MINUTES

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

September 12-13, 1985

Statehouse

Members Present

Representative Joe Knopp, Chairman
Senator Jack Walker, Vice-Chairman
Senator Roy M. Ehrlich
Senator Paul Feleciano
Senator Frank D. Gaines
Senator Jeanne Hoferer
Senator Nancy Parrish
Senator Jack Steineger
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

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

Jerry Slaughter, Kansas Medical Society
Dr. Larry Anderson, Kansas Academy of Family Physicians, Wellington
Harold Riehm, Kansas Association of Osteopathic Medicine
Dr. James Rider, D.O., Valley Falls
Dr. Mike McClintick, D.O., Eureka
Anita Jacoby, R.N. and ARNP
Dr. Samuel Jones, Johnson County
Dr. Steve Myrick, Lawrence
Dr. Stanley Skaer, Eureka
Rick Clasen, Eureka Chamber of Commerce
Dodson Bradbury, Greenwood County Hospital Administrator
Ann Rogers, Kansas Association of Nurse Anesthetists, Emporia
Tom Bell, Kansas Hospital Association
Curt Erickson, Great Plains Health Alliance
Dr. Lauren Welch, Wamego
Martha Carr, Concerned Consumers, Wichita
Kathern Forrest, American Association of Retired Persons
Ralph Gundelfinger, Providers Insurance Company
Mike Mullen, Medical Protective Company
Bob Olsen, Kansas
Bobbi Steinbacher, Great Bend

Others Present (continued)

Jan Payne, Wichita
Dr. Dan Roberts, Wesley Medical Center, Wichita
Ron Smith, Kansas Bar Association
Kathleen Sebelius, Kansas Trial Lawyers Association
Marsha Hutchison, Kansas Medical Society
Charles Belt, Wichita Chamber of Commerce
Ted Fay, Kansas Insurance Department
Stacie Hedges, Office of Judicial Administrator
Jack R. Cooper, M.D., Johnson County Medical Society
Lori Class, United Way and League of Women Voters
Joan Tempero, Kansas Medical Society Auxiliary
Mary Skeldon, Nursing Student, Washburn University
Jim McBride, United Way of Topeka
P. L. Davis, Governor's Office

September 12, 1985
Morning Session

The meeting was called to order by the Chairman, Representative Joe Knopp, at 9:00 a.m. in Room 313 of the Statehouse.

Jerry Slaughter, Kansas Medical Society, testified that a family practitioner doing obstetrics today is likely to pay $13,000 for required coverage and that an obstetrician can expect to pay $45,000 for required coverage. He stated the total medical malpractice insurance premium collected in Kansas for FY 1986 is estimated to be $48.5 million, or four and one-half times the $11 million paid in FY 1982. He also estimated that there will be 300 claims filed against the Health Care Stabilization Fund in 1986, which is over 12 times the amount of claims filed in 1979. He said the amount of money paid to claimants has increased from $3.6 million paid in 1980 to an estimated $22 million to be paid in 1985. Also, the average paid claim has increased from $23,700 per claim to $113,800. He further stated increased numbers of physicians are stopping high-risk services, such as obstetrics, due to the current liability environment. This affects the access to care, especially in the rural areas, he noted (Attachment I).

Mr. Slaughter stated the Kansas Medical Society recommends the following: (1) caps on awards, both pecuniary and nonpecuniary; (2) mandatory screening panels, with findings admissible in evidence; (3) peer review and reporting law changes suggested by the Kansas Healing Arts Board and Post Audit; (4) a uniform method of calculating future damages; (5) requiring expert witnesses to devote at least 75 percent of their professional time to clinical practice; (6) deletion of the "sunset" provision on Substitute for S.B. 110; (7) tying post judgment interest rates to a fixed standard, such as the T-bill rate; and (8) mandatory settlement conferences.

He said that he would have more specific recommendations for the October Committee meeting. The Committee questioned Mr. Slaughter about what causes the escalation of insurance premiums. He replied lawyers, physicians, insurance companies, courts, hospitals, and claimants all contribute to the problem.

Dr. Larry Anderson, President of the Kansas Academy of Family Physicians, testified his malpractice insurance premium is 7 percent of his gross income. He stated insurance premiums would have to be controlled or rural medicine would suffer. He said two doctors in LaCrosse paid malpractice insurance premiums of $8,600 in 1983 and in 1984 they paid $26,000. They delivered 30 babies in 1984, of which only 20 patients paid. They charged $500 a delivery and received $10,000. They paid out, however, approximately $18,000 in increased malpractice insurance. If these doctors quit delivering babies, he said, eventually the hospital in Rush County will have to close. Kansas produces about 40 family physicians a year, however, a lot of the new physicians are joining groups of practitioners in large communities instead of going to the smaller rural communities. He stated medical malpractice premiums in Nebraska are one-third of the Kansas premiums; in Oklahoma the premiums are 40 percent of the Kansas premiums; and in Missouri, 20 percent of the Kansas premiums. He stated when the malpractice insurance problem is eased, physicians will be more willing to practice in rural communities.

Dr. Anderson said that a system that will adequately compensate a damaged individual and identify, reprimand, educate, or rehabilitate the physician involved is needed.

Harold Riehm, Kansas Association of Osteopathic Medicine, introduced Dr. James Rider, D.O., of Valley Falls.

Dr. Rider explained he was appearing as Chairman of the Legislative Committee of the Kansas Association of Osteopathic Medicine and the Kansas Chapter of the American College of General Practitioners. In his testimony (Attachment II), he stated the Osteopathic Association recently adopted procedures for peer review and is now revitalizing its impaired physician procedures. He said they support the adoption of the Indiana Plan for tort reform.

Dr. Rider expressed the concern that osteopathic physicians in Kansas have only one large company, St. Paul Fire and Marine, that will write malpractice insurance. He said St. Paul's rates are twice as much as Medical Protective's rates. He urged the Legislature to provide the Insurance Department with the authority to correct the problem. He also urged that the Health Care Stabilization Fund be given adequate staff, both in size and experience, and that the Fund eventually be phased out entirely. Dr. Rider said that since his medical malpractice insurance fees had doubled, he felt he should double his $500 fee for delivering a baby.

Dr. Mike McClintick, an osteopathic physician, said that he has been practicing for five years at Eureka, Kansas. He delivers about 50 babies a year, he noted. He distributed a letter from his insurance company (Attachment III) showing his premiums. He said for a family physician, or general practitioner who performs obstetrical procedures, and excluding Caesarean sections, the projected premium was $6,911, plus the 110 percent surcharge of $7,602. For a family physician or general practitioner who performs minor surgery but no obstetrical, the projected premium was $5,222, plus the 100 percent surcharge of $5,745. He said this would mean that he and his partner will be paying $24,580 a year for medical malpractice insurance, in comparison to $3,496 in 1981.

Anita Jacoby, R.N. and ARNP, testified she works for two obstetrician/gynecologists in a Wamego clinic. She said these doctors were considering giving up their medical practice due to the extremely high malpractice insurance premiums and the increasingly uncomfortable atmosphere under which doctors must practice. Their malpractice insurance premium for 1983 was $13,500; for 1984, $27,500; and for 1985, $65,000. It is estimated that for 1986, the premium will be over $100,000, or one-third of their gross income. She said their income is fixed by Blue Cross/Blue Shield, Medicare and Medicaid, and by voluntarily freezing their other fees in response to a request from the American Medical Society (Attachment IV).

Dr. Samuel T. Jones of Kansas City, testified he is in favor of tort reform. He addressed the problem of the abusive treatment that children are subjected to in operating rooms in hospitals, and listed suggestions for legislative action to correct the problem (Attachment V).

Dr. Steve Myrick of Lawrence testified there is a need to revamp the legal treatment of medical injuries. He suggested it be modeled after workman's compensation. In the interim, before such a plan is implemented, he recommended restricting awards similar to the Indiana Plan. He said that the Health Care Stabilization Fund should be completely restructured or abolished.

In response to Committee question, he stated that he had recently attended a meeting on medical malpractice at Stormont-Vail Hospital. He also responded that the younger physicians are more likely to speak out when a colleague needs discipline. He said the hospitals and the State Board of Healing Arts will have to do more than they are doing now to alleviate the malpractice problem.

Dr. Stanley Skaer, Eureka, testified that he has never had a malpractice case filed against him, but his malpractice insurance premiums have increased from $921 in 1978 to $17,976 in 1985. He said this amounted to 25 percent of his gross income. He stated his overhead expenses are 50 percent of his gross income. He estimated that for each baby he delivered, over $300 of the fee was needed to pay for his malpractice insurance.

Dr. Skaer said doctors are quitting their practices and for every dollar of health care lost in small communities, three dollars are lost that would be spent for for food, lodging, and transportation. He also pointed out the problem of the increasing number of patients over 65 and the freeze on Blue Cross/Blue Shield and Medicare and Medicaid payments. He stated 28 percent of the physicians practicing obstetrics have stopped delivering babies and another one-third plan to stop. This greatly affects the availability of health care. He predicted small towns will not have hospitals and will have bandaid physicians.

He recommended structured settlements, a community standard of care, and restrictions on the use of out-of-state expert witnesses to those from Kansas and adjoining states. He also recommended that expert witnesses should have practiced or taught medicine during the last five years. He recommended limiting awards and the denial of all punitive damages.

In answer to Committee questions, Dr. Skaer stated the Board of Healing Arts should penalize physicians who have multiple claims by restricting their practices. He said he would support a revised rate structure that would take into consideration that he had no claims filed against him and which would not penalize him for the type of practice he was performing. He said that he had closed his practice for 30 days and later reopened it due to public support, loss of income for the hospital, and the belief something would be done by the Legislature to correct the problems. Dr. Skaer, in response to a question from a Committee member, said it was sound public policy to require medical liability insurance. The Chairman noted he had a folder of letters from citizens of Eureka, Kansas.

Richard Clasen, Editor and Publisher of the Eureka Herald and spokesman for the Eureka Chamber of Commerce Medical Task Force, testified (Attachment VI). He stated Eureka has one hospital which serves Greenwood, Elk, and Woodson counties. People attending weekend retreats at Fall River Reservoir, Toronto Reservoir, and Eureka Lake use the hospital for medical services. The hospital has the services of one surgeon, four full-time doctors, and two semi-retired physicians. Due to high malpractice premiums, the doctors have discussed cutting back on services or quitting altogether. There are 310 people directly involved in medical services in the county. The loss of these jobs would seriously impact the economy. He stated the hospital alone has an annual payroll of $1.2 million. He also said emergency medical care and overall health care is an important aspect in securing new businesses, and in holding on to those already located in rural communities.

Mr. Clasen recommended: (1) tort reform, specifically in the area of medical malpractice, with a cap of $500,000; (2) mandatory screening of all medical malpractice suits; (3) action by the Board of Healing Arts to curb health care providers who continually have malpractice litigation; and (4) allowing medical providers to pay into the stabilization fund monthly, rather than in advance.

Mr. Clasen's testimony included letters from EDCO Drilling Company of El Dorado, Eureka Unified School District 389, and the Greenwood County Farm Bureau Association supporting the recommendations of the Eureka Chamber of Commerce Medical Task Force.

Dodson Bradbury, Greenwood County Hospital Administrator, testified he is concerned that the doctors who serve the hospital may leave and the hospital will have to close. This would cause an economic impact on the community and the county. He stated during the month that Dr. Skaer quit practicing, the hospital had a shortfall of $69,000. Dr. Skaer resumed his practice and last month the hospital had a profit of $4,000. He said although not all of this was directly attributed to Dr. Skaer, a lot of it was. Mr. Bradbury requested the 1986 Legislature take action to solve the problems of the physicians.

Ann Rogers, Kansas Association of Nurse Anesthetists, testified she represents 370 practicing anesthetists in the state of Kansas (Attachment VII). She said part-time nurse anesthetists must pay the entire cost of malpractice insurance. Next year's premium is projected to be $6,000. Some will quit giving anesthesia, as they could make more money working part-time as a staff registered nurse, she said. A nurse anesthetist employed by a doctor or a hospital now usually receives malpractice insurance as a benefit, she said, but the insurance is becoming so expensive that job security is threatened in some areas.

Mr. Rogers recommended lowering the cost of malpractice insurance through limiting amounts of awards and how they are paid. She further recommended some mechanism to guarantee that qualified providers are administering anesthesia.

Tom Bell, Kansas Hospital Association, stated the Kansas Hospital Association supports the recommendations made by the Kansas Medical Society. He introduced Mr. Curt Erickson, President of the Great Plains Health Alliance.

Mr. Erickson testified his organization operates 24 hospitals in Kansas, including the Greenwood County Hospital. All of the hospitals except one are county, city, or district owned and have less than 50 beds. He expressed his concerns about the malpractice problems affecting the total health care of many people in rural Kansas. Malpractice coverage for some of the hospitals has increased 225 percent in the last three years. Some of their hospitals are located near Nebraska, where lower premiums exist. Doctors in Kansas are having second thoughts about practicing in Kansas, as some pay $12,000 a year for malpractice insurance, whereas doctors in Nebraska pay $1,000 a year.

Mr. Erickson stated they provide risk management services in their hospitals and they have set up a program of quality assurance to review all aspects of the hospitals operations. In answer to questions by the Committee, Mr. Erickson replied that when a physician, due to the cost of malpractice insurance, drops his obstetrical services, the whole family of the patient often seeks medical services elsewhere. This not only affects the local hospital, but also the economy of the community. A large amount of the patients in hospitals are elderly Medicare patients, he said. Due to the reduced coverage, the occupancy rate has dropped dramatically which increases the tax levy for public-owned hospitals, he said.

He said Nebraska does not have a Health Care Stabilization Fund, but they do have a cap on payments. The physicians who utilize his hospitals, he said have had very few malpractice claims filed against them. Mr. Erickson said he would not support a rating for rural doctors. All 24 hospitals are covered with malpractice insurance by St. Paul Fire and Marine.

The Committee recessed for lunch.

Afternoon Session

Dr. Lauren A. Welch of Wamego testified that he quit practicing as a surgeon on August 6, 1985, due to the high cost of malpractice insurance. He estimated his premiums for this year would be 40 percent of his income (Attachment VIII). He said he paid for an umbrella policy due to the risks involved. Dr. Welch cited inequalities which physicians encounter when obtaining malpractice insurance, such as being assigned to certain risk groups and no merit ratings. He recommended strongly that the tort system in medical malpractice should be abolished. In 1974, New Zealand adopted a no-fault system of compensation for medical "misadventure." In New Zealand, 90 percent of the premiums paid for medical misadventure insurance actually reach the injured as compensation, he said. Sweden also has a no-fault system, he noted.

In answer to questions by the Committee, Dr. Welch replied that the information he has obtained about New Zealand's no-fault system has come from books and periodicals, which are listed in his attachment, and from meetings and seminars he has attended. New Zealand has a national compensation system. There is one fund for all types of injuries that everyone pays into. They do not have a separate system for workman's compensation. A

Committee member stated New Zealand's no-fault pays in tiers, depending on the severity of the injury, and suggested the Committee obtain more information about New Zealand's no-fault plan.

Martha Carr, Concerned Consumers of Wichita, testified that 25 years ago, the bill for delivering her first child was $90 and five years ago, the bill was $950 for delivering her fourth child. A preschool physical this year she said cost $144. She said something had to be done to cut the cost of medical services. Mrs. Carr stated that doctors that have not had a claim filed against them should not have to pay the same malpractice insurance rates as a doctor who has had a claim. She also recommended lawyers should have a flat fee for medical malpractice cases and that there must be a cap on awards and settlements. She favored structured payments. In answer to Committee questions, Mrs. Carr said the Concerned Consumers are becoming organized and they will be informing legislators of their concerns soon. She also said that she did not believe a jury of 12 "lay people" should determine medical malpractice awards. She believed malpractice awards should be comparable with automobile accident awards.

Kathern Forest, American Association of Retired Persons, testified she repesents 230,000 members in Kansas. Her association supports mandating that medical review committees, governing boards of health care facilities, and the Board of Healing Arts investigate improper conduct, incompetence, and repeated malpractice of physicians. Boards, committees, and persons testifying before them should be given immunity from liability unless intentional fraud is involved. Health care facilities should be required to report unforeseen deaths or neurological damage to the Department of Public Health for investigation. She said that the state should limit the number of times that an applicant can take the physician licensure examination. She also recommended increasing the number of consumers on the State Board of Healing Arts (Attachment IX).

Ralph Gundelfinger, Providers Insurance Company, stated that the morning paper had a headline about a malpractice suit for $35 million filed against the University of Kansas Medical Center. He suggested there should be a law such as the federal court has which limits the amount which may be stated to "over $10,000." Staff stated that is the Kansas law, and it might be that the plaintiff released the information to the newspaper.

Mr. Gundelfinger said Providers Insurance Company supports the Indiana model law, with one exception. The exception concerns the medical review panel. The medical review panel, or screening panel, should be held after the suit is filed, then the evidence from the review panel would be admissible in court.

Mr. Mullen, Medical Protective Company, testified the Indiana Plan is the answer to the medical malpractice problems in Kansas. He said 30 percent of their total company payout in the last five years, has been to defense attorneys. The average payment in Kansas for the past five years has gone from $23,000 to $32,000. The average payment in Indiana, with a cap, went from $17,000 down to $14,000. In answer to a question by a Committee member, Mr. Mullen explained the $113,000 average payment figure given to the Committee by Mr. Slaughter included amounts paid by the Health Care Stabilization Fund.

Mr. Mullen stated Kansas has a medical malpractice lottery. Part of the problem is with the plaintiff's experts. He showed slides to the Committee and distributed two items on this subject (Attachments X and XI). Mr. Mullen stressed caps and structured settlements and awards. He said 90 percent of large lump sum awards are squandered by recipients within five years of the award. In answer to Committee questions, Mr. Mullen replied that his company does use out-of-state medical witnesses. They usually use the testimony of the first medical expert they select. If the expert finds there is a breach of care, the insurance company should try to settle the case. He stated they do not have any books or manuals on how to negotiate with the plaintiff's attorney. The amount of money they reserve is determined on the basis of whether they believe there is liability and what they believe the damages might be. The interest earned on the reserves does not cover the defense cost. Their reserves are examined annually by the various states' insurance departments and by the Internal Revenue Service. He stated their charter did not include osteopaths, but he had talked to his company and they will, in the future, write osteopaths on the same basis as they do medical doctors.

In reply to a question concerning negotiated structured settlements, Mr. Mullen said there should be a cap. He suggested a $500,000 cap. A lump sum is paid upfront and from this amount, attorney fees are paid. The attorney also receives a percent of the structured payments each time they are paid.

The Indiana Act is a limited no-fault act, he said. The no-fault aspect is on the layer from $100,000 to $500,000. In Indiana, the Fund pays out claims without regard to fault. The fault is determined before the claim is made on the Fund.

Bob Olson, Kansas City, testified that his son Brent was awarded the largest verdict to date in Kansas. He said the case should never have gone to trial. The hospital's expert, the doctors' experts, and the plaintiff's experts all agreed that it was obviously severe gross negligence. The parties involved, however, could not decide who was going to pay what amounts. He stated they offered to settle for about $4 million for their son. The jury awarded almost $15,000,000, of which $6,200,000 was for actual damages. The jury assessed punitive damages of $7,600,000 against the hospital and $1,200,000 against the doctors.

Mr. Olson stated putting a cap on awards would not take care of cases such as his son. He advocated settlements of cases and that something should be done to encourage settlements. He recommended that a better review be done of cases and that judges take a more active role in settlements.

In answer to Committee questions, Mr. Olson stated the jury for his son's case was predominantly male, but there were some older women. The occupations of the jury members were varied, such as a housewife, a school principal, a laborer, a Western Auto supervisor, and a retired grandmother. He said that the testimony lasted approximately a month. The parties involved did not protest that there was liability anytime up to the trial. All 12 jurors agreed on all parts of the verdict. The judge used Pattern of Instructions of Kansas (PIK) to instruct the jury on punitive damages. There was a motion for a new trial, but the amount of the award was not argued in the motion. In his experience, he said, jurors become swayed by emotion only when they become incensed, and most jurors take very seriously their responsibilities to society.

A Committee member asked whether this case had been settled for $4 million and the attorney fee had been 50 percent, would that have caused a problem. Mr. Olson responded that it would not have created a problem since the contract with the attorney was later modified. He also said he would not have been able to fund the $100,000 that it cost to prepare the case. He said that the attorney for the plaintiff should itemize the hours spent preparing a case, the hourly rate charged, and should itemize the expenditures. The judge should review this statement to see that the fees were not excessive, he said.

In reply to further questions by the Committee, Mr. Olson said they have received 30 percent of the $6.2 million award from the doctors. Part of the award was in a lump sum and the rest is structured. The probate court administers large sum judgments for minors. The hospital was found to be 70 percent liability and the doctors 30 percent by jurors. The hospital has appealed. He said the policy decision to assess premiums on health care providers to pay for losses due to malpractice is better than assessing taxes on the general populace, he said.

Bobbi Steinbacher of Great Bend testified that her daughter was misdiagnosed as having Hirschsprungs disease and was operated on three times by the physician who had misdiagnosed her daughter and ten other children. Subsequently, her daughter has had ten major abdominal surgeries in an effort to correct what the physician did to her daughter for a nonexistent disease. The doctor in question has been sued nine times and has settled out of court nine times, she said.

Mrs. Steinbacher said it would be wrong for the Legislature to further victimize the victims by placing caps on pain, suffering, and punitive damages. If doctors would police their own ranks by revoking the licenses of repeat offenders, she said the claims paid by insurance carriers and the Health Care Stabilization Fund would be greatly reduced and so would the premiums. She said malpractice cases are no different from any other civil lawsuit and they should be judged solely on their merit by a jury of their peers, not by legislators who cannot have full knowledge of each individual case (Attachment XII).

Jan Payne of Wichita testified her daughter was a victim of malpractice by the same doctor and for the same misdiagnosed disease as Mrs. Steinbacher's daughter. Her daughter underwent 23 surgeries, 11 of which were done by the doctor who had misdiagnosed the disease. She stated that it is wrong to limit awards to victims. Consumers should have the right to a trial by a jury of their peers with awards based on the facts of individual cases. She further stated it was also wrong to put a limit on what a victim is allowed to pay their attorney unless the doctor's defense attorney also has his fee restricted. The defense should also be restrained on how long they can postpone and drag out cases.

Mrs. Payne, in answer to Committee questions, said medical expenses for her daughter since September, 1975, have been $250,000. It now costs $400 a month for medical expenses for her daughter. The reason it was settled out of court was because they were offered enough money. She would not settle out of court if she had to make the decision again, she said because she felt that the doctor needed to be exposed by a competent attorney. She said a $500,000 structured settlement would have limited the recovery she received for her daughter but that the settlement her daughter received was structured. The settlement was made in December, 1980, and the money is in a conservatorship in the Hutchinson State Bank, she said.

