governing the Fund. Evaluation of the attorney's expertise also includes consideration of his or her exposure to the particular topic involved in the lawsuit. Some attorneys have had specialized experience trying particular types of medical malpractice lawsuits. For example, brain damaged baby cases will generally be defended by attorneys who have had experience trying brain damaged baby cases.

In those cases where the Fund appoints an attorney to defend a particular health care provider, preference will be given to the choice of the health care provider if the provider volunteers his preference. The provider will be more cooperative and make a better appearance in depositions and in trial if he or she feels comfortable with his or her attorney. If the provider's choice is not appropriate for the particular situation, the reason for making an alternative appointment are carefully explained to the provider so that he or she may appreciate that the Fund weighed the choice.

Location of the attorney may be important. Attorneys located in the same general location of the court or location of the alleged malpractice episode may have greater familiarity with the people or procedures involved with the case. However, in some instances, it is advantageous to have a fresh prespective, an "outsiders" view of the situation. The choice, again, depends upon the exigencies of the particular case.

July 17, 1985
DM/sd

7/18-19/85

Alternative Health Care Stabilization Fund
Surcharge Strategies
As Requested By The
Citizens Advisory Committee

The attached exhibits provide HCSF balance information which has been derived from the HCSF past experience data that has been modified by utilizing different HCSF surcharge percentages. The graph on the reverse side of this page provides a visual comparison of the constant 45% surcharge model and the actual HCSF surcharges levied.

Exhibits I and II develop what the HCSF balance would have been if a constant 45% surcharge had been levied by the insurance department. The constant 45% surcharge model is no consistent with the statutory surcharge provisions of K.S.A. 40-3401 et seq.

Exhibit III provides another HCSF surcharge model by attempting to determine what the HCSF surcharge percentage would have been if the accrual funding requirement had been implemented immediately after the $10 million balance was achieved. This model, like the 45% constant surcharge scenario is not consistent with the statutory provisions of K.S.A. 40-3401 et seq.

Finally, the following table presents a comparison of the total HCSF surcharge levied by the insurance department.

Surcharge Procedure	FY-77 to FY-84 Total HCSF Surcharge Revenue
In accordance with K.S.A. 40-3401	$17,282,016
At 45% - Exhibits I and II	$36,521,683
Accrual Funding after $10 million balance - Exhibit III	$45,736,478