In addition to her prepared testimony (Attachment XIII), Mrs. Payne presented to the Committee copies of "Public Citizen, Medical Malpractice, the Need for Disciplinary Reform, Not Tort Reform" (Attachment XIV); "The Washington Post National Weekly Edition," September 16, 1985, "Dangerous Doctors: Few Are Disciplined by State" (Attachment XV); Journal of Health, Politics, Policy and Law, Volume 9, Number 4, Winter, 1985, "State Responses to the Malpractice Insurance "Crisis" of the 1970s, an Empirical Assessment" (Attachment XVI); "National Insurance Consumer Organization, Insurance Companies "On Strike" NADER/NICO Charge: Federal Solution Sought" (Attachment XVII); Address by Natwar M. Gandhi, Group Director, Tax Policy, General Government Division, U.S. General Accounting Office (Attachment XVIII); Omnibus Reinsurance Act of 1985 (Attachment XIX); a letter and attachments from Ron M. Landsman, Counsel, National Insurance Consumer entitled Organization (Attachment XX); and from the New England Journal of Medicine, March 21, 1985, a special report, entitled "The Ethics of Professional Regulation" (Attachment XXI).

In reply to further questions by the Committee, Mrs. Payne stated that the tissue committee at the hospital should have discovered her daughter did not have Hirschsprung's disease. The State Board of Healing Arts was reluctant to proceed against the doctor. The parents filed a complaint before the Board by petition.

A letter was passed out to the Committee from Mrs. Joseph A. Vaughn, Bird City, Kansas (Attachment XXII), requesting that the Committee set legal guidelines to standardize actual damage awards in medical malpractice cases.

The meeting was adjourned until 9:00 a.m., Friday, September 13, 1985.

September 13, 1985
Morning Session

The meeting was called to order by the Chairman, Representative Knopp at 9:00 a.m. in Room 514-S of the Statehouse.

Dr. Dan Roberts, Chairman, OB/GYN, Wesley Medical Center, Wichita, testified (Attachment XXIII) on the subject of risk management in a changing liability environment and showed slides explaining his risk management program. He stated a clinical screening system called risk management is used to improve the clinical identification and early analysis of any problem that has occurred, for intervention as well as for assessment, and also for the future assessment for quality care. The purpose is to eliminate bad practices that may be going on and to replace them with up to date practices. This model program is being developed for Wesley Medical Center. He stated if an unexpected patient care event occurs, it would be reported on an appropriate form, the critical analysis worksheet, that goes to the quality assessment coordinator for loss prevention. The quality assessment coordinator is a trained triage person who makes sure that facts are reported, who checks on the condition of the patient, and who sends the form to a physician for analysis or puts the form into the system as having been reported. The triage person would probably be a combination medical records clerk analyst as well as a nurse. The chart then goes from the quality assessment coordinator to the clinical risk management committee. A physician analyst evaluates the completeness of the medical record and formulates alternate hypotheses as to the circumstances precipitating the event. The case is referred to the clinical chairman when indicated. The clinical analysis worksheet and all supporting documentation is considered confidential information and is not duplicated except for one copy to the senior vice-president. This copy is maintained in a locked file cabinet.

In reply to Committee questions, Dr. Roberts stated a regional reporting system for the entire state would be desirable. At Wesley Medical Center, there had only been two events in the last six months that Dr. Roberts, as Chairman, had to be involved in, and the physician analyst probably had 25 events he had to be involved in. He said this system was designed to reduce the injuries to patients, reduce the amount of malpractice claims, and eventually reduce insurance rates. He said there should be reasonable caps on injuries. The caps should be large enough to adequately compensate the individual. He also agreed that structured settlements were reasonable.

A Committee member asked if this peer review and risk management plan had made an impact at Wesley Medical Center. Dr. Roberts replied peer review is confidential, however, he could say he has seen a significant impact on small things. No major things have taken place. He stated he was requested by the Medical Society to share with the Committee the risk management plan. He is Chairman of the personal liability subcommittee of the Medical Society and has been requested to set up a risk management program for the state. He is not requesting the Committee to enact any legislation.

In response to a question about standard of care, Dr. Roberts said there is a standard involving standard deviations above and below it. There is more than one way to do things. The standard of care in small rural communities is not the same as in large medical centers, because they do not have the same environment.

Ron Smith, Kansas Bar Association, informed the Committee that a recent trial magazine article, "Jury Verdict Research," indicated Kansas was 9 percent above the national average for jury verdicts on all lines of personal injury cases. He noted that one of the conferees had said Kansas ranked ninth among the states in regard to high jury awards. In response to the testimony presented by Mr. Mullen yesterday on expert witnesses, he stated the fees paid to expert witnesses and the method of payment is relevant evidence for the jury because it goes to the bias of the witness. He further testified when the Indiana Plan was enacted, the Governor of the state was a physician and the Legislature was sympathetic to insurance concepts and major insurance companies had made Indiana their home state. The Indiana Plan is an insurance company's idea of what constitutes justice in the malpractice area.

Mr. Smith suggested further fine tuning of the tort system may be needed. He recommended the repeal of the excessive post-judgement interest rate. He stated it could be tied to the T-Bill rate. He recommended requiring proof of the present value of future damages through the use of special verdicts and restructuring screening panels to make them do what they were intended to do (Attachment XXIV).

In answer to a question by a Committee member, Ron Smith stated the law defines malpractice as the deviation from the ordinary standard of care. The ordinary standard of care is set by another physician of similar training who testifies as an expert witness.

Kathleen Sebelius, Executive Director of the Kansas Trial Lawyers Association, informed the Committee that the Brent Olson malpractice case which was presented yesterday has been the only punitive damage award malpractice case in Kansas. In regard to the no-fault plans referred to in New Zealand and Sweden, she stated in countries that have socialized medicine, medical care is an automatic part of the tax base for all citizens. They do not have to buy medical care on the open market. The doctors are part of this system and cannot charge whatever they choose. Everyone is compensated regardless of negligence, therefore, awards are limited. Future medical costs are automatically paid for, so they do cap awards. She explained the Indiana Plan should not be compared to the no-fault plan. She also said the $500,000 cap in Indiana was instituted in 1975, which was ten years ago. No state has imposed a cap on victims' payments since the mid 1970s. During the recent wave of medical malpractice legislation, states including Illinois, Florida, and New York, have rejected a cap on awards.

Pennsylvania recently conducted a study which was co-sponsored by the Medical Society, the Trial Lawyers Association, and the Bar Association. Pennsylvania also rejected caps on awards. She suggested the Committee should hear from representatives from Pennsylvania. In regard to structured settlements, she said, most large awards are structured now. The Health Care Stabilization Fund now cannot pay out more than $300,000 per claim, per year. If the award was large, then the payments from the Fund would be a form of structured payments.

Ms. Sebelius recommended requiring the claimant's attorney file an affidavit, setting forth that a medical expert had reviewed the claim and found it to be meritorious with every case filed in court. If no affidavit was filed or no expert was available, the claimant then would be required to proceed with a screening panel comprised in the manner set forth under current law. Sanctions should be set forth in the law for any findings by the court of any false statements in the affidavit. Mandatory settlement conferences, she said, should be required in every medical malpractice case within the first 90 days to be conducted by a judge other than the trial judge. She said trial judges should educate attorneys on the use of the current frivolous lawsuit statute.

She also recommended that the liability of the Fund be reduced from $3 million to $1 million. To further reduce the financial pressure on nonnegligent providers, she suggested that a rating experience factor should be added to the surcharge for those providers with claims, settlements, or judgements against them. Providers insured with St. Paul pay almost double the premiums paid by doctors insured with Medical Protective, she noted. To further reduce the burden on doctors with the highest premiums, the surcharge should be averaged, then all doctors in one class would pay the same surcharge, regardless of their primary carrier. The premium burden under the Fund could be reduced by requiring risk management programs and by better monitoring of insurance rates and data.

The Trial Lawyers recommendations for preventing medical negligence were to toughen reporting requirements and repeal the confidentiality of peer review. She said that every settlement or judgement of malpractice against a provider should be automatically referred to the Board of Healing Arts. She said the Board of Healing Arts should be given powers such as public censure, suspension, delicensure, and the ability to impose fines. She said peer review and risk management should be mandated and that a class E felony crime should be created to cover providers who, while under the influence of alcohol or drugs, treat patients. She supported all of the recommendations of the General Counsel of the Board of Healing Arts and the Legislative Post Audit study. She said the Western Insurance Company, which operates the state JUA, should be required to notify the Board of Healing Arts when the likelihood of repeated negligence or questionable procedures become evident in claims filed.

In regard to structured judgements, she said the Trial Lawyers Association does not recommend that all judgements and settlements over a certain amount be mandatorily structured. The Association recommends the consideration of itemized jury verdicts as long as the basic issue of liability was not reopened and that consideration should be given to structuring payments for future medical care. She opposed limitations on the amount or percentage of contingent attorney fees. Ms. Sebelius suggested the Committee should not accept any remedy which restricts or impedes the rights of the victims to be fully compensated for their damages, or limits the liability of negligent health care providers, or which is not designed to benefit the nonnegligent providers (Attachment XXV).

Ms. Sebelius distributed to the Committee copies of "Medical Malpractice State-by-State Review" (Attachment XXVI), and "Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform."

In answer to Committee questions, Ms. Sebelius said no state requires doctors to carry more than $1 million of insurance. Some doctors do carry more insurance and she would find out the names of reinsurance companies for the Committee. Offers of settlements are not told to the jury because it is totally irrelevant as to the negligence of the doctor. Attorneys do participate in structured settlements and do spread their fees out through the structured settlements.

Ms. Sebelius said she would give staff and the Chairman the complete state-by-state laws. She said she would be willing to provide some people from Indiana for the October meeting who could give a different view of the Indiana tort system. She also offered to contact some representatives of the Bar Association and the Medical Society in Pennsylvania and see if they would come to Kansas and testify before the Committee.

The Committee recessed for lunch.

Afternoon Session

Staff noted that the August 15-16 Committee minutes on page 7 needed to be corrected to add Representative Buehler's name and delete Representative Knopp's name as one of the Committee members appointed informally to review the Bell Committee's activities. Staff noted punctuation and grammatical errors would be corrected in the minutes.

Representative Brady moved the Committee approve the minutes of July 18-19 and August 15-16, as corrected. Senator Walker seconded the motion. The motion passed.

Mike Heim summarized the material the staff would be presenting to the Committee. He distributed information on closed claims against doctors (Attachment XXVII). He stated that he had requested from the Insurance Department claims paid information reflecting payments by the primary carriers and the Fund on individual health care providers with multiple claims in a way in which the identity of the provider would be protected from the mid 1970s to the present time. He noted that he had offered the services of the Research Department to compile this information. He noted, however, that the Insurance Department had provided only a part of the information requested. The 1984 and 1985 data for primary carrier payments was not complete, Mr. Heim noted. He also said that the Insurance Department had said it could not match the primary carrier closed claims with the claims information of the Health Care Stabilization Fund distributed in July (see Attachment XXVIII).

A Committee member asked why the information was not available from the Fund. Ted Fay from the Insurance Department explained the figures on the two reports were from two different computer systems. He said they have a new claims person employed who will start Monday and his first task will be to pick out the information from the files that go with the claims that were reported on the closed claims reports of the primary insurers. Mr. Fay said the Insurance Department would like all of the information to be available, but the statute covering closed claims reports received from the insurance companies will not allow any information to be provided that might identify a doctor. He noted that some of the files are sealed by the courts. He stated the Insurance Department plans to merge the two reports into one report that will give the Committee the information requested. He said they have asked for legal opinions on what information they can release. He suggested maybe the Legislature needed to clarify the matter.

The Chairman asked if the Committee issued a subpoena for the files if this would eliminate the problem. Mr. Fay said that he was not certain a subpoena would give the Insurance Department the authority to open the sealed files or violate the closed claims statute. Mr. Fay mentioned that Mike Dodson, who was the attorney for the Health Care Stablization Fund, had sent a letter to the Committee offering to testify as to the settlement process. A Committee member expressed dissatisfaction on not receiving the complete information that had been requested repeatedly. A Committee member suggested a court order could be obtained. The open meetings law and executive sessions were discussed. Staff counsel explained the procedure that was used where there was a situation similar to this.

Staff noted that Mr. Homer Cowan of the Western Insurance Company earlier had suggested to the Committee that there needed to be some way to deal with the problem of a small number of health care providers that are generating a large number of the claims. Staff noted also that the Board of Directors need to be able to determine whether an individual provider is causing an unreasonable drain on the Fund and therefore the claims history of an individual provider is needed. A Committee member suggested that the Insurance Department show on the report the defense costs paid by insurance companies and by the Fund.

Mike Heim reported he had asked the Insurance Department for a listing of the actual premiums and surcharges paid by physicians, DOs, chiropractors, and hospitals. He explained that the Insurance Department stores the information by Zip Code and that there were problems in clarifying what was needed and with the computer program. The report therefore was incomplete.

Staff then distributed a copy of a report (Attachment XXIX) which shows the average premium and surcharge costs for a physician based on the current 110 percent Fund surcharge prepared by the Insurance Department.

A Committee member asked why the Committee had not received the actuary report from the Insurance Department regarding the Fund and certain proposed tort reforms. Mr. Fay replied the report had been prepared, but needed some corrections and should be ready in a week.

Emalene Correll, Kansas Legislative Research Department, reviewed for the Committee a memorandum dealing with physician income for 1983 (Attachment XXX). A memorandum on malpractice insurance rate setting — Commonwealth of Virginia (Attachment XXXI) was distributed. She also handed out to the Committee copies of two articles from the publication Medical Economics, entitled "How Doctors' Economic Profiles Vary in 13 Major States" (Attachment XXXII), and "City vs. County Practice: Which Pay Off Best Today?" (Attachment XXXIII).

Bob Coldsnow, Legislative Counsel, reviewed articles from Best's Reviews, Property/Casualty Insurance Editions, July and August, 1985, "Insurance Premium Distribution — 1984" (Attachment XXXIV); "Property Casualty Executives Speak Out" (Attachment XXXV); "No More Free Lunches" (Attachment XXXVI); "U.S. Claims - - A Body Blow for Lloyd's" (Attachment XXXVII); "The Second Time Around" (Attachment XXXVIII); and "World Insurance Forum" (Attachment XXXIX).

Mary Torrence reviewed a memorandum on the recent Illinois, New York, and Florida medical malpractice legislation (Attachment XL).

Representative Buehler reported to the Committee on his attendance at the subcommittee meetings of the Citizens Committee for Review of the Tort System (Attachment XLI). He attended three meetings, the legal subcommittee meeting, the insurance subcommittee meeting, and the peer review subcommittee meeting. He said that no one had suggested no changes in the tort system were needed. He said the consensus was there was a problem that needed to be corrected. The concept of the Indiana Plan was favored by several of the

subcommittees. The peer review subcommittee examined the Board of Healing Arts. Representative Buehler said that in his opinion a significant amount of change needs to be made in the functions of the Board. Comments were made that the Health Care Stablization Fund has created a problem and progress should be made toward a point in time when the Fund could be eliminated and coverage turned over to private insurance carriers. He stated he was pleased with the effort made by the Bell Committee members to make meaningful recommendations.

Representative Sprague reported to the Committee on the subcommittee meetings of the Citizens Committee for Review of the Tort System. He distributed copies of the major recommendations and reports from the four subcommittees (Attachment XLII). He stated the reports of the subcommittees will be submitted to the full Committee on October 8, 1985. Hopefully, final copies of their recommendations will be available for the Medical Malpractice Committee meetings October 10-11.

Mike Heim distributed to the Committee copies of a working paper on medical malpractice issues prepared by the Legislative Research Department (Attachment XLIII).

An article was distributed (Attachment XLIV) from the National Underwriter, August 30, 1985, entitled "Illinois Lawyers Rush to Beat New Malpractice Law; File 1,000 Suits."

The Committee discussed proposals they would like to submit to an actuary to see what effect they would have on premiums, including: (1) a $500,000 cap, with no cap on future medical expenses; (2) a $500,000 cap; (3) a $1,000,000 cap; and (4) a $500,000 cap on nonpecuniary damages.

Senator Gaines made a motion that, based on all of the testimony, there is a major medical malpractice problem existing in Kansas and that this Committee should address itself to the problem and attempt to resolve the problem or Kansas will lose many of its medical providers. Representative Hoy seconded the motion.

After considerable discussion of the original motion Senator Steineger made a substitute motion that the Committee finds there is a problem with medical malpractice insurance premiums and surcharges and that the Committee believes in the future this problem could affect the health care delivery system in Kansas. Further, the Committee feels it is necessary that action be taken to address the medical malpractice insurance premium problem. Senator Feleciano seconded the motion. The motion passed unanimously.

The Chairman announced at the next meeting the Committee will discuss medical malpractice issues on Thursday, October 10, 1985, and on Friday, October 11, the Committee will hear comments from conferees from Indiana and from Pennsylvania.

The Chairman requested Committee members and conferees to draft proposals to be considered by the Committee at the October meeting. He also requested that staff update the working paper on issues and forward it to all of the Committee members.

The meeting was adjourned until 10:00 a.m., Thursday, October 10, 1985.

Prepared by Mike Heim

Approved by Committee on:

November 8, 1985
(date)

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Medical Malpractice: Update and Recommendations
Special Committee on Medical Malpractice
September 12, 1985

Update on Data

Malpractice Premiums: Earlier estimates on the increases effective July of this year were low. Current data shows that a family practitioner, doing obstetrics, is likely to pay $13,000 for required coverage. An obstetrician can expect to pay $45,000 for the required coverage. The total premium paid by health care providers in Fiscal Year 1986 is estimated at $48.5 million, almost 4.5 times the $11 million paid in FY 1982.

Claim Frequency: The number of claims filed continues to increase at an alarming rate. It is estimated that there will be 300 claims filed against the HCSF in 1986, up from 26 in 1979, almost a 12-fold increase.

Total Indemnity: The amount of money paid to claimants is also increasing at an alarming rate. We estimate that over $22 million will be paid in awards and settlements during 1985, up from $3.6 million in 1980, a 6-fold increase. During that same time, the average size of paid claims has gone from $23,700 per claim to $113,800 per claim.

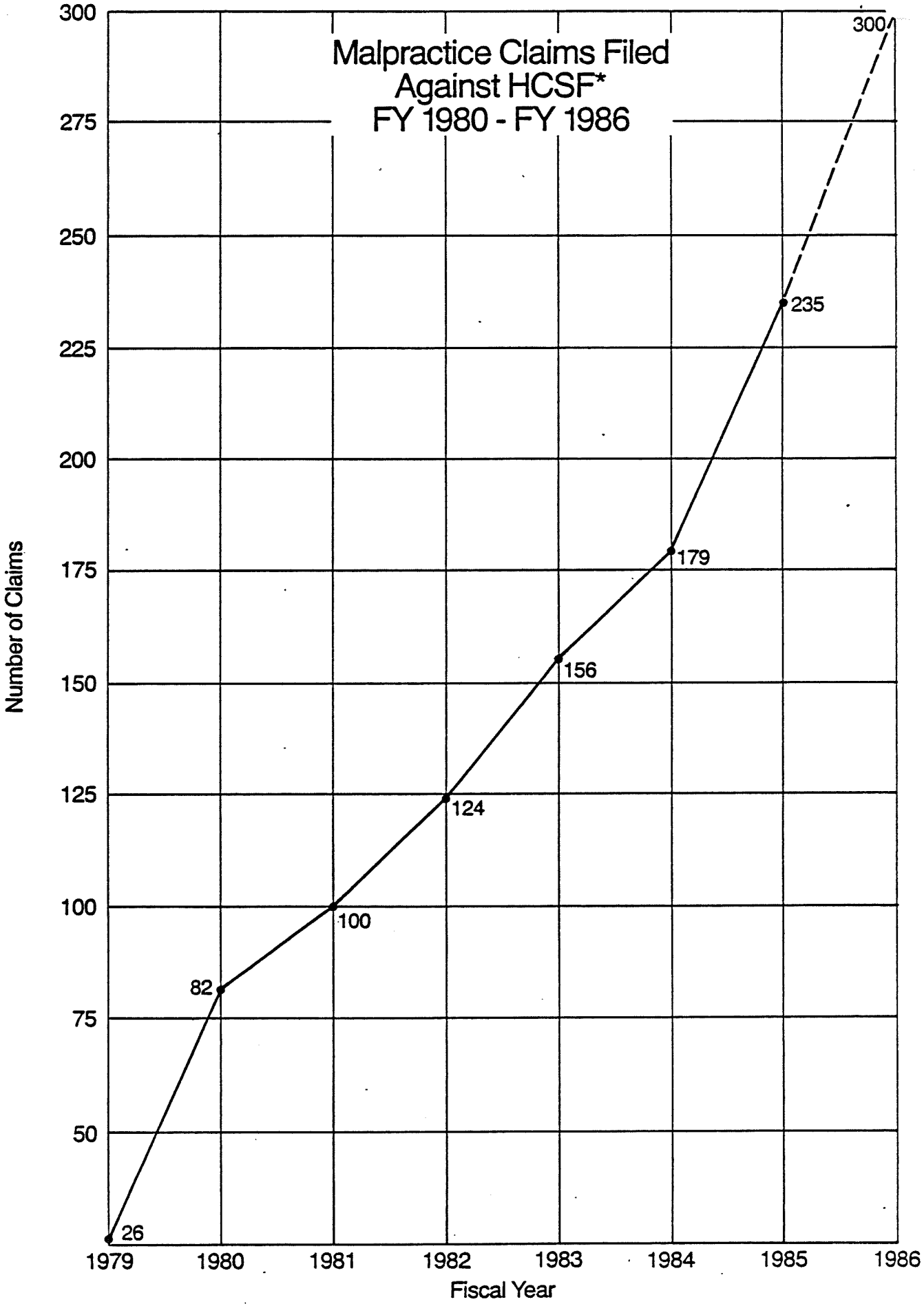
Access to High-Risk Services: As our October, 1984 survey showed, increasing numbers of physicians are stopping high-risk services such as obstetrics. The current liability environment, if not changed soon, will cause this trend to accelerate with a corresponding problem of access to care, especially in rural areas.

KMS Recommendations

The Kansas Medical Society recommends and supports the following items for enactment by the 1986 Legislature:

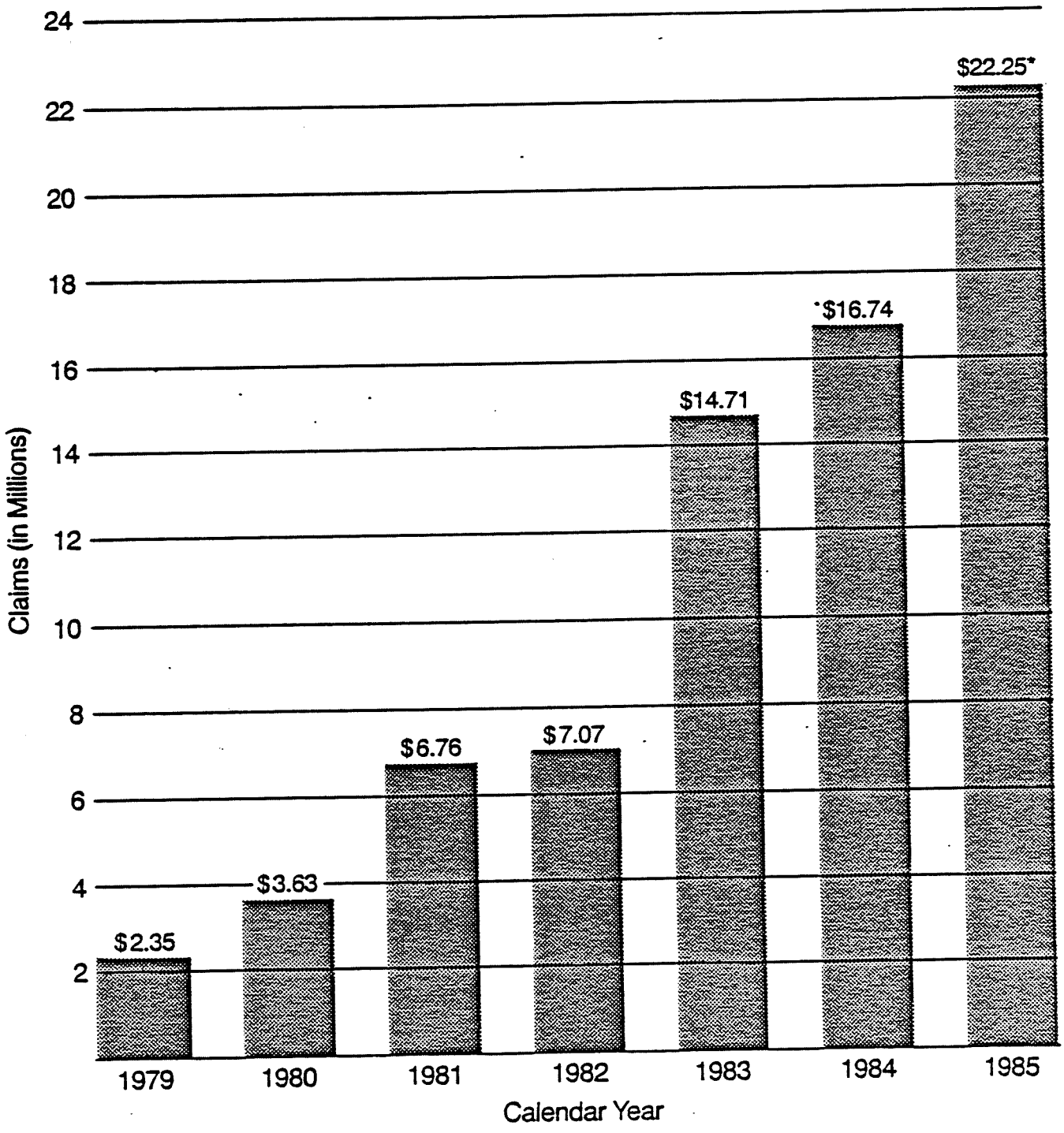
1. Caps on awards, both pecuniary and non-pecuniary.
2. Mandatory screening panels, with findings admissible in evidence.
3. Peer review/reporting law changes suggested by Healing Arts Board and Post Audit.
4. Uniform method of calculating future damages.
5. Require expert witnesses to devote at least 75% of professional time to clinical practice.
6. Delete the "sunset" provision on Substitute for SB 110.
7. Tie post judgment interest rates to a fixed standard, such as the treasury bill rate.
8. Mandatory settlement conferences

9/12-13/85



*Health Care Stabilization Fund

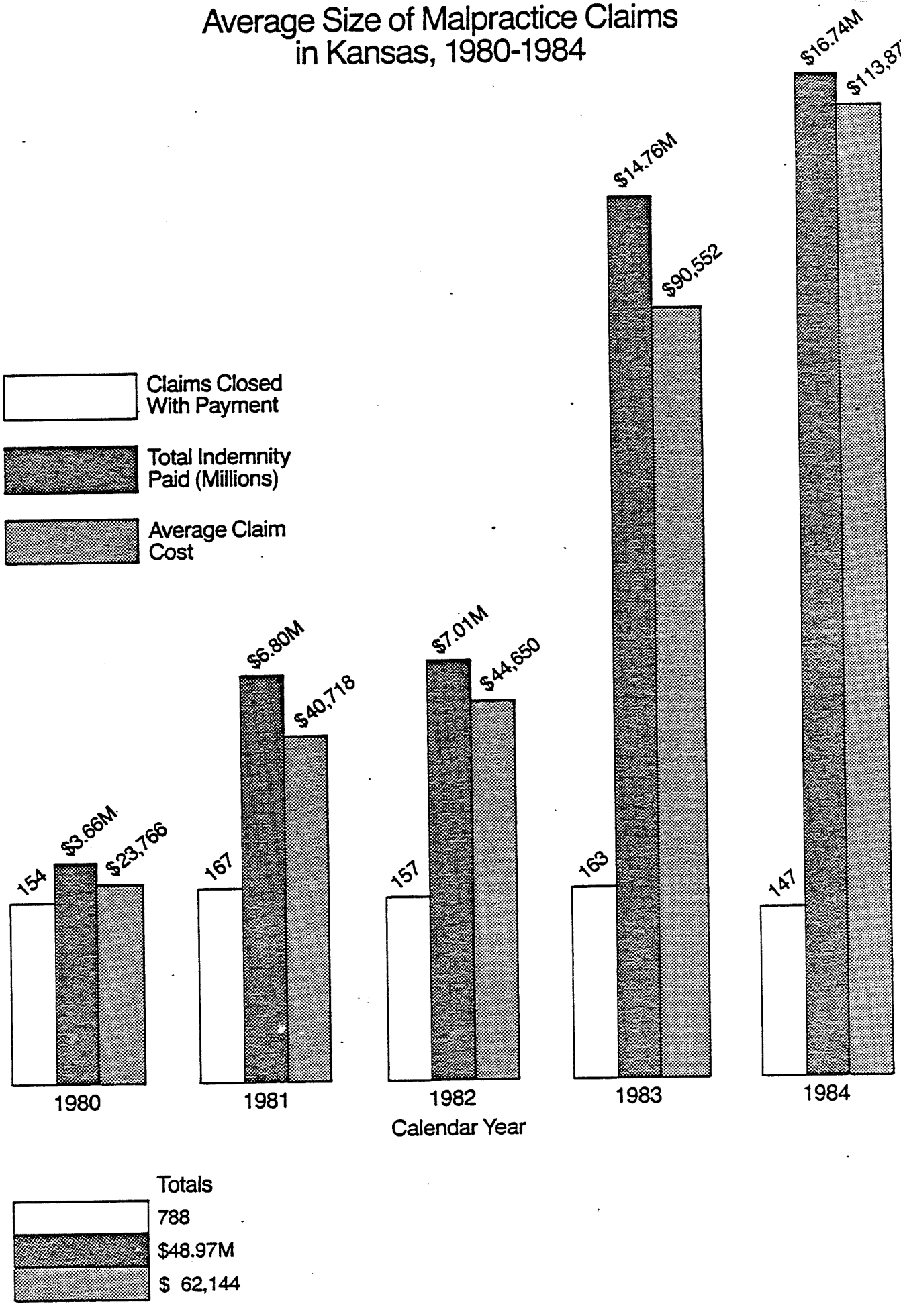
Total Awards and Settlements for Kansas Malpractice Claims (in millions)



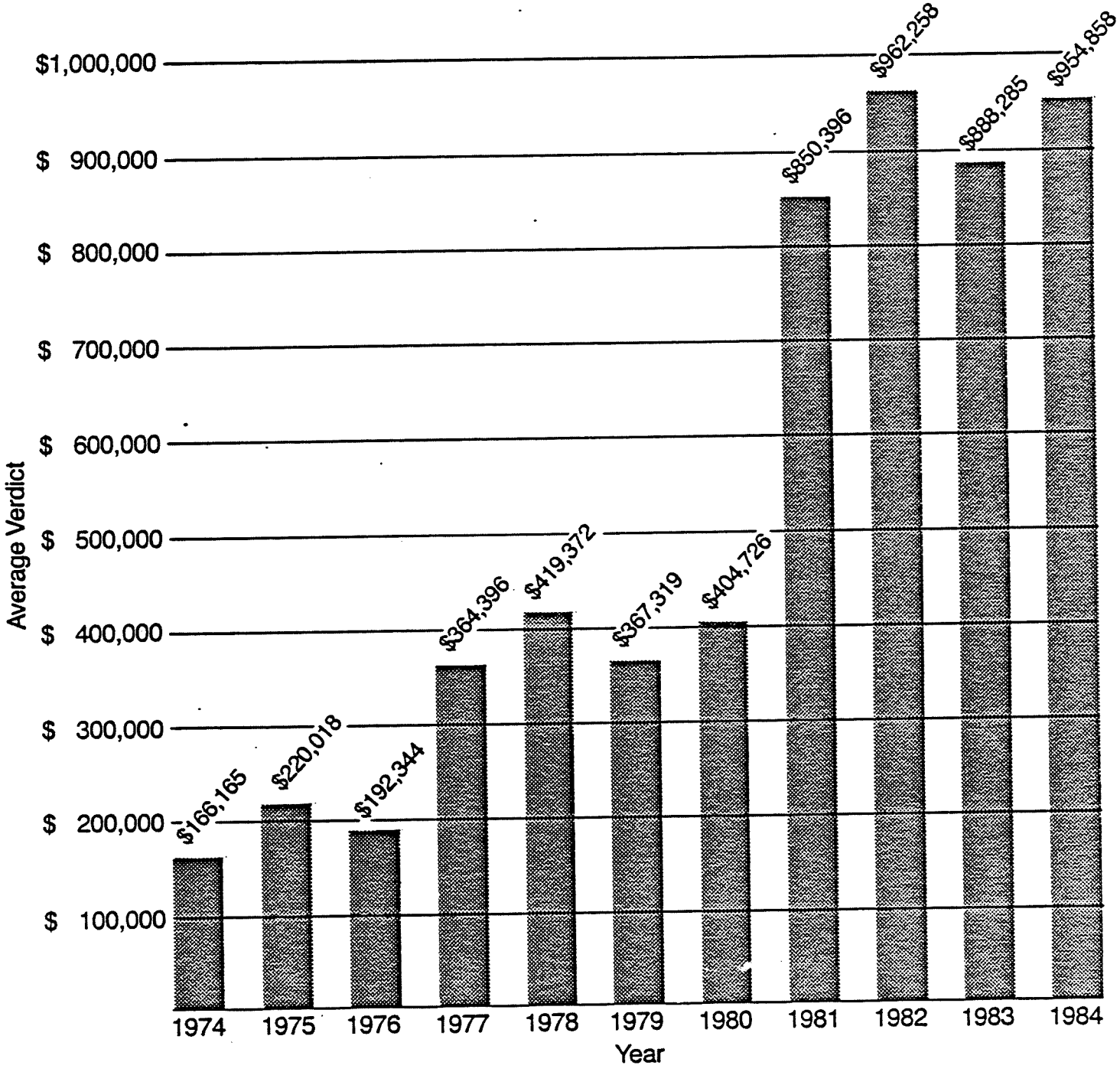
*Estimated Based on Half Year Data

Source: *Report on the Health Care Provider Insurance Availability Act*, July 1, 1985

Average Size of Malpractice Claims in Kansas, 1980-1984



Average Medical Malpractice Verdict Nationwide



Source: Summary of Injury Valuation Reports from
"Current Award Trends," 1985, Jury Verdict Research, Inc.

Professional Liability Survey

Kansas Medical Society, October 1984

In October 1984, the Kansas Medical Society surveyed its member physicians for data and opinions on the medical professional liability environment in Kansas. In all, 1,261 responses were received, which represents about one-half of the active, practicing membership. The responses were classified by specialty area of practice.

Results of the survey showed a considerable degree of concern among Kansas physicians about the professional liability situation. Nearly nine of ten physicians (86%) said problems associated with medical malpractice have affected their practices. Many felt the physician-patient relationship had suffered because of medical malpractice problems. Physicians apparently are delegating less responsibility to assistants (42%), and more than one-half (51%) are limiting their practices to less risky procedures.

The phenomenon of defensive medicine is very much an outcome of professional liability pressure. More than three-fourths (76%) of physicians who responded to the survey are prescribing additional diagnostic tests; and two-thirds (66%) use consultants more frequently.

Data on frequency of claims in Kansas seem to parallel national trends. Almost 40 per cent of Kansas physicians have been sued during their careers. Of those who have been sued, two-thirds (66%) have been sued once, one-third had two to four suits, and fewer than 1 per cent had five or more claims. These data dispel the myth that it is only the "bad doctor" who gets sued. Frequency of suits varies by specialty, with physicians in higher risk practices having greater claim activity.

Respondents whose practices have included obstetrics were asked to answer a specific set of questions to determine if the professional liability situation might be creating problems of access to obstetrical care. The results provide a bleak picture of what lies ahead in this high risk field of practice. About three of ten physicians (28%) who had practiced obstetrics had stopped altogether. Another one-third indicated they planned to discontinue obstetrics practice in the near future if the liability situation didn't improve. Taken together, 61 per cent of the respondents had either quit obstetrics practice or were planning to quit in the near future. Significantly, a large number of those who plan to discontinue obstetrics practice are family practitioners, presumably many in rural areas. The responses to this particular question clearly indicate potential access problems for obstetrical patients in many Kansas communities.

The respondents were also asked for the names of their insurance carriers. Medical Protective insured the most physicians at 40 per cent of the market. St. Paul Fire and Marine was close at 35 per cent of the market. Two relative newcomers to the state — Pennsylvania Casualty and Medical Defense — had 9 and 6 per cent of the market, respectively.

About 3 per cent of respondents were insured through the state insurance availability plan administered by Western Casualty of Fort Scott. The remaining 7 per cent were spread among several smaller insurers, mostly specialty-related carriers.

In summary, the 1984 survey showed serious concerns among Kansas physicians about problems associated with medical professional liability. A significant number of physicians surveyed indicated the professional liability situation is adversely affecting their practices and contributing to early retirement decisions. Physicians who practice obstetrics are especially concerned about the future, and problems of access to care may not be far away. Widespread defensive medicine and a more conservative practice approach are significant trends among Kansas physicians. Overall, the survey indicates that problems associated with professional liability are escalating rapidly, and that physicians are extremely concerned about the future of patient care in such an environment.

Case Background: Claimant sustained brain damage during birth: resulting in severe neurological and functional impairment.

PLAN	COST	BENEFITS	GUARANTEED BENEFITS
Up-Front Cash	$200,000	$200,000	$200,000
To Mother as Guardian: Pay $1,250/mo. for life with 30 years guaranteed compounding 3% annually		$3,431,023*	$740,803
To Mother and Father, individually and as husband and wife			
$ 25,000 payable 11-15-88		25,000	25,000
$ 50,000 payable 11-15-93		50,000	50,000
$ 75,000 payable 11-15-98		75,000	75,000
$100,000 payable 11-15-03		100,000	100,000
$150,000 payable 11-15-08		150,000	150,000
$200,000 payable 11-15-13	$295,414	200,000	200,000
TOTAL COST AND BENEFITS	$495,414	$4,231,023	$1,540,803

*Benefits based on the normal additional life expectancy of a three year old male - 68.3 years.

Case Background: Mis-diagnosed urinary tract infection resulting in the loss of both kidneys. A kidney transplant was required and permanent hearing and balane impairment occurred.

PLAN	COST	BENEFITS	GUARANTEED BENEFITS
Up-Front Cash	$120,000	$120,000	$120,000
Commencing 11-1-83,			
$750/mo. for 1st 15 years		$135,000	$135,000
$1,250/mo. for 2nd 15 years		$225,000	$225,000
$2,000 for life thereafter		$1,488,000*	- 0 -
Commencing 11-1-84,			
$5,000/yr. for 4 years		20,000	20,000
$ 20,000 payable 11-1-88		20,000	20,000
$ 30,000 payable 11-1-93		30,000	30,000
$ 40,000 payable 11-1-98		40,000	40,000
$ 50,000 payable 11-1-03		50,000	50,000
$ 60,000 payable 11-1-08		60,000	60,000
$ 70,000 payable 11-1-13		70,000	70,000
$ 80,000 payable 11-1-18		80,000	80,000
$ 90,000 payable 11-1-23		90,000	90,000
$100,000 payable 11-1-28		100,000	100,000
$150,000 payable 11-1-33	$180,334	150,000	150,000
TOTAL COST AND BENEFITS	$300,334	$2,678,000	$1,190,000

*Benefits based on the normal additional life expectancy of a 17 year old female - 62.0 years.

TESTIMONY OF JAMES RIDER, D.O., FOR THE KANSAS ASSOCIATION OF OSTEOPATHIC MEDICINE -- PRESENTED TO THE SPECIAL INTERIM LEGISLATIVE COMMITTEE ON MEDICAL MALPRACTICE

Mr. Chairman and Members of the Committee:

My name is Dr. Jim Rider. I am an osteopathic physician practicing in Valley Falls, Kansas. I appear before you today in my capacity as Legislative Committee Chairman of The Kansas Association of Osteopathic Medicine, and The Kansas Chapter of The American College of General Practitioners. May I first state that for myself and all those for whom I speak, we appreciate the thoroughness of this Committee's examination and your openness to suggestions for change.

Numerous times we have made the case that there is a problem of professional liability insurance premium levels. We think that problem is serious now, but what we really fear is what will happen if the spiraling increases of 30 to 40 percent a year as in the past two years, continues for the next few. Wtihin the past eight weeks, three osteopathic physicians who wanted to wind down their practice into a gradual retirement, went into total retirement because they could not afford to pay malpractice insurance premiums. I deliver babies, and I talk with many colleagues throughout the State that do also. I think it can be stated without doubt that should premiums continue to rise, what is now a few that are dropping obstetrics--will become many.

There is a problem, but what I appear today primarily to do is to pass along our thinking on the changes we urge you to make. Let me start by saying that we have, and will continue to support and pursue all means to making sure that the quality of medical care delivered by osteopathic physicians is of the highest quality possible. The osteopathic association has recently regularized the procedures of its peer review efforts and is now revitalizing its impaired physician efforts. To this end we will also continue to support those efforts by the Board of Healing Arts in "policing" the providers of medical services.

These efforts on our parts to emphasize quality care, however, will not be sufficient to control a system that in many respects is out of control. We have considered several alternatives and reviewed information presented to you. Based on this, we urge your serious consideration and adoption of the feature of what is called <u>The Indiana Plan</u>. Briefly, we think it has merit for these reasons:

9/12-13/85

(1) It is a tried and proven system in states like ~~Kansas~~ INDIANA and Nebraska, both of which share some of the cultural characteristics of Kansas.

(2) It offers a minimum of substantive changes in procedures of the tort system. Any party to the case may pursue his or her interests beyond the screening panel stage, but the fact that screening panels are mandatory and that their findings and evidence are admissible weighs heavily in acceptance of decisions made at the screening panel level

(3) We favor adoption of a cap on settlements and judgments and think the Indiana cap of $500,000 is a level that, with creative structured provisions, can provide extended adequate compensation to injured parties, yet introduce an element of reason into the system that can halt rapidly upward spiraling malpractice premiums.

(4) We support the limitation on attorney contingency fees as that provision is operative in Indiana. Here also, we think this is fair and adequate in assuring the availability of legal assistance for those who feel they are injured parties.

There is, of course, always a danger in urging adoption of a package plan like the Indiana plan, because the parts of that plan are subject to alteration in the deliberative process now underway. We wonder, for example, the extend to which the Indiana Plan has succeeded because each of its component parts complements the others. The insurance executive from Medical Protective, for example, has stated that part of the success of The Indiana Plan was due to the $500,000 cap, and that to raise that lid significantly would raise questions of impact upon the smooth operation of other parts of the system. We ask that you consider that perspective in your deliberations.

The cap, we think, is the key to both introducing reason into the system as well as hastening the day that we lay the Health Care Stabilization Fund to rest. And, about the Fund, we confess to questions whether it has operated as the steward or our contributions with maximum efficiency. We urge that the Fund have adequate staff--both in size and experience--to make sure that it gives to its function the same care and attention you as legislators would expect any State agency would give to any responsibility entrusted to it.

Lastly, may I express the considerable concern of osteopathic physicians on the continuing problem of availability of medical liaibility insurance. Presently, other than Plan coverage through Western and coverage written by a company that insures only groups of four or more (which excludes almost all D.O.s from coverage) there are only two companies that are writing osteopathic physicians, one of them a small company out of Missouri.

What is of most concern to us is the fact that one of the two largest writers in Kansas will not write osteopathic physicians unless they are in practice with an M.D.

The Medical Protective Company will not write D.O.s, leaving St. Paul as the only large carrier available. You have already been presented testimony that, within several classes of coverage, St. Paul's rates are twice those of Medical Protective. Thus, D.O.s are denied access to the most reasonably prices insurance available in the State. If, for example a D.O. had an identical practice to an M.D., and assuming the physicians met other selection criteria, the M.D. might have base coverage through Medical Protective for $5,000 while the D.O. would have no choice but coverage at $10,000 from St. Paul. Applying the Fund surcharge (currently at 110%) the comparative premiums would be $10,500 and $21,000.

As one of the two branches of full service medicine in Kansas, osteopathic physicians fail to understand why Medical Protective should be permitted to selectively exclude D.O.s This is not selection based on risk of practice or basic nature of practice (such as doctors of chiropratic), but it is selection, or discrimination, based on a factor we fail to understand.

We wonder why the Insurance Department continues to permit this. The Department responds that they do not have legislative authority to prohibit this type of selectivity. If this is the case, we urge you to provide that authority to the Insurance Department. Most certainly, changes should be made to give physicians--no matter what branch of medicine--relief from having to pay the total Fund surcharge on the excess base premiums caused by a Company's policy of refusing to write for unjustified reasons.

In conclusion, we appreciate and think proper the changes made in the last session. We think, however, that additional attention is needed and we urge you to adopte the tenets of The Indiana Plan including the lid on recovery . We pledge our concerted efforts to the end of lessening the instances of malpractice that make recovery necessary. Thank you for this opportunity to appear.