7/18-19/85
Attachment XV

COMPARISON OF THE 45% HCSF MODEL SURCHARGE TO THE ACTUAL HCSF SURCHARGES

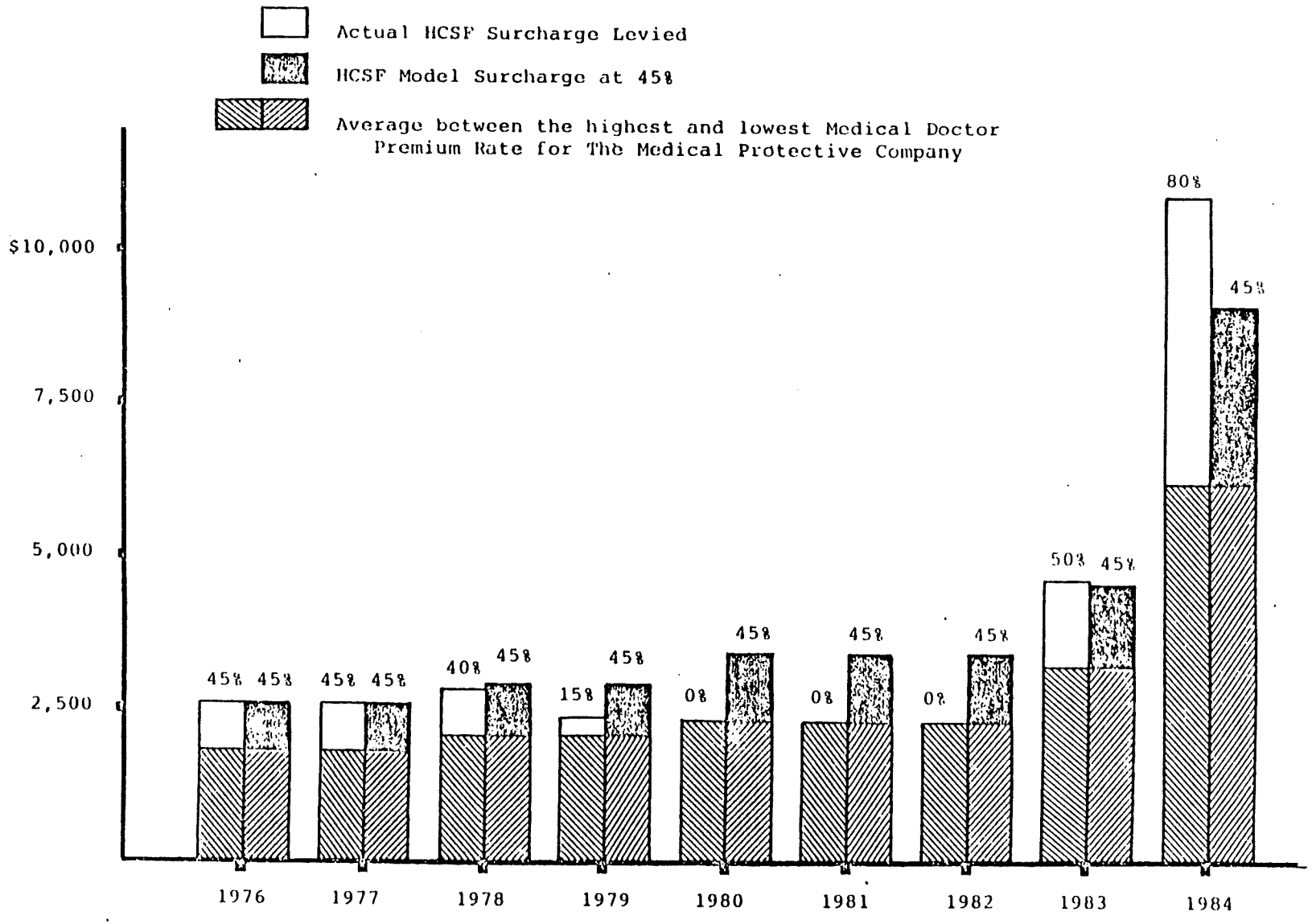

Exhibit I

Fiscal Year Ending June 30	Basic Coverage Premium*	HCSF Revenue at 45% Surcharge*	Actual Losses and Expenses	Cummulative Balance with Est. Invest. Income**	Actuarial Estimation of HCSF Accrual Losses Payment Responsibility
1977	$ 7,427,684	$ 3,342,458	$ 176,574	$ 3,482,472	$10,000,000 By Statute
1978	7,638,346	3,512,160	74,811	7,611,803	$10,000,000 By Statute
1979	7,842,064	4,094,168	216,561	12,638,351	$10,000,000 By Statute
1980	8,157,421	3,774,023	161,111	17,876,389	$10,400,000
1981	9,392,632	4,512,033	1,265,671	23,235,026	($18,687,000 Discounted)
					$24,851,000 Undiscounted
1982	10,782,790	5,215,876	3,208,737	27,766,381	($19,877,000 Discounted)
					$27,464,000 Undiscounted
1983	11,73[illegible],289	5,279,980	6,005,222	29,745,253	($22,632,000 Discounted)
					$32,277,000 Undiscounted
					($37,746,000 Discounted)
1984	15,091,012	6,790,955	7,881,026	31,520,700	$47,183,000 Undiscounted
6-30-1984	$78,065,238	$36,521,683	$18,989,713	$31,520,700	$47,183,000

*Based on policies made effective July 1 through June 30 of each fiscal year. HCSF revenue includes excess income from the HCPIA Act in FY 78, FY 79, FY 80, FY 81, and FY 82.