Insurance
•
Real Estate

THE EUREKA REALTY COMPANY

316-583-5581
BOX 589
220 N. MAIN
EUREKA, KANSAS 67045

August 14, 1985

Dr. Michael McClintick,
Dr. Terry Morris
d/b/a Bluestem Medical Clinic, P.A.
1602 North Elm St.
Eureka, Kansas 67045

Gentlemen:

Find below approximate premiums paid for Physicians' Professional Liability, according to our records:

DATES	COMPANY	PREMIUM	SURCHARGE	TOTAL
2/15/85-86	Western/KHCPIAP	$9,092.00	$7,272.00	$16,364.00
2/15/84-85	Western/KHCPIAP	5,705.00	2,853.00	8,558.00
2/15/83-84	WesternCasualty	2,014.00	-0-	2,014.00
2/15/82-83	St. Paul Fire & Marine	4,202.00	-0-	4,202.00
2/15/81-82	St. Paul Fire & Marine	2,418.00	-0-	3,496.00
	(Dr. Morris)			
	(Dr. McClintick)	1,078.00	-0-	

Projected Premiums

	BASIC	SURCHARGE
Family Physicians or General Practitioners including obstetrical procedures (excluding caesareon sections)		
Code 80421	$6,283.00	$6,911.00
Corporation Liability #80999	628.00	691.00
	$6,911.00	$7,602.00
One person total	$14,513.00	
Family Physicians or General Practitioners, minor surgery - no obstetrical		
Procedures #80423	$4,747.00	$5,222.00
Corporation Liability #80999	475.00	523.00
	$5,222.00	$5,745.00
One person total	$10,067.00	

$24,580
1986-'8

Hoping this information is of some help to you. Please call me if you have any further questions.

Ben Fox

9/12-13/85

estimony of Anita Jacoby, R.N., F.N.P.
September 12, 1985

I am Anita Jacoby. I am an Advanced Registered Nurse Practitioner licensed in the state of Kansas and I work for two board certified obstetrition/gynecologists in Wamego, Kansas who are considering giving up their medical practice due to the extremely high malpractice insurance premiums and the increasingly uncomfortable atmosphere doctors must practice under now days. 1979 through 1983 Kansas was 9th in the nation for number of awards of $1,000,000 or greater. All funneled directly back through insurance premiums to physicians overhead. If the clinic is forced to close, not only will I lose my job but Pottawatomie County and the surrounding community in which they practice will lose two very caring, devoted, and skilled physicians. I am hoping that this committee can help prevent that from happening.

The facility opened 1982 using their own money. They deliver 280-300 babies per year at the community hospital as well as other women's health care needs including vaginal birth after Cesarean Section; a service not available to these patients at that time. They employed (including the physicians) 13 people, all who lived in Pottawatomie and Wabaunsee County except 1 and that is myself. I have voluntarily commuted from Topeka for 3 years because I agree with their philosophies and their methods of practice. Of the original 13 employees 5 were Registered Nurses and worked in the office as well as working labor and delivery at the hospital on an on-call basis 24 hours per day, 7 days per week in an effort to increase quality of care patients received as well as the concept that patients were less apprehensive when attended in labor by a nurse that they were already familiar with. This service was in effect for 1 year and then was discontinued because the volume of patients increased to a level that all of the nurses were burned-out and unable to keep up with this rigorous schedule. The city hospital employs 75 employees (55 FTE, full time equivalents) to support these services. All of this now is in danger of being strangled in its early years.

9/12-13/85

While the gross income is fixed, the principal overhead item has increased. The malpractice premium for 1983 was $13,500, in 1984 it was $28,500, and in 1985 the premium was $65,000; 1/5 of their gross income. Next year it is predicted to be over $100,000 for two physicians; 1/3 of their gross income!

Some of the measures taken in 1983-1984 to cut costs included increasing employee efficiency, laid off 2 employees but fees were frozen by BC-BS, Medicare/ Medicaid and also they froze their other fees voluntarily in response to AMA.

The physicians income declined significantly. No one feels sorry when physicians' income drops. I do. Rural doctors do not make the same income that physicians in the cities do. These doctors make 1/3 to 1/2 of what ACOG estimates obstetrician specialists make nationwide.

While earning this decreased income they work 60-80 hours per week. They are available all of the time, take enormous risks in order to give the care needed -- health risk (fatigue, high blood pressure and many other stress related conditions), compromise their family life, and recently (the most tragic of all) the need to regard everyone not as someone to care for as well as their judgment and skill allow, but as a potential adversary for whom defensive medicine at its most expensive must be practiced, with whom no relationship of trust or confidence can be established.

Obstetricians are at risk for sensationalistic court cases which result in huge settlements and awards. Many people cannot have the birth experiences they want because of the need to practice defensive medicine. For example, some patients do not want the electronic fetal monitor used at all during their labors but because of the risk of being found negligent if fetal monitoring is available but not utilized and there is a poor outcome, all of our labor patients are monitored intermittently during their labors. We have even had patients change doctors during their pregnancy when they found that this was our policy.

Everyone expects perfect outcomes and when they don't happen, someone has to pay. You can't sue God so people have been encouraged to sue the physician. Some of this encouragement is presented in the form of unethical TV commercials aimed directly at obstetricians. Incidentally, many feminists have suggested that God is female. I disagree; no woman would have created this process of childbirth!

A residency trained physician has a minimum of 23 years of formal education. Why are lay people on a jury allowed to make the decision of whether or not a physician made the right decision? There is a difference between an error in judgment and malpractice. Jurors make their decisions many times on the testimony of so called "expert witnesses" who are paid for their court appearances and are in fact for hire and motivated by profit.

If some of these remarks seem emotional, please make allowances for this; the issues are emotion-provoking. Those of us employed by doctors face loss of jobs, security, and professional standing. Those who seek care from our clinic face loss of access to thoughtful, individualized medical care and loss of services close to home. It seems to me that the present situation is heading toward "conveyor-belt" obstetrics, depersonalized services centered in a few major cities, and loss of the freedom of choice we once felt entitled to.

Thank you for your attention.

SAMUEL T. JONES. M.D., F.A.C.S.
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September 3, 1985

SUITE 401
(816) 531-1295

Ms. Emalene Correll
Legislative Research Department
Room 545-N, Statehouse
Topeka, KS 66612

Dear Ms. Correll:

I am scheduled to appear before the Special Committee on Medical Malpractice on September 12.

Information that serves as background for my presentation is included in the two articles that are enclosed. One of the articles ("Reducing Children's Psychological Stress in the Operating Suite") will be published in the next issue of Ophthalmic Plastic and Reconstructive Surgery, which is targeted for distribution in October 1985. The other article ("Child Abuse in the Operating Room") appeared in the July 1985 issue of the Greater Kansas City Medical Bulletin.

You will also find enclosed my thoughts and suggestions for legislative action to correct the problems described in the two articles.

With every good wish, I remain

Sincerely yours,

Samuel T. Jones

Samuel T. Jones, M.D.

STJ:cg

Enclosures

9/12-13/85

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My thoughts and suggestions for legislative action include the following:

(1) Enact legislation establishing a model program on proper management of children in the operating suite at the University of Kansas Medical Center. Appropriate $10,000.00 for remodeling in the operating suite and for other expenses (consulting fees, cost of sending key personnel to the Children's Hospital National Medical Center in Washington, D.C., and other expenses). Stipulate that a course must be offered by the Department of Postgraduate Medical Education at K. U. Medical Center after complete development of the model program. Require periodic reports on progress to a special committee of the State Legislature.

(2) Enact legislation requiring key personnel in Kansas hospitals and surgical centers to attend the course offered at K. U. Medical Center. The course could be organized into three subdivisions: (a) one for anesthesiologists and nurse anesthetists, (b) one for other nursing personnel serving in operating rooms, and (c) one for hospital administrators and allied health care executives.

(3) Enact legislation to require hospitals caring for children to have anesthesia induction rooms meeting the specifications of the state bureau licensing hospitals in order to be licensed for surgical procedures on children. Require that the specifications for the induction rooms be provided to the state hospital bureau by the University of Kansas Medical Center, based on its model program.

(4) Enact legislation requiring that anesthesiologists report their methods of anesthetizing children to the Kansas State Board of Healing Arts. Amend the Healing Arts Act to provide for disciplinary action by the Healing Arts Board in the event that an anesthesiologist is deemed to be anesthetizing children inappropriately. The decision as to whether or not an anesthesiologist ought to be disciplined ought to be made on the basis of a hearing before a special subcommittee of the Board. This special subcommittee ought to be composed of a preponderance of persons with special knowledge and training in human behavior, especially child development, child psychology, and child psychiatry.

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THE GREATER KANSAS CITY JULY 1985
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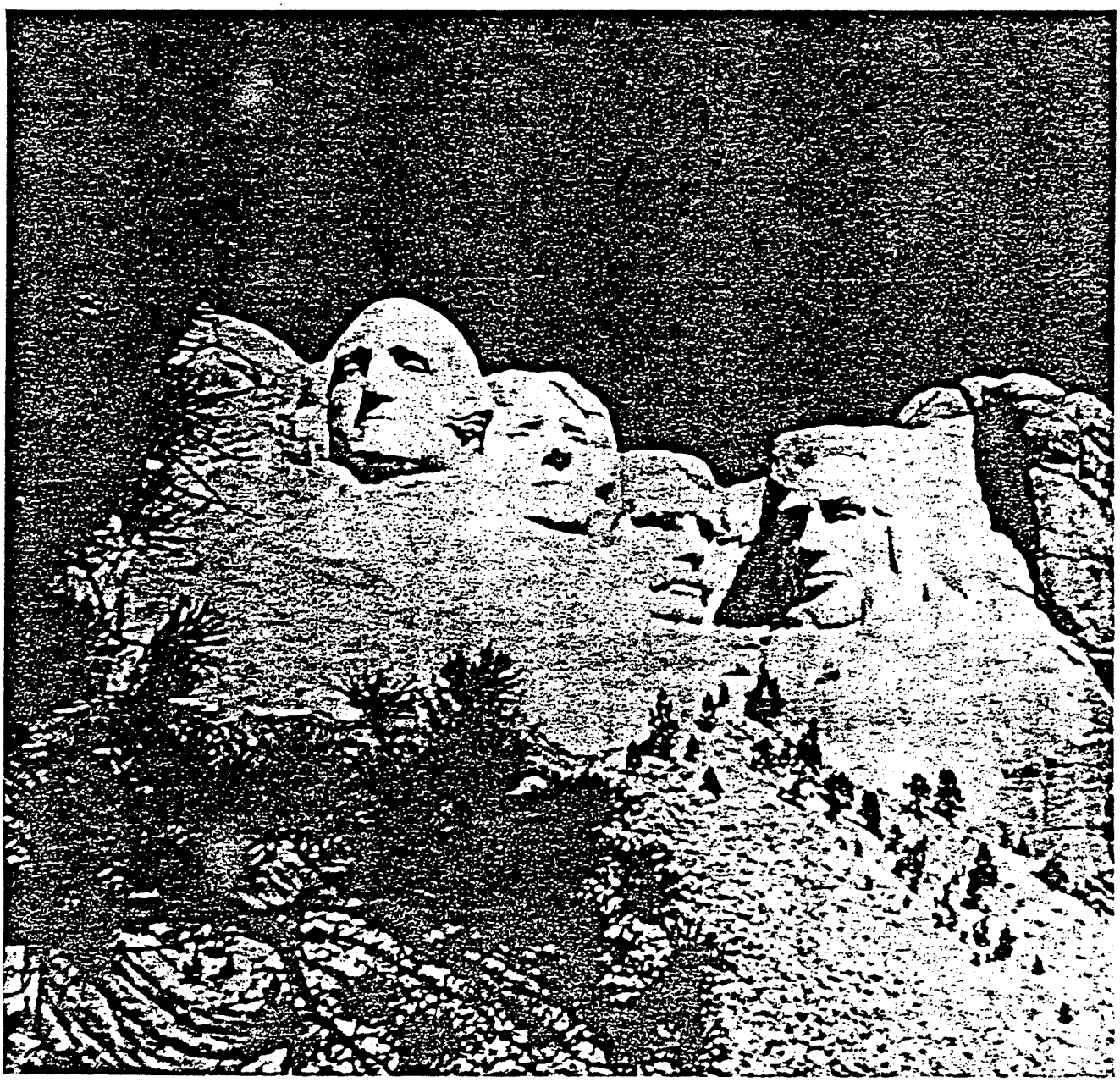
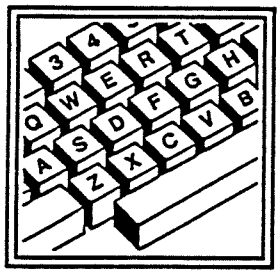


See *On The Cover* . . . Page 3



PERSONAL COMMENTARY

Child Abuse In the Operating Room

A report appeared on the front page of the *Kansas City Star* last May 15th describing a workshop at the Missouri Conference on Child Abuse and Neglect in Columbia, Missouri. The title of the workshop was "Child Abuse in the Operating Room." The newspaper article recounted how "heavy-handed techniques by anesthesiologists in the operating room can so traumatize children that they suffer psychological problems for years" and how thoughtlessly conceived hospital rules prescribe procedures for the operating room and recovery room which, by failing to consider the unique needs of children, seriously endanger their emotional health.

The serious psychological problems that can develop in children after their inept treatment in the operating suite include hallucinations, stuttering, enuresis, and sleep disorders (e.g., nightmares and fear of falling asleep).

The mistreatment to which children are subjected in the operating room includes: (1) their separation from their parents in the holding area instead of induction of anesthesia in a special induction room with parents present; (2) the firm pressing of the anesthetic mask over the mouth and nose of fully conscious children, interfering with their normal breathing pattern in a manner suggestive of suffocation; and (3) the use of force to restrain children who have already been frightened as a result of separation from parents and interference with normal breathing.

The improper treatment of children in the operating room is only part of a much larger problem that was addressed by Spitz[1-3] in the 1940s. In a series of articles on hospitalism and anaclitic depression, Spitz pointed out that children who were treated in hospitals without maternal love and affection regularly failed to show normal developmental progress and that they frequently died. His work led to the changing of hospital policies so that parents could stay with their children while they were in the hospital.

Even after the institution by hospitals of more enlightened policies for children, hospital-induced mental trauma was still found to occur frequently[4-7]. Studies [8-13] were carried out on various aspects of the hospital experience to determine the causes of this trauma and to try to prevent it. Schulman *et al.*[8] studied children's mental anguish during anesthesia induction and found that children were less upset if their mothers were present during anesthesia induction. Meyers and Muravchick[9] reported fewer behavioral problems in children after surgery if they were given preoperative medications so that they were asleep before being separated from their parents and moved into the operating room.

Despite the publications of Schulman, Meyers and their coworkers, there has been an increasing tendency by anesthesiologists in the United States (but not in other countries) to omit medications which allay the anxiety of children before surgery; and, with increasing frequency in the United States, children are being separated from their parents in the holding area and transferred to the operating room without preoperative sedation. Anesthesiologists have tended not to use preoperative sedation because the effects of premedicant drugs are less predictable in children and because children having outpatient surgery may not be ready to go home when the outpatient surgical facility closes for the evening if they have been given long-acting premedicants.

A study by Hannallah and Rosales[14] published in 1983 leaves no doubt about the fact that anesthetizing children with their parents present alleviates their anxiety in the majority of cases. To decrease children's distress in the operating suite a number of other measures ought to be taken, as I have discussed in a paper entitled, "Reducing Children's Psychological Stress in the Operating Suite," which is to be published in *Ophthalmic Plastic and Reconstructive Surgery*. The reforms that I visualize include the screening of parents to determine their ability to provide emotional support for their children during induction of anesthesia and the mandatory use of an induction room with parents present in the case of younger children whose parents can provide emotional support.

The last bastion of resistance to the enlightened and rational care of children in hospitals is the operating room, where the most acute and distressing emotional damage is apt to occur. Pediatricians and child psychiatrists have long been aware of the serious psychological consequences of separating children from their mothers and of treating children harshly in medical institutions, but many anesthesiologists and some nurses in operating suites of hospitals have insisted on separating children from their mothers and subjecting them to rough, insensitive and inappropriate treatment. There is a need for the medical profession as a whole to be aware of the issues involved in the care of children in the operating room, and this article has been written to address that need.

Samuel T. Jones

REFERENCES

1. Spitz, R.A.: Hospitalism: An inquiry into the genesis of psychiatric conditions in

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Personal Commentary

(Continued from page 15)

early childhood. Psychoanalytic Study of the Child *1*:53-74, 1945.
2. Spitz, R.A.: Hospitalism: A follow-up report on investigation described in volume I, 1945. Psychoanalytic Study of the Child 2:113-117, 1947.
3. Spitz, R.A., and Wolf, K.M.: Anaclitic depression: An inquiry into the genesis of psychiatric conditions in early childhood, II. Psychoanalytic Study of the Child 2:313-342, 1947.
4. Douglas, J.W.B.: Early hospital admissions and later disturbances of behavior and learning. Dev. Med. Child Neurol. *17*:456-480, 1975.
5. Quinton, D., and Rutter, M.: Early hospital admissions and later disturbances of behavior: An attempted replication of Douglas' findings. Dev. Med. Child Neurol. *18*: 447-459, 1976.
6. Vernon, D., Schulman, J., and Foley, J.: Changes in children's behavior after hospitalization. Am. J. Dis. Child. *111*:581-593, 1966.
7. Jessner, L., Blom, G.E., and Waldfogel, S.: Emotional implications of tonsillectomy and adenoidectomy on children. Psychoanalytic Study of the Child *7*:126-169, 1952.
8. Schulman, J.L., Foley, J., Vernon, D.T., et al.: A study of the effect of the mother's presence during anesthesia induction. Pediatrics *39*:111-114, 1967.
9. Meyers, E.F., and Muravchick, S.: Anesthesia induction technics in pediatric patients: A controlled study of behavioral consequences. Anesth. Analg. *56*:538-542, 1977.
10. Visintainer, M.: The effects of pre-admission psychological preparation on children's stress responses and adjustment during and following hospitalization for minor surgery. Am. Nurses' Foundation *12*:3-5, 1977.
11. Visintainer, M.A., and Wolfer, J.A.: Psychological preparation for surgical pediatric patients: The effect on children's and parents' stress responses and adjustment. Pediatrics *56*:187-202, 1975.
12. Peterson, L. and Shigetoni, C.: The use of coping techniques to minimize anxiety in hospitalized children. Behavior Therapy *12*:1-14, 1981.
13. Apt, L., Beckwitt, M.C., and Isenberg, S.: Emotional aspects of hospitalization of children for strabismus surgery. Ann. Ophth. *6*:11-20, 1974.
14. Hannallah, R.S., and Rosales, J.K.: Experience with parents' presence during anesthesia induction in children. Can. Anaesth. Soc. J. *30*:286-289, 1983.

Support Bulletin Advertisers

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Dear Dr. Jones –

I'm pleased to inform you that the paper you submitted, Reducing Children's Psychological Stress in the Operating Suite

has been accepted for publication in our journal.

Again, we thank you for submitting this article and hope to receive other articles from you in the future.

Very truly yours,

Henry I. Baylis, M.D.
Editor-in-Chief

REDUCING CHILDREN'S PSYCHOLOGICAL STRESS IN THE OPERATING SUITE

Samuel T. Jones, M.D.

Abstract

Children may experience extremely high levels of psychological stress in the operating suite because of anxiety associated with the separation from their parents, the unfamiliar and intimidating environment, the presence of strangers in unusual attire (masks, caps, gowns), the act of being forcibly restrained, and the forceful pressing over the mouth and nose of an anesthetic mask which emits a foul-smelling gas and which seems to restrict breathing in a manner reminiscent of suffocation. The recovery room can be very frightening for children because of the separation from parents and the frequently overpowering scene of human injury and suffering.

If the personnel in the operating suite are trained in child development, and if they are encouraged to practice elementary "preventive psychiatry" and to use common sense, then the psychological morbidity resulting from the experience in the operating suite can be minimized. Arrangements ought to be made for children undergoing relatively simple and short operations to go to a place different from the "intensive-care" type of recovery room.

Introduction

The purposes of this article are (1) to present briefly the rationale for reducing psychological stress in children in the operating suite by discussing and giving examples of psychological trauma that may result from excessive stress and (2) to present briefly a program for stress-reduction

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in the operating suite.

Psychological Trauma

Although the experience of going to the operating room for surgery is often emotionally stressful for adults, this experience is sometimes associated with overwhelming psychological stress for children. In the majority of American hospitals, children are separated from their parents, often fully awake, and are taken to the intimidating environment of the operating room, where anesthesia is induced. In children, as Cairns[1] has stated, "forced separation from the mother is a traumatic and disorganizing experience." When the fully conscious child is separated from the mother and taken to the operating room, he sees not only the unfamiliar furnishings in the room (the operating-room lights, anesthesia machines, suction apparatus, monitoring equipment, and surgical equipment), but also the strangely garbed personnel with caps, gowns and masks, the latter especially evoking the image of bandits or kidnappers. Freud[2] has stated, "The psyche develops the affect of anxiety when it feels itself incapable of dealing (by adequate reaction) with a task (danger) approaching it externally."

A normal child will cry[3] when confronted with such fearful circumstances but this normal reaction is often labeled as "lack of cooperation" by the personnel in the operating room, who regard the child inappropriately as a miniature adult. The crying, struggling, "uncooperative" child is typically restrained forcibly by the masked strangers in the operating room, leading to a reaction of rage.[4]

While the child is being forcibly restrained, anesthesia is usually induced by the administration of either inhalation anesthetic drugs or intravenously administered anesthetic drugs. If the latter method is decided upon, the pain inflicted on the child may be significant as multiple needle punctures are made or as the needle probes for a vein in the frightened, struggling, moving

patient. If inhalation anesthesia is used, the anesthetic mask is often pressed firmly over the mouth and nose, evoking a sensation of suffocation as a foul-smelling gas fills the mask. Perls et al[5] have stated, "Anxiety is the experience of breathing difficulty during any blocked excitement."

If a child experiences one such unpleasant experience, he/she then becomes conditioned to expect unpleasantness on subsequent visits to the operating room, leading to the use of ever cruder methods to enforce the submission of the child who requires multiple operations. A state of panic may thus occur in the operating room in children who have endured multiple experiences that are psychologically traumatic. Children who are properly handled may lose their fear if they are gently shown that the situation is not threatening and if they are able to master the circumstances. The contrast between the panic-stricken behavior of children who have been inappropriately treated and the calmer behavior of those who have been properly managed is striking.

The emotional disturbance resulting from high levels of fear or anxiety can lead to regression in a child's mental development,[6] including enuresis (a regression to the normal infantile pattern of urinary incontinence) and stuttering (a regression to an earlier speech pattern and failure to develop fluent speech[7]). Other psychological complications resulting from excessive levels of emotional stress are sleep disturbances (fear of falling asleep, nightmares) and hallucinations, which may occur at the time of anesthesia induction or which may occur afterwards. In some cases, hallucinations may be caused by the drugs that are used; in other cases hallucinations may result from extreme fear. More than one factor may be involved in a given case.

Emotional disturbances associated with a visit to the operating suite are illustrated by the following case reports.

Case Reports

Case 1. Stuttering. A 4 year old boy was not upset while sitting

on the operating room table talking to me. He had visited my office frequently since the age of 10½ months for treatment of strabismus, and he regarded me as a friend. While talking with the child and comforting him, I was asked by a nurse to go immediately to the recovery room to see an emergency case. Since no person from the anesthesia department was in my operating room, I was reluctant to leave my patient. However, I thought that I ought to leave the room briefly to determine the nature of the emergency problem. Before departing, I told the circulating nurse and the scrub technician, "Don't let anyone put this patient to sleep until I return."

When I returned, a nurse anesthetist was sitting at the head of the operating table administering anesthesia and my patient was already asleep.

When the patient woke up, he told his mother that he had been held down in the operating room, a mask had been firmly pushed against his face and held there, and that he was frightened and had cried.

The next morning when the patient came to my office, he acted as though he was terrified at the moment he came through the door. When I greeted him, he tried to hit me. When his parents tried to usher him into my examining room, he threw himself against a wall and furiously fought attempts to bring him into the room. I was unable to examine him on that date.

On the way home from my office, the patient said that he was extremely afraid of me and of doctors. This seemed surprising to his mother because of the friendly and trusting relationship that had existed in the past. Later the patient spoke about his

fear of the hospital experience that he had had. He told his parents that he was frightened most of all when the mask was "held down over his face and he couldn't breathe." These were the exact words used by his father in describing the event.

Several weeks after the operation the patient began to stutter. A speech therapist told the family that a frightening experience had probably caused the stuttering.

During the next six months the patient became very upset on two occasions when he accompanied a friend or his family to the hospital for the purpose of visiting relatives or obtaining records.

About 11 months after the operation the father of the patient, feeling frustrated and angry, came to my office to complain about the manner in which his son had been treated in the operating room. After the father talked with me for many hours over a period of six weeks, he realized that I was genuinely concerned about what had happened, and his anger subsided as he saw that I was making efforts to improve the psychological management of pediatric cases in the operating room.

The patient received treatment for stuttering during a period of two years. During this time his speech impediment gradually grew less severe and eventually vanished.

Case 2. Stuttering. A 4 year old boy brought to the hospital for strabismus surgery was given a sedative drug preoperatively. He became too deeply sedated, and an anesthesiologist ordered naloxone (Narcan) to counteract the respiratory depression. After the administration of the naloxone the patient became hyperactive; in describing the boy's behavior the ophthalmologist said that he was "trying to climb the walls." In this excited state the child was taken to the operating room, separated from his mother and forcibly held down. An anesthetic mask was clamped over his mouth and nose. After

a struggle, he lost consciousness. Shortly afterward he began to stutter, and he is still stuttering three years after the stormy anesthesia induction.

Case 3. Nightmares. A 12 year old boy came to the hospital for ptosis surgery. He had become extremely frightened because of pain associated with the insertion of needles for intravenous anesthetic drugs when he had previous ptosis surgery. The night before the operation the boy requested the anesthesiologist who was making rounds to administer an inhalation anesthetic the next day, and the anesthesiologist promised that a mask would be used to induce anesthesia rather than a needle for intravenous medication. On the morning of the operation a different anesthesiologist entered the operating room. He did not ask the patient any questions, and he later said that he was unaware of the conversation held with the other anesthesiologist on the night before surgery. The second anesthesiologist told the patient that he was going "to put him to sleep by a solution in a vein." He then selected a large needle and induced anesthesia by the intravenous administration of drugs. The patient later said that he was too afraid to express objections to the needle.

On the evening of the day of surgery the patient had a frightening nightmare. He dreamed that a large man resembling the anesthesiologist was chasing him with a needle and that he was having difficulty running away. During this nightmare the boy's mother was in the room, and she heard him screaming and observed his legs moving with a running motion. She encountered great difficulty awakening her son. Severe nightmares like this one occurred every night or two for at least six weeks, disturbing the sleep of the rest of the family. The family doctor was called, and he could not understand how such an error

in administration of anesthesia could have been made.

Case 4. Hallucinations. A 13 year old boy with strabismus came to my office for examination, and surgery was recommended. He refused surgery because of psychiatric problems after surgery for a bladder diverticulum at the age of 9 years. After the bladder surgery he was taken to the recovery room, where he could see adult patients with bloody bandages adherent to various parts of their bodies, with tubes coming out of various orifices, and with bottles of blood dripping into tubes attached to their limbs. Occasionally he heard moans of pain from patients going into shock and being treated with a defribrillator for cardiac arrest. His mother was not allowed to visit him because "she might have become upset by what she saw," and the child was told to "shut up" and not to ask to see the doctors because "they were at lunch" and there was no doctor available "to dismiss him" from the recovery room, where he was held for two hours. He expressed fear at being exposed to a scene like something from "Frankenstein." He was especially upset that his mother was not allowed to comfort him.

The night of the day of surgery he had an hallucination in which monsters resembling the people in the hospital were roaming the hallway outside his room. He has continued to have hallucinations of this type periodically over the last four years.

Reducing Stress

In a beautifully done film, "We Won't Leave You," Mason[8] showed how the use of methohexital sodium (Brevital) administered rectally in the holding area to a six-year-old girl caused her to fall gently asleep before she was separated from her parents and taken to the operating room for hernia surgery. The use of preanesthetic medications, especially if not administered by a needle, may

be an effective means of alleviating the stress and anxiety occurring before and during induction of anesthesia. Some conscientious anesthesiologists have been concerned about the greater frequency of idiosyncratic reactions to sedative drugs in children and with the less predictable response of children to these drugs. "The dose of many drugs is not a simple linear function of body weight, and to calculate the dose as so much per kilogram of body weight is often inaccurate."[9] The possibility of unpredictable responses is illustrated by case 2 in this article. Some anesthesiologists may be hesitant to order heavy preoperative sedation for children having outpatient surgery because such sedation might have a prolonged and profound effect postoperatively, and this effect might alter the safety of parents' transporting the patient from the surgical facility on the day of the operation.

Smith[10] has stated, "We have not yet found either a suitable tranquilizing agent to help children tolerate hospitalization or a satisfactory method of preanesthetic sedation. Instead, we continue to inject illogical doses of unpredictable agents. Nor have we worked sufficiently to encourage the alternative concept, as have many pedodontists, i.e., that normal children gain valuable self-confidence by facing such trials without utilizing a pharmacologic crutch upon which they may become increasingly dependent."[11]

In their excellent review of the emotional aspects of hospitalization of children for strabismus surgery, Apt and co-workers [12, 13] emphasized the importance of the child's age in determining the emotional effect of the surgical procedure, and they offered age-specific recommendations for preventing emotional trauma.

In some cases when a child's emotional state cannot be satisfactorily managed in the holding area or in the induction room, cancellation or postponement of the surgical procedure may be advisable if the procedure is an elective one.

The stress that children experience in the operating suite can be reduced in a number of ways:

(1) Painful laboratory tests (e.g., blood counts) can usually be performed several days before an elective surgical procedure.

(2) Separation anxiety can be eliminated by allowing parents to remain with their offspring while anesthesia is being induced.[14] The overwhelming majority of parents will be supportive of their children during induction of anesthesia.[15] Anesthesiology residents at an institution in which parents were allowed to be present during anesthesia induction came to accept the concept of the parents' presence,[16] and the faculty at this institution found that for some preschool children, allowing the parents to support an anxious child during anesthesia induction was "very effective in relieving anxiety" and minimized the need for preanesthetic medication. The support of the parents in the induction room can be enhanced by preparing them for this experience (1) by the viewing of videotapes or films showing the induction of anesthesia in children and (2) by instruction from doctors, nurses and technicians.

In obstetrics well-organized programs have been developed to prepare the fathers and indeed the entire family for the birth of a baby. The need for similar programs for children who require surgery must be recognized.

Peterson and her co-workers[17-20] have reported extensively on preparation of children for medical procedures, including modeling procedures, coping techniques, the development of cost-effective presurgical preparation, preparation of well children, stress inoculation, and the role of the family in preparation for hospitalization.

Parent support groups working as hospital volunteers can help to condition parents to the idea of observing induction of anesthesia in their

own children. Screening of parents by special personnel can be considered to determine the rare parent who is not capable of giving his/her child emotional support during anesthesia induction. As Smith[10] has said, "the parents themselves must be carefully considered, for parental fear must first be controlled if the child is to be calmed." Adolescents probably ought to be given their choice of having parents present or absent during induction of anesthesia. The parents ought to be sitting rather than standing in the induction room to reduce the chance of syncope. The chairs on which the parents sit ought to have casters to facilitate movement. An observer ought to be present to evaluate and help manage stress in the parents.

(3) An attempt can be made to disguise the unpleasant odor of anesthetic gases by applying oil of orange or other substances with pleasant odors on the mask or in the tubing supplying the anesthetic gases. (Research is needed to find or develop a suitable anesthetic gas without an offensive odor.)

(4) The anesthetic mask ought not to be forcibly held over the mouth and nose while the child is conscious. It ought to be held far enough away from the face to reduce anxiety, and it may then be gradually brought closer as anxiety wanes. A transparent plastic mask is less frightening to a child than is an opaque black mask, and a transparent mask is safer for other reasons.[21] If the mask causes anxiety, it can be removed from the tubing, and a stream of gas can be directed toward the child's face from the bare tube until the child becomes so drowsy that he/she does not show anxiety when the mask touches the skin of the face. Sometimes the tube can be camouflaged in a puppet or thin blanket.

(5) Parents should be encouraged to bring to the induction room

familiar objects from home (stuffed animals, a blanket, favorite books.)[22] A favorite bedtime story read to a child during the induction of anesthesia is often superior to a sedative or tranquilizer in alleviating anxiety.

(6) Allowing the child to sit on the table for anesthesia induction rather than requiring the child to lie down seems to reduce anxiety. A less anxious child is less likely to vomit. The reflux of gastric contents into the esophagus is probably more likely if certain drugs have been given preoperatively, including atropine, scopolamine, and glycopyrrolate. These drugs reduce the resting tone of the lower esophageal sphincter.[23,24] Gastric contents are less likely to flow from the esophagus into the pharynx with the child in the sitting position than in the recumbent position because of the effect of gravity.

(7) For relatively simple operative procedures (tonsillectomies, insertion of ear tubes, strabismus surgery) children probably ought not to be sent to the same recovery room as adults recovering from major surgery, e.g., surgery on the heart, lungs, or brain. Since children usually awake rather quickly and recover uneventfully after these less serious operations, they ought to go to a different type of recovery room, where suction apparatus is present in the event of vomiting, and where the mother can be waiting so that she can be present with her child the moment he/she awakes.

Finally, to reduce stress in children in the operating room common sense and good judgment should be relied upon rather than rigid rules. If the personnel in the operating room are indoctrinated in the concept that a child is not a miniature adult, then many of the inappropriate methods used for children in the past will be avoided.

REFERENCES

1. Cairns, R. B.: Beyond social attachment: The dynamics of interactional development, in Alloway, T., Pliner, P., and Krames, L. (eds.): Attachment Behavior, Advances in the Study of Communication and Affect. New York, Plenum Press, 1977, vol. 3, pp. 1-24.

2. Freud, S.: Sigmund Freud: Collected Papers. New York, Basic Books, 1959, vol. 1, pp. 101-102.

3. Mussen, P. H., Conger, J. J., and Kagan, J.: Child Development and Personality, ed. 4, New York, Harper and Row, 1974, pp. 193-230.

4. Watson, J. B., and Morgan, J. J. B.: Emotional reactions and psychological experimentation. Am. J. Psychol. 28:163-174, 1917.

5. Perls, F., Hefferline, R., Goodman, P.: Gestalt Therapy. New York, Julian Press, 1951, p. 128.

6. Prugh, D. G.: Children's reactions to illness, hospitalization, and surgery, in Freedman, A. M., and Kaplan, H. I.: The Child: His Psychological and Cultural Development. New York, Atheneum, 1972, vol. 1, pp. 181-194.

7. Ilg, F. L., and Ames, L. B.: Child Behavior. New York, Harper and Row, 1955, pp. 148-149.

8. Mason, E. A.: We Won't Leave You, 17 min. color film, 1975. Documentaries for Learning, Harvard Medical School, 58 Fenwood Rd., Boston, MA 02115.

9. AMA Division of Drugs: AMA Drug Evaluations, ed. 5. Chicago, American Medical Association, 1983, pp. 60-63.

10. Smith, R. M.: The pediatric anesthetist, 1950-1975. Anesthesiology 43: 144-155, 1975.

11. Croston, W. L.: Child behavior and the dental experience. J. Dent. Child. 34:212-217, 1967.

12. Apt, L., Beckwitt, M. C., and Isenberg, S.: Emotional aspects of hospitalization of children for strabismus surgery. Ann. Ophth. 6: 11-20, 1974.

13. Apt, L., Beckwitt, M. C., and Isenberg, S.: Preparing the child and parent for strabismus surgery. Amer. J. Ophth. 75: 898-900, 1973.

14. Schulman, J. L., Foley, J. M., Vernon, D. T. A., and Allar, D.: A study of the effect of the mother's presence during anesthesia induction. Pediatrics 39:111-114, 1967.

15. Hannallah, R. S., and Rosales, J. K.: Experience with parents' presence during anesthesia induction in children. Canad. Anaesth. Soc. J. 30:286-289, 1983.

16. Hannallah, R. S., Abramowitz, M. D., Oh, T. H., et al: Residents' attitudes toward parents' presence during anesthesia induction in children: Does experience make a difference? Anesthesiology 60: 598-601, 1984.

17. Peterson, L., and Mori, L.: Preparation for hospitalization, in Routh, D. (ed.): Handbook of Pediatric Psychology. New York, Guilford Press, to be published.

18. Peterson, L., Schultheis, K., Ridley-Johnson, R., et al: Comparison of three modeling procedures on the presurgical and postsurgical reactions of children. Behavior Therapy 15:197-203, 1984.

19. Peterson, L., Ridley-Johnson, R., Tracy, K., and Mullins, L.: Developing cost-effective presurgical preparation: A comparative analysis. J. Ped. Psychology 9:439-455, 1984.

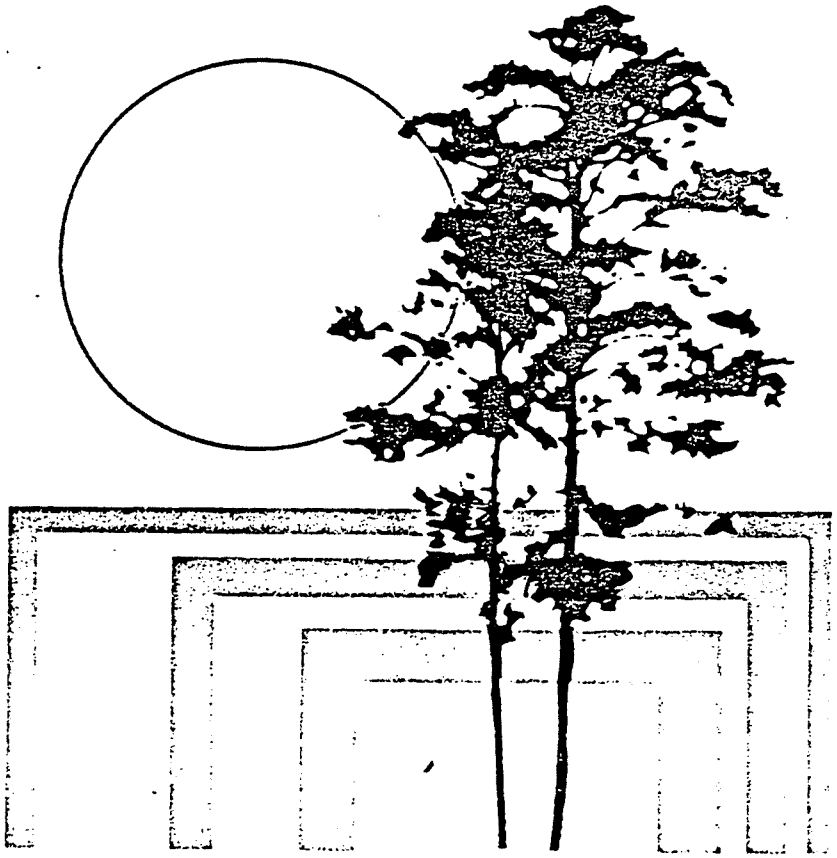
20. Peterson, L., and Shigetomi, C.: The use of coping techniques to minimize anxiety in hospitalized children. Behavior Therapy 12:1-14, 1981.

21. Stetson, J. B.: Patient safety: Prevention and prompt recognition of regurgitation and aspiration. Anesth. Analg. 53:142-147, 1974.

22. Bothe, A., and Galdston, R.: The child's loss of consciousness: A psychiatric view of pediatric anesthesia. Pediatrics 50:252-263, 1972.

23. Brock-Utne, J. G., Rubin, J., Welman, S., Dimopoulos, G. E., Moshal, M. G., and Downing, J. W.: The effect of glycopyrrolate (Robinul) on the lower oesophageal sphincter. Canad. Anaesth. Soc. J. 25:144-146, 1978.

24. Sehhati, G., Frey, R., and Star, E.: The effect of premedicants upon the lower esophageal sphincter. Acta Anaesthesiologica Belgica 29:351-360, 1978.



EUREKA, KANSAS

9/12-13/85

Special Committee on Medical Malpractice
Statehouse
Topeka, Kansas

RE: Medical Malpractice Legislation

September 12, 1985

Thank you Mr. Chairman and members of the committee for the opportunity to comment today.

I am Richard Clasen, Editor and Publisher of The Eureka Herald and spokesman for the Eureka Area Chamber of Commerce Medical Task Force.

In an extremely rural setting, Greenwood County is the second largest county in Kansas with 1139 square miles. We have only 8500 rural citizens, with 3500 of them living in Eureka, and one-fourth of the entire county population is over 65 years of age. Our people are basically middle and lower income.

Our rural patients have the services of one hospital in the county, one surgeon, four full time doctors and two other semi-retired physicians. Medical services are also extended to the neighboring counties of Elk and Woodson and to many visitors.

For many years, Greenwood County has had a high priority for quality health care. With area support, the hospital bond issue passed in 1975 and four new physicians came to our county. Now because of high malpractice premiums, health care has become seriously threatened. As a result, this task force was formed. The Kansas Insurance Commissioner met with our task force in Eureka last month,

and we are aware that he has formed a Citizens Committee to study and make recommendations on malpractice laws.

Greenwood County depends on farming, ranching, and oil production, areas far from stable in today's economy. We do not have any large manufacturing industries, and every job COUNTS. Presently 310 people are directly involved in medical services of one form or another in the county. Our doctors have discussed cutting back on services, or quitting all together. This could mean the loss of those jobs to the economy.

Those 310 jobs might seem minimal, especially in an urban area, but in rural Greenwood County there are only 4200 jobs available. The loss of seven percent would be drastic. The hospital alone has an annual payroll of $1.2 million, and those dollars are shared time and time again in the county. We survive by helping each other.

Farming, ranching, and oil production are all high risk professions, not only in terms of making a living, but they are hazardous. Our hospital and medical staff serves the needs of the Greenwood County area.

With US 54, K-96 and K-99 all running through our county, numerous travelers seek aid from our doctors and hospital. Weekend retreats to Fall River Reservoir, Toronto Reservoir, and Eureka Lake continue to bring patients to Eureka for medical services.

We do not have mass transit. There is no bus service as the Kansas Corporation Commission approved the abandoning of bus service in Greenwood County, and we do not have passenger train services. Our elderly citizens rely on the Senior Citizens Van or private vehicles to get everywhere, including the doctor's office for checkups.

We do have an excellent county ambulance service to rush citizens to the hospital or doctor. Still, a few miles for emergency help and to stabilize a condition is far more important than an hour or more on the highway hoping to get to the city in time.

All the high powered equipment found in the urban hospitals will still be needed by rural Kansans, but the rural communities need the same services found in the city--those being, doctors on call and available day or night and on weekends, close by and able to continue their practice.

Emergency medical and overall health care is an important aspect in securing new business or industry and in holding on to those already located in rural communities. Along with these prepared comments you will find letters from two large employers and a farm organization, all stressing the importance of reforms in the current statutes.

Without changes, Greenwood County and many other rural areas in the State will be faced with the loss of necessary medical services.

We would recommend your continued investigation towards reform of the current statutes, and suggest as possibilities:

* Tort reform specifically in the area of medical malpractice, with a cap of $500,000;
* A mandatory screening of all medical malpractice suits;
* Strengthening action by the Board of Healing Arts to curb health care providers who continually have malpractice litigation;
* Allow medical providers to pay into the stabilization fund monthly, rather than in advance.

Greenwood County, and all of rural Kansas, is looking to you, our legislators, for guidance and leadership. We must have reform if we hope to survive. Thank you.

EDCO DRILLING COMPANY, INC.

114 WEST LOCUST — P.O. BOX 645 — EL DORADO, KANSAS 67042

Joint Interim Committee on
Malpractice Legislation
Topeka, Kansas

September 9, 1985

Re: MALPRACTICE LEGISLATION

Dear Sirs:

On behalf of EDCO Drilling Company, Inc. (EDCO) and our employees we are writing to express our concerns regarding the current state of malpractice legislation in the state of Kansas. EDCO is one of the largest employers in the city of Eureka, Kansas and we are concerned that the continuing crisis in the medical malpractice arena will have an adverse effect on the health and welfare of our employees.

Recently, one of our local surgeons decided to forgo continuing his practice in Eureka because of the high cost of malpractice insurance. In addition, we have noticed numerous newspaper accounts of other doctors around the state of Kansas who have been forced to make the same decision. As an oil drilling contractor, EDCO is in a very hazardous, high risk industry and our need for continued proper coverage for our employees has never been greater.

We support a proposal to put a cap on malpractice recoveries as well as the use of mandatory screening committees in malpractice cases. The intended result of such proposals would be to limit the number of malpractice cases filed, decrease the cost of medical malpractice insurance, afford doctors a continued practice, and afford our employees the proper medical support necessary. In addition, the related "snowball" effect would be to help keep our medical insurance premium costs from increasing at such an astonishing rate.

We believe that legislative efforts to curb the malpractice crisis are necessary and should be given top priority. Accordingly, we support the continued efforts of your committee in this regard.