**Investment Income estimated at 10%.

Rev:7-19-85

Exhibit II

HCSF MODEL BALANCE AT 45% SURCHARGE

HCSF ACTUAL BALANCE

HCSF ACTUARIAL ACCRUED LOSSES

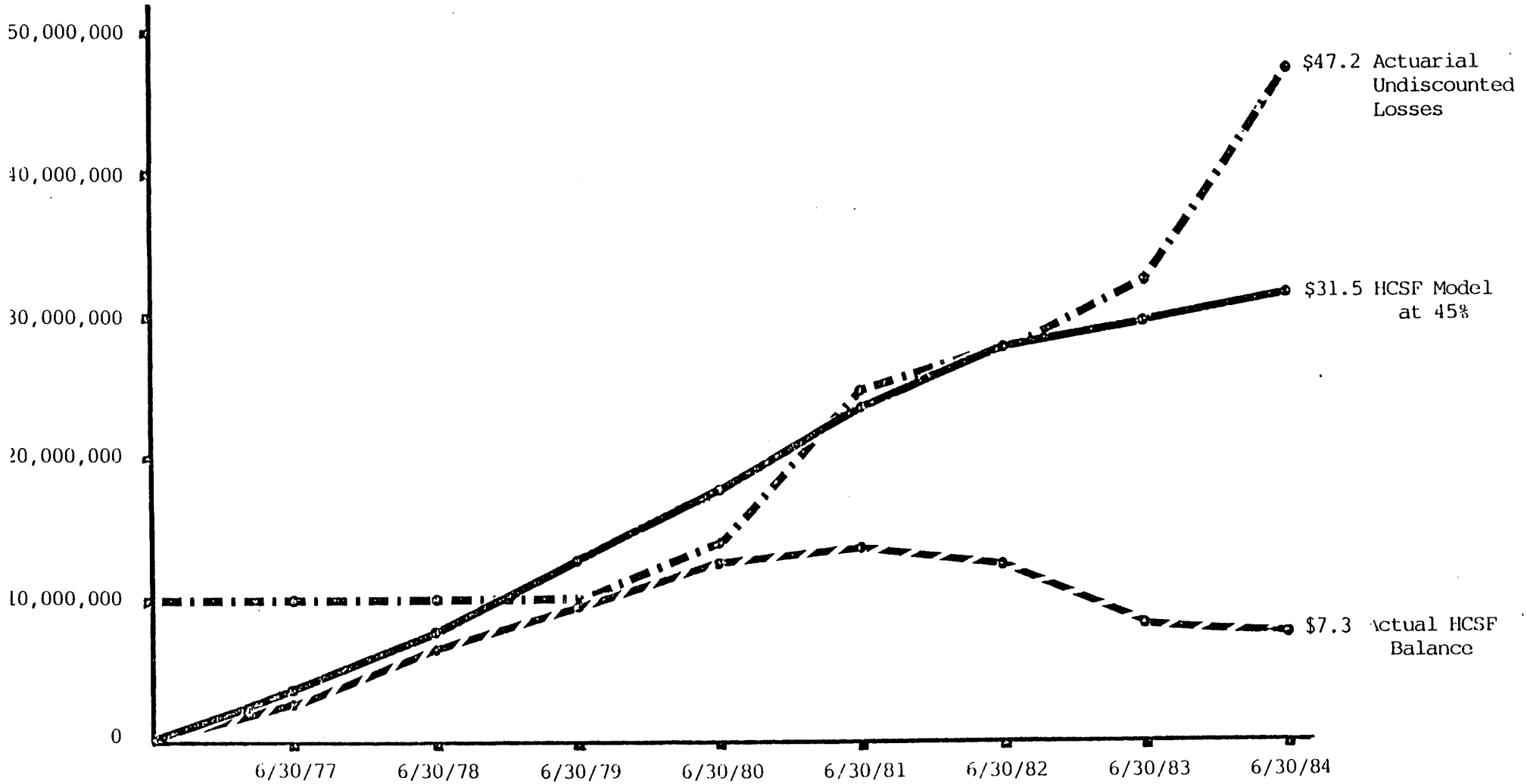

Exhibit III

ASSUMED HCSF MODEL

ACCRUAL FUNDING OF DISCOUNTED* LOSSES

Fiscal Year Ending 6/30	HCSF Surcharge Percentage	HCSF Surcharge Receipts	Cummulative HCSF Balance
1977	45%	$ 3,342,458	$ 3,482,472
1978	45%	3,512,160	7,611,803
1979	40%	3,702,064	11,313,867
1980	0		12,217,073
1981	65%	6,460,000	18,762,274
1982	30%	3,234,837	20,667,211
1983	50%	5,866,644	22,581,497
1984	130%	19,618,315	37,750,665

*Discounted means that future interest income projections have been estimated in determining the needed HSCF accrual balance. For example, if the HCSF ceased operation on June 30, 1984, and the HCSF balance was $37,750,665 future investment income would pay out a total of approximately $47,183,000.