Yours very truly,

A.C. Teichgraeber

A.C. Teichgraeber

Leon J. Attebery
Superintendent

Edith Roglin
Clerk

Alma Boardman
Secretary

Eureka Unified School District 389

106 W. Sixth — Eureka, Kansas 67045 — 316-583-5588

September 6, 1985

Interim Committee on Medical Malpractice Insurance

Mr. Chairman:

The threat of the loss of our hospital and the professional employees necessary to staff such a facility and the loss of the medical physicians from our community are incomprehensible. This service is simply a necessity to the school district and to our community. I can not visualize our community without the essential service; yet, I am informed that if the malpractice insurance rates continue to increase, our community must face that possibility.

A school district with an enrollment of approximately 900 students with an active extra curricular program encounters several emergency situations yearly that demand the medical expertise found in our local hospital. I hesitate to consider the consequences if those services were not available.

The doctors and our hospital are also important to me as an employer of approximately one hundred fifty employees. When evaluating a community in which to begin or to continue one's professional career, the medical services and the hospital are important considerations. I have been able to attract quality personnel due to our services.

To conclude this request to examine the increase in malpractice insurance for the medical profession, I am hopeful that some positive action can be demonstrated and that the medical profession can continue to provide services to communities the size of Eureka, Kansas.

Sincerely,

Leon J. Attebery

Leon J. Attebery
Superintendent U.S.D. #389
Eureka, Kansas

Greenwood County Farm Bureau Association

AFFILIATED WITH THE KANSAS FARM BUREAU AND AMERICAN FARM BUREAU FEDERATION

Phone: 583-7151

P. O. Box 71

Eureka, Kansas 67045

INTERIM SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

Farm Bureaus position on medical malpractice is stated on Page 28 of Kansas Farm Bureau Resolutions 1985 which reads as follows:

Health Care and Professional Liability-

1. Prohibit publication of the dollar amount sought in a medical malpractice suit;
2. Limit the amount of money which can be recovered in a medical malpractice suit;
3. Modify and restrict the use of the contingency fee system by the legal profession; and
4. Reduce the statute of limitations and time of discovery for an alleged act of negligence or omission.

We the members of Greenwood County Farm Bureau strongly urge passage of legislation of this type concerning this problem.

If we were to lose our health care in Greenwood County I can see the following problems:

1. Loss of adequate emergency health care.
2. Increased costs due to transportation, lodging, and meals to receive health care.
3. A loss of revenue which Greenwood County desperately needs.
4. Loss of industry that might want to locate here.
5. Loss of jobs that has kept skilled, educated people living in Greenwood County.
6. An important loss of revenue to farm families, due to the fact that many farm debts are paid by wives who may be nurses, lab technicians, medical secretaries, ect.
7. A continuation of economic decline in our county.

Your action is needed to draft and pass legislation to stabilize health care costs, in this case, medical malpractice insurance.

Respectfully, Raymond L Bilson

Raymond Bilson, President
Greenwood County Farm Bureau

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

To: Special Committee on Medical Malpractice

From: Kansas Association of Nurse Anesthetists
Ann J. Rogers, CRNA

Date: September 12,1985

Thank you for the opportunity to speak on behalf of the nurse anesthetists practicing in Kansas.

The largest concern of the nurse anesthetists in Kansas is the rapidly escalating cost of malpractice and how this is affecting our job situations. One of the most affected groups is the part-time anesthetist that must pay the entire cost of malpractice insurance themselves. I have personally talked to three individuals in the Kansas City area that are going to stop giving anesthesia next year if the cost of their insurance doubles to $6,000.00 per year as projected. Since these people work only part-time they could make more money working as a staff RN without the attendant risks and pressures that exist in the anesthesia field.

The second group affected is the nurse anesthetist employed by an MD or hospital. Malpractice Insurance coverage is considered a benefit in these areas but is rapidly becoming too expensive to cover for several anesthetists. Because of this, job security is threatened in some areas.

The above situations show a definite need to lower the cost of Malpractice Insurance through limiting award amounts and how these are paid out. Also some mechanism should exist to guarantee that qualified providers are administering anesthesia.

I will be happy to answer any questions the Committee may have. Thank you.

9/12-13/85
Attachment VII

Medical Malpractice Hearings
Kansas State Legislature
September 12, 1985
Lauren A. Welch, M.D.

My interest in medical malpractice in the state of Kansas has been inspired because I was a practicing surgeon in rural Kansas until August 6, 1985. At that time I was unable to pay my malpractice insurance premium, which would have been roughtly 40% of my gross income. My malpractice insurance premiums, like those of nearly all Kansas physicians, have doubled every year since 1982. In 1984, 20% of my gross income went for malpractice insurance; this year (1985) it would have been 40%; and next year (1986), I anticipate it will be 80% of the income I would have been able to earn as a rural Kansas surgeon. I am not the only physician in Kansas who has been forced out of business by the exhorbitant cost of medical malpractice insurance. Physicians are discontinuing services previously provided, physicians are moving to other states, because they simply cannot raise their fees sufficiently to offset this cost. Our fees are of course already outrageous, and many of our patients are already unable to pay them.

When we hear about the problem of medical malpractice, we usually hear from those two groups who are most verbal: the physicians and the lawyers. Unfortunately, the consumer of medical care, the Kansas farmer, the Kansas teacher, the Kansas carpenter, or other ordinary individual, has been much less verbal and much less listened to than either of the other two groups. Physicians are verbal because they must directly pay the cost of medical malpractice insurance; lawyers are verbal because medical malpractice litigation can be quite lucrative; the ordinary Kansan

9/12-13/85
Attachment VIII

who has never been a victim of medical malpractice is for the most part unaware of how much (s)he must pay for malpractice (for example, $350.00 of the fee charged by physicians for delivering a baby, goes to pay the physicians' malpractice insurance[1]). Since the usual consumer of medical care is for the most part unaware of the impact of medical malpractice on his pocket book, he tends to let the doctors and lawyers fight it out without him.

I believe most physicians are now in a position where they must view the medical malpractice crisis as a primarily financial problem, without first giving primary consideration to the needs of the injured patient. There are numerous inequalities physicians encounter in obtaining their medical malpractice insurance. They are categorized into "risk" groups on the basis of their specialties. There is however, no differentiation between those who see many, many patients, and those who see far fewer patients. There is no differentiation between those who do many, many operations or procedures, and those who do fewer. The surgeon in a metropolitan area who operates all day, every day, may haul in half a million dollars a year. If he then pays $20,000 for malpractice insurance, that's only 4% of his income. But a rural, country surgeon like myself, who "hauls in" only $50,000 in a year, must pay the same amount for malpractice insurance. In my case, that is not 4% of my income, but 40%!

A second glaring inequality for physicians is that there is no real "merit" rating of Kansas physicians by malpractice insurance companies. That is, whether there have been malpractice

decisions against a physician in the past, has very little effect on the amount (s)he must pay for insurance. The surgeon who has been sued for malpractice seven times in the past two years, pays the same for his malpractice insurance as I must pay, even though I have been doing surgery for fourteen years, and have not yet been sued.

Lawyers find themselves in the middle. Doctors are continually blaming them for the present cost crisis of medical malpractice coverage. In spite of this they must continue to represent their clients, trying to obtain for them the maximum amount of compensation possible. This involves in many cases a formal suit, and even a trial. This is a right they feel guaranteed every citizen by our Constitution. It is the duty of a lawyer to see that his client maintains this right to his "day in court". And yet when the lawyers succeed for their clients, then receive compensation themselves for their work in medical malpractice, the doctors say the lawyers' motivation is less a concern for clients' rights, and more a concern for money. This accusation by physicians is certainly not entirely unfounded. I have myself listened to a Kansas attorney, who specializes in medical malpractice against physicians (and other health care providers), say that he no longer accepts a case of medical malpractice unless he believes ahead of time that he can make at at least $1,000,000 from it himself. Add to this insult a serious injury for the lawyers. Their malpractice insurance premiums are skyrocketing also. Another lawyer acquaintance of mine in Wamego, says his insurance went up five-fold this year.

Yes, I am afraid most physicians and most attorneys are more interested in the money side of medical malpractice, than

they are in the well-being of their patients or clients.

The consumer of medical care is the victim. Misdiagnosis, amputation of the wrong leg, unnecessary surgery, over medication... the horror stories are endless. And even if no medical malpractice occurs to him directly, he isstill the victim of increased cost of medical care caused directly by the high cost of malpractice insurance. But is the Kansas consumer only the victim? Who has grown so accustomed to high quality medical care that he expects doctors to be perfect, to never make a mistake? Who agrees with his lawyer to sue, frequently for insignificant complications or undesireable sequelae of medical care? Who agrees with the lawyer to seek a multimillion dollar settlement? And who sits on the juries that make such irrational and irresponsible awards? The medical care consumer is himself his own victim!

If there is anyone left whom I have not yet insulted, I apologize. I intended to insult everyone, for we are all to blame: physicians who have so far not succeeded in weeding out their incompetent members; lawyers for taking far more than their reasonable share of malpractice awards; and our society in general, which has become so irresponsible and sue-happy that we cannot accept even the normal risks of life. Anytime something goes wrong, we must <u>blame</u> someone else, and make them pay for it.

Yes, we are all to blame. But there is yet another culprit, more directly the cause of the present malpractice crisis than any of us, or even all of us combined: the TORT system.

TORT is slow. It requires prolonged delay to receive any compensation for malpractice victims. It is often five or more

years between the time of the injury and payment of any compensation.

TORT is unfair. Some injured people never receive any compensation because they will not sue. Some never receive any compensation because they lose in court. Some receive a few thousand dollars for the same injury for which another receives several million dollars. Some receive compensation for alleged malpractice when no malpractice ever really occurred.

TORT is expensive. Lawyers must make a living (both the plaintiff's and the defendant's), witnesses must be paid for their time and testimony. Court costs must be paid. Only 25% of the premium physicians pay for malpractice insurance ever reaches the injured patient as compensation[2]. An obscene 75% is pilfered by the expensive TORT system.

TORT has got to go!

Other countries have abandoned TORT in the area of medical malpractice (and some have abandoned TORT entirely), and have not regretted it. As long ago as 1974, New Zealand adopted a no-fault system of compensation for medical "misadventure", as the New Zealanders call it. Problems persist with the scheme, but it works, and lawyers, doctors, insurers and most importantly the medical-care-consuming public are satisfied with it [3, 4].

Sweden is another country where medical malpractice compensation is derived from a no-fault system. Since its inception there, the number of patients compensated has increased, the amount paid as compensation has increased, and the cost of providing this compensation has decreased.

Under these no-fault systems, individuals who feel they have

a compensable injury present themselves to the Compensation/ Malpractice Board. Compensation is swift and continuous as long as it is needed (unlike TORT). It is not necessary to prove fault or negligence (unlike TORT). Compensation is fair (unlike TORT). Physicians with recurring or repeated acts of malpractice are investigated and eliminated as health care providers if indicated (unlike TORT). In New Zealand, 90% of the premiums paid for medical misadventure insurance actually reaches the injured as compensation[5, 6].

Besides abolishing TORT in relationship to medical malpractice (which the lawyers of the USA don't want), more fairness in financing of medical malpractice compensation should also be accomplished. Physicians' risk for being sued depends on their specialty, and this should continue to be a means of assessing their share toward malpractice insurance/compensation. Physicians with previous malpractice settlements against them are more likely to be sued again, so they should pay a larger share than their colleagues of the same specialty with fewer incidents of malpractice. Also, the more patients a physician sees, and the more procedures he does, the greater is the exposure to incidents which may lead to malpractice. Since a physician's income depends on these numbers, his share should depend also on his income. In other words, if it is determined that a Johnson County surgeon should pay 4% of his income of $500,000 toward medical malpractice insurance, then the country surgeon who makes only $50,000 should pay only 4% of his income also. (The doctors, especially those

who make the most money, don't like this proposal.)

In the end, a no-fault medical malpractice compensation system will mostly benefit the true victims of medical malpractice or misadventure, by providing more compensation, quickly and fairly delivered. Even those not injured will benefit by less out-of-pocket payment for their injured fellow-patients' compensation. Doctors can settle down and worry about really providing good health care, instead of worrying with each patient what should be done to protect against a suit. And the lawyers can rest easy, knowing that their would-be clients are well taken care of and in most cases will not even need their services. Constitutional right to "equal" protection under the law will be replaced by better protection under the new law, as is now enjoyed by workman's compensation participants.

The time to act is now. Any delay will compound the problem. Unless the system is changed and malpractice insurance premiums decrease, physicians will either quit, as I have had to do, or they will leave the rural areas and move to the cities, or they will leave the state of Kansas entirely. Rural hospitals will close. Women will be traveling a hundred miles, in labor, to have a baby, or babies will be born at home. Ruptured appendices, ruptured spleens, car accidents, industrial accidents will all have to be transported to the city because the country doctor is gone, and the rural hospital is closed. A physician who could save a life, will be afraid to because he could not pay his malpractice insurance, and it's against the law for him to practice

without it. There will be very limited access to medical care in rural communities in Kansas, and it will not be long thereafter, that the urban communities will also be unable to obtain medical care.

I predict that if nothing significant is done in this legislative session to curb the horrendous cost of medical malpractice insurance, the above described situation will exist by 1987. There will be only uninsured physicians, providing only emergency medical care in all of Kansas. TORT must go, hopefully before it destroys medical care in Kansas.

Sources:

1. Barron, Senator Dempsey (Florida), in addressing medical malpractice seminar, Stormont Vail Regional Medical Center, Topeka. September 6, 1985.

2. Woodhouse, Justice Arthur Owen, Supreme Court Judge, New Zealand, in addressing medical malpractice seminar, Stormont Vail Regional Medical Center, Topeka. September 6, 1985.

3. Smith, Richard. Compensation: The world's best system of compensating injury? British Medical Journal, Volume 284, April 24, 1982

4. Bigler, F. Calvin, M.D. President's Message: of Kiwis and Keas. Kansas Medicine, April, 1985.

5. Woodhouse, Justice Arthur Owen, Supreme Court Judge, New Zealand, in addressing medical malpractice seminar, Stormont Vail Regional Medical Center, Topeka. September 6, 1985.

6. Bigler, F. Calvin, M.D. President's Message: of Kiwis and Keas. Kansas Medicine, April, 1985.

TESTIMONY TO SPECIAL SUBCOMMITTEE
ON MEDICAL MALPRACTICE
SEPTEMBER 12, 1985

I am Kathern Forest, member of the State Legislative Committee of the American Association of Retired Persons (AARP) representing 230,000 members in Kansas. Our national membership is approximately 20 million. The American Association of Retired Persons interest and study related to the issues of medical malpractice stem from our concern over the need to restrain the rate of increase in medical care prices -- cost containment in health care.

The problems of medical malpractice are intricately linked to the problem of quality care. Efforts to deal with the medical malpractice problems must include all elements of the malpractice issues:

* Recognition of the occurrence of medical malpractice

* Resolution of malpractice claims

* Insurance industry practices

Illinois State Senator Prescott Bloom, Chairman of the NCSL Special Committee on Health Care Cost Containment said, "I think that medical malpractice will be on the platter of every state. The titans of clout -- medical societies, trial lawyers and to an extent health insurers who write medical malpractice policies -- will be doing battle. It may not be a priority for legislatures but it certainly is for the affected groups." Certainly, the public has a vital interest in the need to rein in the spiraling costs of medical malpractice while retaining a quality of health care that is affordable and accessible to us all. In Kansas, a rural state, the high malpractice insurance premiums for the family physician makes it difficult for sparsely populated areas to recruit new doctors.

These rural, underserved areas have a high percentage of elderly. Physician distribution and patterns of practice are regional.

9/12-13/85
Attachment IX

The focus of the medical malpractice issue should be an acknowledgement of the complexity of the malpractice issue -- with regard to cost, quality and responsibility (blame). All contributing factors should be addressed.

Medical malpractice does occur, therefore, it is important to set up procedures to weed out incompetent physicians. At the same time, an examination of proposed tort reform of the medical malpractice system can be addressed. Options supported by AARP include:

1. Kansas should mandate that medical review committees, governing boards of health care facilities, and the Board of Healing Arts to investigate the improper conduct, incompetence, and repeated malpractice settlements of physicians. To facilitate such investigations, health care facilities should report disciplinary actions taken against physicians to the Board of Healing Arts.
2. Boards, committees, and persons testifying before them should be given immunity from liability suits unless intentional fraud is involved. This measure would enable these organizations to <u>be more effective in disciplining incompetent physicians</u>.
3. Health care facilities should also be required to report untoward deaths or neurological damage to the Department of Public Health for investigation. This would alert the Department to patient care problems.
4. The State should limit the number of times that an applicant can take the physician licensure examination, thus preventing some unqualified people from becoming physicians.
5. Another option is to increase the number of consumers on the licensure board. The Board's actions then would reflect more than just the physician's point of view.

There are several trends discussed beginning on page 9 of the NCSL Report (July, 1985, Robert M. Pierce, Research Analyst) such as:

* "Impaired doctor/patient communication and trust resulting from the increasing depersonalization of health care".

* "Rising expectations by patients and jurors of success in medical practice".

To these may be added the expanding spectrum of health care practitioners and, as a result, the need for continued and additional regulation of the scopes of practice of these practitioners. There should be uniformity in the interpretations of regulations for all credentialled (registered or licensed) occupations/professions. Each of these segments of the health care industry has an area of professional responsibility.

* "Increased willingness to sue in general and urbanization in particular which explains much of the difference in the frequency of claims between areas."

As the incidence of litigation occurs, there occurs additional deterioration of the doctor/patient relationship.

* "Liberalization of legal doctrine and increased sophistication of malpractice attorneys."

The legal profession also has an area of professional responsibility to which it has not responded. What impact do attorney contingency fees have as an incentive influencing the regulation and the incidence of litigation? Modification to civil practice laws needs to be evaluated. Conflict between the involved professional groups has been a deterrent to progress so far. Structural and administrative changes such as pre-screening or arbitration are possible. In states where tort reform has survived constitutional challenge, studies (by the Institute for Civil Justice of the Rand Corporation) include evidence of the tort reform effect on malpractice claims:

"Dollar gaps on awards, elinination of specific dollar claims by the plaintiff, and authorization of installment payment of large awards appear to have significantly reduced jury awards and settlements in the states where they were enacted. Notification of the collateral source rule to admit evidence that the plaintiff is eligible for compensation from other sources has apparently had a much weaker effect. Statutory limits on the contingency fees charged by plaintiffs' attorneys have had moderately depressive effects on settlement amounts on the number of cases going to verdict."

One of the strategies mentioned in this Report is that of limiting plaintiff awards. However, AARP believes that those who are truly victims must be adequately compensated for their injuries.

In addition, insurance industry practices must come under closer scrutiny. The legislature and the insurance industry need to analyze all areas of medical malpractice claims. The Association of Trial Lawyers in testimony before a Senate Committee alleged that the malpractice insurance companies have made more in investment income of medical malpractice reserves than they have paid out in claims. The facts and figures behind this allegation need to be explored. Certainly such actuarial studies need to be done in Kansas.

There are dramatic changes occurring in health care. "Competition in the health care industry has created new opportunities for consumers ... to contemplate private solutions to the problems posed by tort law for medical care providers and their patients." (C. C. Havinghurst). The advent of the prospective payment system, DRG's, and HMO's emphasize other alternatives to the present practice of medicine. Prevention of medical malpractice is also a vital

part of any malpractice reform. Legislation must contain measures for systemic reporting of medical negligence to the Healing Arts Board and require the Board to take effective action against incompetent physicians. Legislations also should require health care facilities to be more responsive for the quality of their entire health care staff.

Rising cost of health care must be brought under control. Money now thrown into an inefficient tort system should be used in programs that contain costs -- not expand them. It is too early to assess the effects of procompetition in health care. Exploration into the practices of the insurance companies needs to move forward. Tort reform proposals should be examined.

You are dealing with a complex problem. It seems evident that no single bill can address all factors. No single committee or commission can address all factors. No single legislative session can address all factors.

Any hasty or premature actions could have detrimental consequences for the entire health care system.

KF:mgf
9/4/85

SPCH-3
MEDMAL

ADVERTISING

BY

PLAINTIFF'S "EXPERTS"

9/12-13/85

Attachment X

TRIAL May 1985

President's Page

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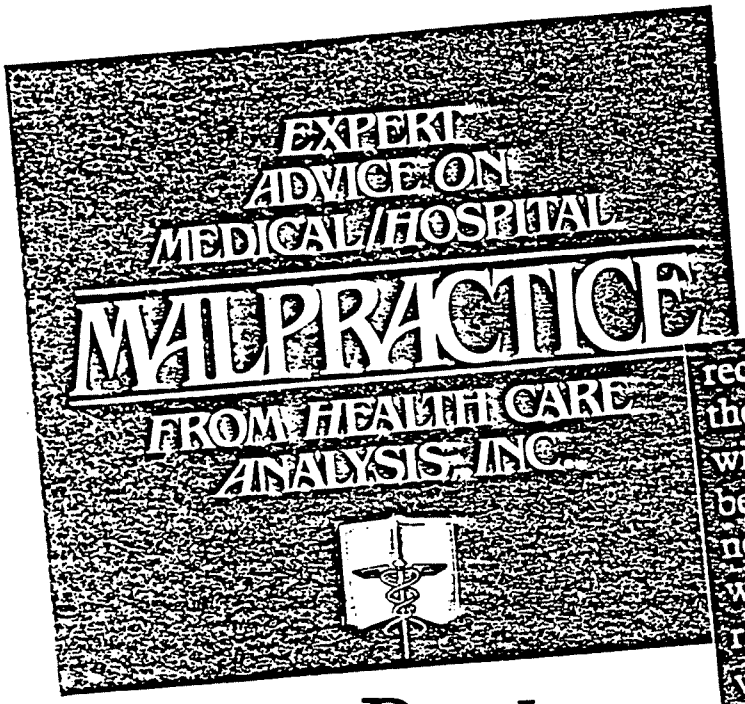

Brochures

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The following professional testimony fees apply for most Experts: deposition in the Expert's hometown is $900 for up to four hours; a video-tape deposition in his hometown is $1500 for up to four hours; an out of town deposition or Court appearance is $1800 per day. Arrangements and payment for a court reporter, as well as any necessary video tape equipment are your responsibility. If any Expert's fees will exceed the above noted costs, we must have your approval prior to engaging the services of that Expert.

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9/12-13/85

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November 27, 1978

Dear Mr.

We have your letter and thank you for corresponding. We have many cases in your area and I am testifying in Lansing and Detroit next month. We have cases with and in Detroit.

Fees for work-up are enclosed as well as a few interesting cases. A new c.v. is being typed up at the present time and shall be forwarded with reports.

Sincerely,

Richard C. Gardner, M.D.

NOV 29 1978

Richard C. Gardner, M.D.

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Arrive Saturday - no charge (expenses only).
Sunday - examine patient and pre-trial conference - no charge (expenses only).
Monday - review records.
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Please wire all fees well in advance to Account No. 112-533, Beach First National Bank, Fort Myers Beach, Florida 33931, Att: Linda Cassidy. Delay in doing so will mean we will be unable to leave the office.

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'No More Vietnams': Nixon tells his side

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FORT MYERS
NEWS-PRESS

Fir

Newspaper

Sunday • April 7, 1985 • Fort Myers, Florida

Have M.D., will travel

Local doctor injects controversy into medical malpractice trials

• This profile of the doctor is drawn from hundreds of pages of his trial and deposition testimony.

By BARBARA JOHNSON
News-Press Staff Writer

The doctor wears a professional white coat with capital letters FUHER on the breast pocket when he greets the lawyers who pile into his office. FUHER: That's Framingham Union Hospital Emergency Room, part of a prestigious medical and teaching center near Boston.

Only this is Fort Myers. And the doctor isn't on the staff of the Framingham hospital.

In the patient waiting room where no patients are waiting, the lawyers' attention is drawn to a certificate nailed to the wall naming the doctor as a consultant to Westborough State Hospital. Westborough is a psychiatric institution in Massachusetts.

Only this doctor is an orthopedic surgeon.

The lawyers have come to a building the doctor tells them is his private hospital. But the state of Florida has no license on file for a hospital at this address.

The lawyers have brought a court stenographer who asks the doctor to raise his right hand. And, once again, he solemnly swears to tell them the truth.

Meet Dr. Richard C. Gardner at his 3653 Central Ave. office. Countless lawyers from at least 23 states, the District of Columbia and Puerto Rico already have.

Gardner is what is known as a hired gun, someone with specialized credentials willing for a price to testify as an expert witness against others in his field.

Taking aim at "hired guns"..6A

The classified ad appeared in 1978 on page 80 in the back of Trial, a magazine for plaintiff's lawyers, the lawyers who file suits.

For those who would write — the lawyers who sue doctors and hospitals in particular — the correspondent at Department RG turned out to be Gardner.

Gardner has a 1962 degree from Tufts University School of Medicine. He says he is licensed to practice medicine in Florida and four other states, is certified by the American Board of Orthopedic Surgery and has written articles for a number of publications.

In the world of medical malpractice litigation where doctors usually are loathe to testify against even their negligent peers, Gardner is a man in demand.

Lawyers say Gardner, who has been at it for almost 20 years, is one of the most prolific and widely traveled professional witnesses in the medical malpractice field. He has never testified in a doctor's defense.

Gardner claims he has been hired by almost all the major law firms in cases from Maine to California and knows of only one other orthopedic surgeon in Washington, D.C., and possibly a few in Southern California who have testified as much or more than him.

See COURTROOM DOCTOR, page 6A

Courtroom doctor

From page 1A

He is listed as a witness in at least two malpractice cases in Lee County and one each in Texas and Indiana.

But lately, some of the lawyers who have hired him and some judges are saying the medical gunslinger from Fort Myers is badly misfiring.

Lawyers in Alabama, Texas and Colorado who hired Gardner have publicly accused him of lying under oath.

"He dances to a different drummer," Sarasota lawyer Peter Martin said.

In Punta Gorda in 1982, Martin dropped his malpractice case in mid-trial while Gardner was on the witness stand and said he then grabbed his check back. From the bench, Judge James Adams was issuing not-so-veiled threats to throw Gardner in jail for being unresponsive to the defense lawyer's questions.

"He can qualify as an expert in evasion and bullshand that's about it," Adams declared in chambers.

Alabama lawyer Robert Cunningham stopped Gardner's deposition in progress in 1982 and dropped him as a witness after concluding Gardner was lying to the defense. Among other things, Gardner testified he didn't recall whether he had been paid for his testimony; Cunningham said he had just delivered to Gardner the $600 advance check he demanded.

"He's a horse of another color," Cunningham said.

Because he didn't have a witness to replace Gardner, Cunningham settled his malpractice suit for one-fourth what his side thought it was worth had it gone to trial.

Fort Myers lawyer Jeff Garvin is suing Gardner for fraud, contending Gardner also lied about his qualifications when Cunningham hired him and in his deposition.

While the jury was out in a Lubbock, Texas, malpractice trial in 1982, Dallas lawyer Lee Steinberg an-

Gardner: Yes, of course.

Franklin: And do you recall, in fact, that it submitted to you for signature?

Gardner: Yes, of course.

Franklin: Isn't it a fact you submitted your signat page by adding to that, right here, no questions asked corrections of anything, these words:

"Both he and his wife know they are in the middle Highland Scotch, Jewish, German, Cherokee Indian tricky, silent and prejudiced redneck mixture area are concerned. I and others will be in Naples to ensu fair trial and explain what malpractice exists in this c Richard C. Gardner, Dec. 12, 1981."

Gardner: Well, sure. . . . That was a correction a mentioned it and, for the benefit of the jury, it's a statement of what happened at the deposition. The was being railroaded and you know it too.

***

On the Central Avenue doctors' row, parking lots crowded with patients' cars. The exceptions are we ends and Wednesdays, when some doctors take off, Gardner's lot, which is more often empty. For days end, calls to Gardner's office go unanswered. No pag service offers to reach him in an emergency.

Though he has been in private practice in Fort My since 1976, Gardner is a relatively unknown figure h operating on the fringes of the local medical communi

Despite his testimony that he has a large priv practice in Fort Myers, Gardner never has been on medical staff of any Southwest Florida hospital, altho

He claims to be a handwriting expert and, unprompted, will swear to the sex of a hospital worker based on notations on a patient's chart.

He keeps handy for his depositions a copy of his 1978 canceled check for $150 dues made out to the American Academy of Orthopedic Surgeons, an invitation-only professional organization. Gardner's application for membership was denied, but the academy by error in 1978 sent him an invoice for dues. Though his money was refunded, he listed the academy on his resume.

Gardner works out of a one-story duplex with an enclosed garage and peepholes in the front doors. There, he has testified, he can do anything a doctor can do in a hospital. He says he performs surgery under general anesthesia, keeps patients overnight and takes X-rays, though the state has no registration for a radiation machine under his name or at his location. He often denies knowing the names of his staff, which he says comes from temporary employment services.

To this building come the lawyers who find him through his advertisements, expert witness referral services and by word-of-mouth.

***

Case No. 82-Cv5-01058, Franklin vs. Bassett, Durham County, N.C.

Defense lawyer E. C. Bryson Jr.: Doctor, have you ever applied to the American Academy of Orthopedic Surgeons?

Gardner: Yes, sir. And I think that application shows the arrogance and irresponsible nature of the organization. Trying to send me a membership and the sloppy way they do things and then circulating a hit list, like Watergate, like Nixon's hit list, and I just seem to think that it's pretty bad and mudslinging.

***

Case No. 77-2208, McClure vs. Dougherty, U.S. District Court for Kansas.

Plaintiff's lawyer Jerry Levy: Does the American Medical Association require any credentials to belong to?

Gardner: Yes, sir.

Levy: What are they?

Gardner: They review your background and, in addition, to get the Physicians Recognition Award, they put you through a strenuous qualifying ordeal.

Levy: What is the Physicians Recognition Award?

Gardner: I was given a Physicians Recognition Award in 1971 for contributing to orthopedics.

***

Interview, Tom Toftey, public information officer for the AMA:

"Physicians Recognition Awards are given out really

Special to the News-Press

DR. RICHARD GARDNER GIVES DEPOSITION
. . . photo was taken from videotape

Gardner's trial and deposition testimony. When Gardner's court schedule is tight, The Box moves by Federal Express. Gardner thinks the information in it has been put on computer.

"It just kind of follows Gardner around. It's a tremendous amount of material where he has contradicted himself," said Worley, the defense lawyer from Lubbock, who once had custody of The Box. "It's cross indexed and so well organized you can almost pick it up and go to trial without even looking into it.

"Like the American Academy of Orthopedic Surgeons membership, you can find where one day he said yes, the next day he said no, one week later he said yes, two weeks later he said no."

And if The Box isn't enough, defense lawyers say they go to James Franklin of Fort Myers, the premier defense lawyer locally for doctors and who — at about 25 times — probably has cross-examined Gardner more than any other lawyer. Out-of-state lawyers vacationing in Florida sometimes schedule a side trip to Fort Myers just to peruse Franklin's files.

"He (Franklin) may have the greatest library of depositions on Gardner of anybody," said Dan Dupre, claims supervisor with the Florida Physicians Insurance Reciprocal, the doctor-owned insurance carrier in Jacksonville.

The most devastating strategy used by defense lawyers who know of Gardner has been to decline to take his deposition before trial.

So the lawyers who hired Gardner — often sight-unseen based on his resume — hear him testify for the first time on the witness stand at trial.

"I just sat there squirming," said Kerry Alexander of Saginaw, Mich., who hired Gardner at the last minute for a 1982 malpractice trial after Alexander's other expert witness backed out. Alexander said he thinks he found Gardner through a mailed advertisement.

Alexander said the defense lawyer at the trial "had a book on him."

"It was like walking into a brick wall," said Martin of Sarasota, who dropped his suit while Gardner was on the witness stand. "We didn't even get to the liability issue. We were still on his qualifications."

During a recess hearing in the judge's chambers to discuss Gardner, Martin pleaded with Franklin, who was representing the doctors and their insurance carrier, to settle the case for some paltry sum just so he could save face with his clients.

"You called him a medical whore," Martin told Franklin. "I can deal with medical whores and they're allowed to testify. He's a medical jerk."

"I just felt like sinking through the floor," said Steinberg of Dallas. "He's very hyper, talks real fast, won't give you a straight answer, really. He's very defensive. He has to be defensive because they (the defense) have so much ammunition to use against him."

Ask Gardner w[illegible] he testifies in so many malpractice cases and he m[illegible] tell you, as he has told so many lawyers, that he does it for "truth, justice and the American way."

Donald Ricard, a lawyer from St. Clair Shores, Mich., is one who wrote to Trial magazine, Department RG. Gardner sent him a brief letter of thanks and a fee schedule:

"A good expert is hard to find. First class treatment is expected and no exceptions will be tolerated . . . Depositions $250/hour (minimum $500) . . . Live courtroom testimony $1,500/day plus expenses (minimum $3,000) . . . (Reservations for two —wife comes along — Eastern Airlines) . . . Please wire all fees well in advance to Account No. 112-533, Beach First National Bank, Fort Myers Beach . . . Delay in doing so will mean we will be unable to leave the office."

Defense lawyers who represent doctors, hospitals and malpractice insurance carriers contend Gardner makes a living as virtually a full-time testifier and no-time doctor. Just how often he testifies and how lucrative it is, only Gardner knows. Courts have ruled Gardner doesn't have to tell them.

In a Kentucky case in 1983, Gardner acknowledged testifying more than 200 times in the previous two years in malpractice and other kinds of personal injury cases. In January, his fee was $2,500 for a deposition in a Tennessee case.

Though his medical specialty is orthopedic surgery, Gardner has offered testimony in neurosurgery, infectious disease, internal medicine, gynecology and obstetrics, pathology and emergency room cases

"If you're an orthopedic surgeon, you're not an expert in neurology. And conversely, if you're a neurologist, you're not an expert in orthopedic surgery. But Dr. Gardner seems to think he's an expert in all of them. From a medical and practical standpoint, you just can't do this," said Joe Colingo of Pascagoula, Miss,, the defense lawyer who cross-examined Gardner in front of Cunningham, the Alabama lawyer.

"This guy's unique in as much as he knows no bounds," said Mike Worley of Lubbock, the defense lawyer who opposed Steinberg at trial. "If you've got a meritorious case — a good case — you can get expert testimony without resorting to someone of Gardner's ilk. We have a word for them synonymous with ladies of the night."

***

Case No. 5181, Redman vs. Decastro, Gratiot County, Mich.

Defense lawyer Jon March: There have been two cases where you were sought to be used as an expert and the court denied you that right as being incompetent to testify, is that right?

Gardner: No. It was a kangaroo court in the South where there was a lot of prejudice and bias and good-old-boys, and that was — the judges errored. It was complete errors on the part of the judges.

March: You say those were kangaroo courts deep in the South?

Gardner: It was in the Deep South and the judges errored. The judges make mistakes, too.

March: Deep South being Florida where you live and work?

Gardner: Yes.

***

They call it The Box, and a few of the lawyers who sue doctors know it exists although it belongs to the defense. It's made of cardboard and filled with excerpts from

looking [illegible] copy of the same document fro[illegible]ich Mr. Cohen [illegible] just questioning you. He skippe[illegible]one paragraph there about the military in 1967 through 1969. Were you in the military?

Gardner: Yes, sir.

Franklin: Your qualifications list here, from which Mr. Cohen was reading, says: "Over 900 operative procedures performed during the Tet offensive and battle of Khe Sanh." Do you recall that being included in there?

Gardner: Yes, sir.

Franklin: You weren't in Vietnam, were you?

Gardner: No, sir. I was not.

Franklin: You did those 900 procedures back in Chanute Air Force Base in Illinois?

Gardner: That's correct, sir.

***

Lawyers disagree on the extent of a "conspiracy of silence" among doctors reluctant to testify against each other.

"In the big city where there are more hungry doctors, they may be more willing to testify," Alexander said. "But I'm in a small town in the middle of Michigan. The conspiracy of silence is alive and well."

"There are people who take advantage of that by offering their services for anything," Martin of Sarasota said.

But many lawyers think Gardner's courtroom career is destined to end.

Defense lawyer Franklin said Gardner's testifying was at its peak from 1979 to 1983 and perceives a decline in his use locally during the past six to 10 months.

Tony Cunningham of Tampa probably has filed more malpractice suits than any lawyer in Florida and says he has about 200 cases in progress at all times. Cunningham said he hired Gardner in the past but never again "because he is so assailable now because he's expressed himself in a crazy way, in a paranoid manner.

"Dr. Gardner is hardly typical. He's too wild. He's unpredictable," said Tony Cunningham, who saw Gardner in court in January for the first time in several years. "I think there's no question that the doctor has changed over the years."

In one deposition recently, Gardner had armed guards roving his office building while he testified. When asked about it, Gardner said, "That's right. That's the kind of characters that came down." He was referring to the defense lawyers.

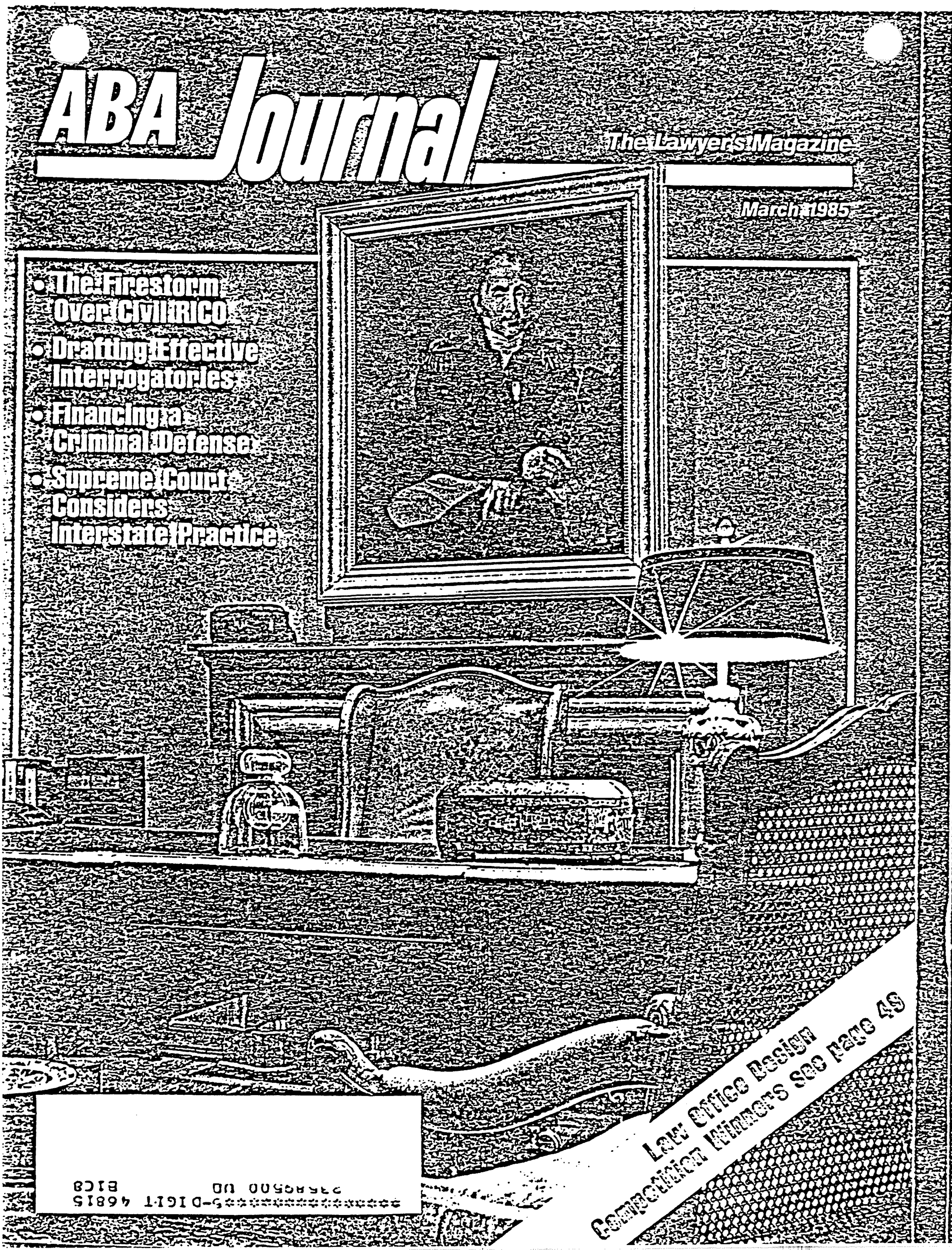
Soon after the fraud suit was filed against Gardner, Alabama attorney Robert Cunningham said he received in the mail an "obviously fake" $15 million legal malpractice suit purportedly filed against him and Garvin of Fort Myers in federal court on behalf of Gardner.

The suit was signed Kenneth Campbell-Ferguson and listed a Miami address and phone number for him. The phone number rings at a large Miami law office, but no one by that name works there. The Florida Bar has no listing for a lawyer of that name. The federal court in Miami has no record of the suit being filed.

While it could not be determined who drafted the suit, it has the ring of Gardner's prose. One of its allegations: Robert Cunningham and his legal associates damaged their own case even though they "were well aware they were in a very conservative clan Highlander-Chickasaw area and not a Cherokee area like Alabama."

Mississippi lawyer Colingo said Gardner's reputation is "pretty widely known" among defense lawyers around the country. And getting more known among lawyers who sue doctors. Alexander said he's told several who have asked that he would not hire Gardner again.

"He will burn himself up like a candle," Lubbock lawyer Worley said. "His usefulness will soon peter out and he will cease to be an issue."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BUSINESS VALUATIONS. LAWYER, C.P.A., A.S.A.; investment banker; courtroom experienced. Yale Kramer, 8033 University Avenue, Des Moines, Iowa 50311. 515/224-0104.

AIR TRAFFIC CONTROL CONSULTANTS, Inc. Aviation accident investigation, technical assistance/research. Post Office Box 694, Hollis, N.H. 03049. 603/465-2444.

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EMERGENCY ROOM MEDICAL SPECIALIST - consultation/testimony. ITC, 167 Willis Avenue, Mineola, N.Y. 11501. 516/747-8400.

MEDICAL-LEGAL CONSULTATIONS BY Board Certified Internist, medical, neurological, industrial, disability consultation, and evaluations. George Lewis, M.D., F.A.C.P. 3937 Roll Avenue, Bloomington, Ind. 47401. 812/336-7175.

DENTAL MALPRACTICE—CONSULTATION testimony. Complete staff covering all dental specialities. H. Bass, D.D.S., 167 Willis Avenue, Mineola, N.Y. 11501. 516/747-8400.

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STATISTICAL ANALYSIS: PSYCHOLOGISTS experienced in Title VII cases; Z tests, binomials, regression, etc. Call Dr. Kenny at 901/682-8569.

NEUROLOGY-CONSULTATION/TESTIMONY. ITC, 167 Willis Avenue, Mineola, N.Y. 11501. 516/747-8400.

DRAIN CLEANERS AND HOUSEHOLD PRODucts. Expert evaluation and testimony. C.J. Abraham, Ph.D., P.E., 167 Willis Avenue, Mineola, N.Y. 11501. 516/747-8400.

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COMMODITIES LITIGATION EXPERT WITness. Former federal investigator and brokerage compliance officer with fourteen years' industry experience in futures regulation and in-house compliance. Available for testimony, trading analysis, consultation. Civil, arbitration and reparations. Leslie Jordan, Suite 1700, 327 S. LaSalle, Chicago, Ill. 60604. 312/831-3769.

CRANE & RIGGING ACCIDENTS. EXPERT witness, investigation and reconstruction. Bob De Benedictis. 305/275-7327.

VALUATIONS CLOSELY-HELD BUSINESSES or minority interests. Expert testimony: CFA; DBA; extensive experience. Mercer Capital Management, Inc., 1503 Union Avenue, Suite 201, Memphis, Tenn. 38104. 901/725-0352.

Journal

September 12, 1985

What I have to say will be unpleasant, however, in order to to understand the point of view of malpractice victims you need to know what a victim has faced and will face for the rest of their lives.

At two and one half years of age my daughter, and ten other children, were misdiagnosed as having Hirschsprungs Disease, which is a complete absence of nerve cells in the lower portion of the large intestine. My husband and I were told by Dr. Medo Mirza "If she did not have the corrective surgery for this ailment she would die in two weeks. Of course, all reason and logic leave a parent when faced with such a statement by a pediatric surgeon. After three surgeries by Dr. Mirza and an excruciatingly painful post operative period, Andrea was taken to U.C.L.A. Medical Center for further evaluation.

From November of 1976 until late February 1977 Andrea could not sit or take solid food. She ran a constant temperature and the pain never stopped unless she was sleeping. During this Three and one half month period, Andrea would stool as many as 50 - 60 times per day. Each stool containing pus and sometimes blood. Dr. Mirza would do rectal exam's that he claimed were to tear out adhesions, these dilitations were unbearable for Andrea, large masses of tissue and blood were torn from her anus, with nothing whatsoever to minimize the pain. During this time Mirza did nothing to help this very sick child. He would tell the nurses and myself she was doing all this for attention. How a child of two and one half years of age can defecate 50 - 60 times a day and run a termerature escapes me completely. Subsequently, Andrea had to undergo eleven major abdominal surgeries, in an effort to

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Attachment XII

correct what this man had done to her for a non-existant disease. Andrea had 3 colostomys at various different times and spent over four months in the hospital.