Attachment XVI

Attachment XVI

BASIC PROFESSIONAL LIABILITY INSURANCE RATES (1)

FISCAL YEAR	The Medical Protective Co.	St. Paul Fire & Marine Ins. Co.	HCPIA Plan
1977	$ 1,800	$ 1,981	The
1978	$ 1,800	$ 2,350	Rates
1979	$ 2,047	$ 2,350	for the
1980	$ 2,047	$ 2,944	Plan
1981	$ 2,394	$ 3,922	have been
1982	$ 2,394	$ 4,599	higher
1983	$ 2,394	$ 4,599	than the
1984	$ 3,112	$ 6,843	Rates
1985	$ 6,102 (2)	$ 12,154 (2)	of the
1986	$ 6,815 (2)	$ 14,022 (2)	companies (3)

HEALTH CARE STABILIZATION FUND INFORMATION

FISCAL YEAR	% Surcharge Levied	Ending FY Balance (4)	Number of Claims/Suits Filed	Number of Settlements	Settlement Amounts	Number of Judgements	Judgement Amounts	Legal Defense Costs (5)
1977	45%	$ 2.6	5	1	$ 137,500	0	0	$ 9,605
1978	45%	$ 6.2	38	0	$ 0	0	0	$ 2,129
1979	40%	$ 9.3	26	3	$ 208,393	0	0	$ 27,038
1980	15%	$ 12.3	82	0	0	0	0	$ 60,012
1981	0%	$ 13.4	100	8	$ 1,773,182	0	0	$ 137,672
1982	0%	$ 12.4	124	24	$ 3,060,127	0	0	$ 169,065
1983	0%	$ 8.3	156	21	$ 5,216,494	4	$ 1,298,757	$ 364,020
1984	50%	$ 7.3	179	30	$ 6,670,288	4	$ 3,786,166	$ 501,128
1985	80%	$ 9.1	230	36	$ 11,680,220	4	$ 1,444,041	$ 612,652
1986	110%	<---------- Current Fiscal Year ---------->						

NOTES:
(1) These are the MEAN rate levels; that is, the average of the lowest and highest rate level for each company.
(2) These rates are at the $200,000/$600,000 limits. Rates for 1977 through 1984 are at the $100,000/$300,000 limits.
(3) The Board of Govenors of the Plan have attempted to maintain rate levels greater than the premium rates utilized by the voluntary insurance companies. At the present time, Plan rates are generally 20% greater than the premium rates utilized by St. Paul Fire & Marine Insurance Company.
(4) Millions of dollars.
(5) Legal Defense Costs shown include Attorney Fees, Court Reporting Fees, Deposition Costs, Doctor Fees and Hospital Fees incurred in the defense of claims and suits.

7/18-19/85

KANSAS CLOSED CLAIMS INFORMATION[2]

Total Number of Closed Claims	No. Closed with Payment	Loss Payment[1]	Total Cost[1]	Average Claim Cost
284	139	$ 2.4	$ 3.5	$ 17,014
298	159	$ 2.0	$ 2.8	$ 12,704
309	156	$ 2.1	$ 3.0	$ 13,746
293	152	$ 3.4	$ 4.2	$ 22,168
366	164	$ 3.5	$ 4.5	$ 21,148
335	155	$ 3.9	$ 5.3	$ 25,564
359	157	$ 4.9	$ 6.6	$ 30,910
328	139	$ 4.3	$ 5.7	$ 31,345

<---------- Current Calendar year ---------->

(Above data is for calendar years 1977 to 1984)

NOTES: (1) Millions of Dollars

(2) Information is summarized on a calendar year basis and does not include HCSF data. Information regarding the number of settlements and judgements was not readily available from the summarized information. See K.S.A. 40-1126 and K.S.A. 40-1127.

KANSAS AUTOMOBILE LIABILITY vs. MEDICAL MALPRACTICE

Year	Line	Direct Written Premium	Direct Earned Premium	Direct Losses Paid	Premium Written to Loss Paid
1983	Auto Liability B.I.*	134,211,000	132,149,000	74,954,000	56.0
	Medical Malpractice	11,519,000	10,885,000	9,105,000	79.8
1982	Auto Liability B.I.*	126,150,000	120,667,000	69,422,000	55.0
	Medical Malpractice	10,085,000	9,768,000	5,280,000	52.4
1981	Auto Liability B.I.*	106,766,985	105,847,018	61,148,473	57.3
	Medical Malpractice	9,406,619	8,826,566	4,579,721	48.7
1980	Auto Liability B.I.*	101,451,245	98,126,997	54,147,282	53.4
	Medical Malpractice	8,327,482	7,709,223	2,294,729	27.6
1979	Auto Liability B.I.*	87,902,112	84,875,399	45,497,322	51.8
	Medical Malpractice	6,982,428	6,784,969	2,684,116	38.4

* Auto Liability - B.I. is Kansas Private Passenger and Commercial Automobile Residual Bodily Injury data. It does not include Personal Injury Protection premium and loss experience.

Attachment XVII

7/18-19/85

Attachment XVII