At the present time this 11 1/2 year old girl lacks the ability to preserve fecal continence in any reliable manner. Her life is burdened by daily, physically and emotionally stressful cleansing routines which have only limited efficacy. She has developed potentially lethal adhesive intestinal obstructions in the past and remains at risk for reoccurance at anytime. She will always experience "accidents" and be burdened by the apprehension of loss of bowel control. Her ovarian function is questionable at this time due to the ovaries being adhered to the anterior abdominal wall by adhesions. This is just one example of what an incompetent or unscrupulous physician can do. I feel it is very wrong to further victimize the victims of malpractice by passing legislation placing caps on pain, suffering, and punitive damages. The answer to the problem of high insurance premiums lies with the physicians themselves. If doctors would police their own by revoking the licenses of repeat offenders. I feel certain the claims paid out by the insurance carriers and the Kansas Malpractice Fund would be greatly reduced, and theoretically this should reduce premiums as well. This statement is based upon the fact, that in a relatively short period of time Medo Mirza has been sued nine times and settled out of court nine times. It would stand to reason that if these were just nuisance suits surely they would have gone to trial.

In february of 1981, after waiting 19 months, a hearing was

finally scheduled by the Kansas State Board of Healing Arts regarding Dr. Mirza. Our state board totally exonerated the man in the face of contraindicating clinical, radiographic, and pathology regarding the diagnosis of Hirschsprungs Disease. This can only be interpreted as one colleague protecting another. Since this board is totally autonomous there is no recourse but to accept their decision.

The February 24th 1985 issue of the Kansas City Star quotes Ms. Betty Jo McNett, then president of the Kansas State Board of Healing Arts, regarding the Mirza case, wherein she states " the board concluded there was not enough evidence to revoke the Dr.'s license.

But now 3 years later, there has been some rethinking. Ms. McNett concedes all of the evidence may not have been presented because the board's part-time attorney was not fully prepared. This same article quotes an expert witness from Los Angeles as stateing "The board was working at protecting the rights of the Doctor with perhaps, not enough consideration for the vulnerability of the patients." With this knowledge it would seem attention to the conduct of this board is necessary, and perhaps, some changes in its proceedure are in order.

Malpractice cases are no different from any other civil lawsuit and for this reason they should be judged solely on their merit by a jury of our peers, not by legislators who cannot have full knowledge of each individual case. It is inconceivable that a select few should be allowed the priviledge of knowing whatever they choose to do they are only liable for X number of dollars to compensate their victims. This piece of legislation would

only serve to help 3000 - 3500 people in our state and the already extremely wealthy insurance companys. Leaving the consuming public, in gross cases of malpractice no chance for fair compensation.

If caps are to be placed on malpractice suits for physicians are we not opening the door for Dentists, Teachers, Lawyers, engineers, realtors, and etc. to ask for the same courtesy? As a realtor I would find it very comforting to know that there were caps on lawsuits involving real estate.

In conclusion I would like to say again, caps are not the answer to the high insurance premiums that physicians are paying, the problem will be solved when doctors stand up and demand that those in their profession who are proven incompetent, unscrupulous, and unethical promptly have their license to practice medicine revoked in this state.

Thank you for your time.

Sincerely,

Bobbi Steinbacher

Bobbi Steinbacher
5416 Apache
Great Bend, Kansas 67530

Sept. 12, 1985

Ladies & Gentlemen:

I come before you as a concerned consumer and the parent of a victim of malpractice. My daughter, Shannon Vyff, was misdiagnosed as having Hirschsprung's Disease when she was three months old. This misdiagnosis was made by Medo Mirza, M.D. of Wichita. This, despite clinical, radiological and pathological findings to the contrary. Dr. Mirza can not plead ignorance on this disease as he has co-authored a book on pediatric surgery which devotes a whole chapter to Hirschsprung's.

Shannon underwent 23 surgeries by the time she was in the first grade. Eleven of these surgeries were done by Mirza and they only compounded mistakes he made. The remaining twelve surgeries were performed in Kansas City, Los Angeles and Chicago. Shannon spent over seven months hospitalized with many more months away from home for post-op follow-up care. She has had two colostomies and one ileostomy.

She currently has her intestines routed to her anus. But, due to having lost half her colon, as well as muscle and nerve damage in the rectal area, she is fecally incontinent. She stools about ten times daily. Her stools are not normal, they have the consistency of soft ice cream one would get at a Dairy Queen. She never sleeps through the night because of bowel movements. Her perianal skin is normally red and sore. She takes upwards of 20 pills daily to aid her food digestion and slow down her peristaltic movement. She always carries a purse with her that contains clean panties, pads and baby wipes. She has been in psycho-therapy for nearly two years to deal with emotional problems stemming from her traumatic preschool surgical history. I am happy to say her psychological health is showing signs of improvement.

Shannon is in the fifth grade and as you can see her life is far from that of an average fifth grader.

Her medical bills, incurred since the act of malpractice, are in excess of $230,000.00. And, she still has a long life ahead of her with many complications and future bills.

But, in a way, she is one of the lucky ones. She has not lost her life, any limbs, her sight, her brain function, been paralyzed, etc., etc. as have other victims of malpractice.

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Attachment XIII

It is wrong to limit awards to victims. Consumers should have the right to a trial by a jury of their peers with awards based on the facts of individual cases.

It is also wrong to limit what a victim can be allowed to pay their attorney unless the doctor's defense attorney also has his fee restricted. If not, the defense should at least be restrained as to how long they can postpone and thereby drag out cases.

Doctors should police themselves better. I was privy to all the information in Dr. Mirza's Hirschsprung cases. I attended and read all the depositions in the cases. I accepted an out of court settlement on behalf of Shannon, with the bulk of the money coming from Mirza's insurance company. I then watched the Kansas Board of Healing Arts white wash the whole affair. The Board's attorney was ill-prepared. An overwhelming amount of evidence was not presented. Testimony Mirza gave at his Board hearing conflicted with his own deposition testimony. It also conflicted with the pathology group's (one of whom Mirza accused as the wrong doer), the chief of surgery's and my own. Yet, the Board attorney chose not to expose the intricacies of this. The Board chose to believe Mirza, the accused. The Board's attorney did try to enter in evidence a fourteen page report written by an expert in Chicago. The Board Panel refused to accept it. Twelve of these pages were quite incriminating. Two of the pages exonerated Mirza in just one of the four cases covered by the report. Mirza's attorney tried to enter these two pages into evidence. The Panel readily accepted them. These two pages didn't even identify the author, one needed the whole report for this. I was astonished! That could never happen in a court of law with a good plaintiff's attorney. At the same time the Board was holding the hearing, Wesley Medical Center held an in-depth peer revue of Mirza. As the Board exonerated him, Wesley only allowed him to continue his practice under non publicized restrictions. Not long ago it was announced Wesley was to be purchased by a for profit company. Shortly thereafter Mirza and Wesley reached a confidential agreement and he discontinued his practice.

On April 8 of this year, NBC Nightly News had a segment on malpractice. It stated that between 1978 & 1983 insurance companies collected 7.3 billion in malpractice premiums. In the same time, they only paid out 1.5 billion in claims and earned another 1.8 billion in

interest on invested premiums. It also said the companies set aside huge reserves so they won't get taxed on the money in them. If one computes the above figures, it leaves the companies with 7.6 billion - this, more than the premiums collected! I might also point out the physician NBC featured as a prime example of malpractice was Dr. Mirza.

I recently contacted the National Insurance Consumer Organization and would like to call your attention to materials they sent me. First and foremost look at the top piece, MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM NOT TORT REFORM. Two of the three authors are doctors. Please take note on the last page that Kansas is tied dead last on medical disciplinary actions.

Ms. Jan Payne
27 Laurel
Wichita, KS 67206-2542

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Public Citizen Health Research Group Report

MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM, NOT TORT REFORM

Sidney M Wolfe, M.D., Henry Bergman, George Silver, M.D.

During the past year, there has been an unprecedented amount of attention given to the most prominent symptom of the problem of inadequate quality control and discipline of American doctors. The "symptom" is the malpractice insurance crisis, wherein some doctors in certain subspecialties in some parts of the country are no longer willing or able to afford the skyrocketing malpractice premiums being requested by the malpractice insurance companies. The "treatment" for this problem of incompetent doctors -- largely prescribed by the AMA and its state affiliates -- has been to focus on the symptoms rather than getting at the underlying disease. Just as it did during the last malpractice crisis ten years ago, organized medicine has succeeded in diverting attention away from the issue of the dangerously inadequate discipline of doctors by going all out to pass state tort reform laws that will, in a variety of ways discipline injured patients or the families of dead patients and their lawyers instead of the doctors.

In this report, we review the following:

I. State-by-state comparisons in disciplining doctors:

- Of almost 400,000 patient care doctors in the U.S., only 563 had their licenses revoked or suspended or were put on probation in 1983.

- Utah, with 5.2 such actions per 1,000 doctors was 36 times higher in discipline than Massachusetts which had only .14 of these serious disciplinary actions per 1,000 doctors.

- 10 states, with a total of over 18,000 physicians had no serious disciplinary actions in 1983. For some of these 10 states, it is possible that they actually disciplined doctors but did not report their actions to the Federation of State Medical Boards from which we obtained the data.

- New York, the state with the biggest increase in malpractice premiums this year, has one of the lowest rates of doctor discipline - only .49 serious actions per 1,000 physicians or 21 such actions per 42,063 physicians. This was less than 1/10th of the rate of disciplinary actions in Utah.

9/12-13/85 Item I, + XIV

II. How Much Malpractice is Actually Ocurring?

The gap between negligent actions by doctors and discipline of doctors. Although there were only 563 serious disciplinary actions in 1983 of the 389,467 non-Federal patient care doctors, the actual number of instances in which a patient was injured as a result of negligence (the definition of malpractice) was at least 250 times higher. Estimates range from 136,000 to 310,000 times a year in which patients are injured or killed due to errors by doctors.

III. How to Decrease the Amount of Malpractice and Therefore the Number of Malpractice Suits.

The striking variation between states in serious disciplinary action is not likely due to inherent differences between the quality of medical practice in one state vs. another. Rather, the main explanation is that some states are much more active than others in disciplining physicians. Among the remedies we propose are:

- Urging that all doctors pay at least $500 per year for their medical license, thus raising about $200 million dollars in state revenues to be used for disciplining doctors. For 1983, state fees for license renewal ranged from $15 to $150. Most states were under $100.

- Passing strong legislation in states to greatly expand the size and strength of the licensing (doctor discipline) function. This would include subpoena power, larger staff, public hearings and non-physician members of boards: states such as California, Florida, Kentucky and others which have done this have better records than most other states do.

- Experience-rating of doctors by insurance companies so the good doctors stop subsidizing the relatively few with worse performance records. Better performance, lower premiums, worse performance higher premiums.

- Requiring attorneys to turn over to state licensing boards information about doctors after patients prevail in a settlement or adjudication of a malpractice suit.

- Requiring all other data, such as that collected by Professional Review Organizations, (PRO's) concerning doctors'performance in treating Medicare and Medicaid patients to be made part of doctors files in the state licensing bureaus.

- Requiring periodic recertification of doctors based on written exams and audit of doctor performance such as medical record review.

In summary, the best and only permanent remedy for the malpractice crisis is not tort reform but doctor discipline

I. State-by-State comparisons in Disciplining Doctors
As seen in the accompanying table, in 1983 there were 563 serious disciplinary actions (revocations or suspensions of license or probations) taken against U.S. physicians by state licensing boards as reported to the Federation of State Medical Boards (F.S.M.B.). This amounts to an average of only 1.45 serious disciplinary actions per 1,000 physicians for the whole country or 1 doctor out of 690. The range is from Utah - the state with the highest rate of 5.2 actions/1,000 --- doctors or 1 doctor out of 192 having their license revoked suspended or being put on probation - to 9 states plus D.C. which, in 1983, had reported no serious disciplinary actions to F.S.M.B. A total of twenty-two states, including most of the largest states - Ohio, Texas, New York, Pennsylvania, Illinois, Massachusetts - reported fewer than 1 serious disciplinary action per 1,000 physicians. Both New York & Massachusetts are facing huge increases in malpractice premiums.

It is of interest that in that mecca of medical excellence, Massachusetts, there were only 2 serious medical disciplinary actions in 1983 for 13,697 physicians for a rate of .14 per 1,000 physicians or one per 6,849 doctors. Despite Boston and environs, there is no reason to believe that the quality of medical practice in Massachusetts is acutally thirty-six times better than in Utah, thereby explaining why Utah's rate of serious discipline is thirty-six times higher than Massachusetts. Rather, Utah probably has, overall, doctors of the same quality as Massachusetts - and other states, but has a more effective system of doctor discipline.

In Florida, for example - now one of the better states as far as doctor discipline (3rd), there was a three-fold increase in total disciplinary actions following a reformation of the organization and operation of the state medical regulatory board for doctors (and other health professionals). Thus, increased numbers of disciplinary actions in states reflect better discipline as also seen in California which during the early 1970's in the wake of the last medical malpractice crisis, set up its Board of Medical Quality Assurance.

From 1982 to 1983, as seen in the table below, there was a 4% increase in serious disciplinary actions, with a 66% increase in probations but a 23% decrease in licenses revoked and 10% decrease in licenses suspended. Thus, among the serious disciplinary actions, the most serious, revocations and suspensions, have decreased.

	1982	1983	Change
Total Actions	541	563	+ 4.1%
Licenses Revoked	234	181	-22.6%
Licenses Suspended	168	151	-10.1%
Probation	139	231	+66.2%

II. How Much Malpractice is Actually Occurring?

Even if all states disciplined doctors at the rate Utah does, (5.2 per 1,000 doctors) this would mean a national total of only 2025 revocations, suspensions and probations instead of the actual national total of 563. That even this expanded figure is but a fraction of the number of times patients are injured or killed as a result of negligence - error - by doctors can be derived several different ways:

1. Medical Malpractice Commission Estimate: 203,000 instances of malpractice.

Based on studies it commissioned, the HEW Malpractice Commission found that a large number of injuries which occurred to hospitalized patients were the result of negligence. Eli Bernzweig, the Director of the Commission, estimated that 3.6% of patients who enter hospitals are injured and that 14.5% of these injuries were due to negligence (J. Legal Medicine, Feb., 1976). Applying these figures to 1983 U.S. hospital admissions, (38.8 million - HHS 1983 Summary: National Hospital Discharge Data) we get 3.6% x 38.8 million or 1.40 million hospital injuries with 14.5% of these or 203,000 people being injured as a result of negligence.

2. Surgical Admission Estimate: 136,000 injuries to patients secondary to doctor errors.

A 1981 study based on 5,612 surgical admissions to Boston's Peter Bent Brigham Hospital found that 36 patients suffered adverse outcomes "due to error during care" (New Eng. J. Med. 1981, 304, 634-7). If this rate of malpractice (injury due to negligence) is applied to all 1983 surgical admissions - there are an estimated 136,000 injuries to surgical patients caused by doctor error. This estimate is lower than the other because it does not include patients admitted to the hospital on non-surgical services.

3. Malpractice Claims Paid to Plaintiffs times 10 = 164,000 instances of malpractice.

Based on 1984 A.M.A. data for doctor-owned insurance company claims paid and extrapolating to all of the 389,467 patient care non-Federal doctors in the U.S., there were approximately 16,400 times in 1983 where patients were awarded damages in malpractice suits either by settlement or adjudication. According to A.M.A. executive Dr. James Todd, "95% of our indemnity dollars go to pay claims that by medical peer review are indefensible (Internal Medicine news Dec. 1-14, 1984). A 1976 California study, recently quoted in Medical World News (July 22, 1985) found that only 1 in 10 cases of adverse patient outcome due to malpractice, in which the patient would probably prevail are actually brought to litigation. Thus, for 16,400 actual plaintiff awards for medical malpractice, there are 10 times as many or about 164,000 which actually occur.

4. California Medical Insurance Feasibility Study Projection to all of U.S.: 310,000 Instances of Malpractice
Based on a study in California it was determined that of 3 million hospital admissions in one year, "24,000 patients had an adverse outcome that appeared to be the fault of one or more health care providers and for which the patient would likely be successful in litigation" (Medical World News, July 22, 1985) Applied to the 38.8 million patients hospitalized in the U.S. in 1983, this amounts to 310,400 instances in which patients were injured (or killed) as a result of negligent medical behavior.

It must be pointed out that all four of these estimates are probably low because none includes those instances of malpractice which occur to people outside of the hospital.

Even using the lowest of these estimates, 136,000 instances of malpractice a year, the number of times doctors are seriously disciplined - 563 in 1983, represents only one in two-hundred forty two. In other words, out of every 242 times that a patient is injured or killed as a result of doctor negligence, only once is a serious disciplinary action taken against a doctor.

In summary, there is a tremendous and dangerous gap between the amount of malpractice - negligent doctor behavior resulting in injury or death - and the amount of doctor discipline.

III. How to Decrease the Amount of Malpractice and Therefore the Number of Malpractice Suits

1. Increase Doctor License Fees to at Least $500 per year
Instead of doctors complaining about spending thousands, tens of thousands a year on malpractice insurance, they should push for annual medical licensure fees to be raised to at least $500 with all of the money going to identification and discipline of doctors who are incompetent or otherwise practicing bad medicine. This would create an annual fund of 200 million dollars for states to use, far more than is now being spent and would prevent malpractice.

2. Passing Stronger State Doctor Discipline Legislation
as has already occurred in Florida, Kentucky and other states, the real remedy to the malpractice crisis has to include greatly strengthening the size and powers of the state licensing and disciplinary function. With these changes, states such as California, Florida and Kentucky have greatly improved their discipline of doctors. Without such legislation as in New York, Massachusetts, and most of the states, the record of disciplining doctors is abysmal.

3. Insurance Companies should Experience-Rate Doctors within a Subspecialty.
Why should the many excellent physicians who have not had adverse malpractice adjudications or settlements against

colleagues who now pay the same as they?

4. All Attorney's Should be Required to Immediately Turn Over To Their Respective State Medical Licensing Board the Results of Settlements or Adjudications Which Result in The Payment of Claims to Injured Patients.
At present, the terms of settlement often prevent attorneys from supplying this important information to the file of the involved doctor.

5.All Data Which Relates to the Performance of a Doctor - Such as PRO (Professional Review Organization) Data Collected on Doctors' Performance Taking Care of Medicare and Medicaid Patients Should Also Be Made a Part of the Doctors File at the State Licensing Board.

6. Require periodic recertification of doctors based on written exams and an audit of doctors performance such as medical record review.

CONCLUSION

In response to doctors' pressures for malpractice premium cost relief, a number of states have already passed anti-consumer laws that met most of the doctors demands; many others are in the process of doing so. Limitations have been placed on the access of plaintiffs to the courts; ceilings have been placed on awards and large payments have been stretched out over many years; lawyers fees have been reduced; limitations have been placed on awards for pain and suffering.

It is time to demand quid-pro-quo to attack the basic source of the problem, malpractice and malpractitioners, to include legislative requirements for more intensive and active pursuit of incompetence among medical practitioners. It is time to realize that the competent and consciencious practitioners who are in the majority and who now suffer the obloquy of guilt by association are unjustly paying the price for an unfortunately too substantial minority of competent, careless, undertrained or disabled physicians. It is time for the medical profession to give more than lip service to the weeding out of bad apples.

All of this will cost money, and priorities must be set on how to spend limited resources. Our response to that is simple: If only 7% of the almost $3 billion now spent to settle medical malpractice claims were devoted to taking the corrective, preventive measures, there would be far less malpractice and no periodic cost crises - and most important, far less injury to patients. Our proposal for a $500 per year license fee would raise the 200 million to carry out these crucial measures.

REVOCATIONS, SUSPENSIONS & PROBATIONS
in 1983 by State Medical Licensing Boards[1]

State	Rank	Actions per 1000 doctors	Total serious actions[2]	Revocations	Suspensions	Probations	Non-Federal patient care doctors[3]
UTAH	1	5.20	12	6	0	6	2306
GEO	2	4.25	32	4	9	19	7521
FLA	3	4.15	71	36	14	21	17105
ARK	4	3.27	9	4	5	0	2753
ARIZ	5	3.22	15	5	4	6	4665
MICH	6	3.00	41	7	21	13	13666
NJ	7	2.83	38	9	20	9	13416
MO	8	2.70	20	5	2	13	7396
COLO	9	2.50	13	5	2	6	5209
KY	10	2.32	11	2	2	7	4736
CA	11	2.29	117	29	26	62	50981
VA	12-13	2.26	20	4	3	13	8816
HA	12-13	2.26	4	1	0	3	1766
NM	14	2.11	4	2	0	2	1899
ALAS	15	2.02	1	1	0	0	493
ME	16	1.84	3	3	0	0	1628
ORE	17	1.80	8	1	0	7	4443
WYOM	18	1.78	1	1	0	0	559
NEV	19	1.70	2	0	0	2	1174
LA	20	1.42	9	2	5	2	6322
NEB	21	1.37	3	1	1	1	2189
S.DAK	22	1.29	1	1	0	0	775
S.C.	23	1.27	5	0	5	0	3944
N.C.	24	1.21	10	7	1	2	8266
IND	25	1.20	8	0	3	5	6675
IOWA	26	1.15	4	1	0	3	3474
N.D.	27	1.14	1	0	1	0	870
WIS	28	1.11	8	6	2	0	7204
MINN	29	1.09	8	3	1	4	7276
CONN	30	0.85	6	2	1	3	6986
OHIO	31	0.65	11	6	5	0	16671
TEX	32	0.62	13	7	4	2	21024
OK	33	0.53	2	0	0	2	3786
NY	34	0.49	21	13	3	5	42063
PENN	35	0.48	10	3	3	4	20937
IL	36	0.45	9	2	4	3	19842
WASH	37	0.43	3	0	1	2	6926
TENN	38	0.42	3	1	1	1	6887
MISS	39	0.37	1	0	1	0	2672
MD	40	0.30	3	0	0	3	9866
MASS	41	0.14	2	1	1	0	13697
DEL	42-51	0	0	0	0	0	955
VER	42-51	0	0	0	0	0	996
MONT	42-51	0	0	0	0	0	1003
IDA	42-51	0	0	0	0	0	1024
N.H.	42-51	0	0	0	0	0	1455
R.I.	42-51	0	0	0	0	0	1797
W.VA.	42-51	0	0	0	0	0	2540
D.C.	42-51	0	0	0	0	0	2628
KANS	42-51	0	0	0	0	0	3472
ALA	42-51	0	0	0	0	0	4706
TOTALS (all states)		1.45	563	181	151	231	389467

1. With the exception of California, all data is from the Federation of State Medical Boards (FSMB). Since they did not supply California data to us, we obtained such data from the California Boards of Medical Quality Assurance and Osteopathic Examiners. Data for Florida, Michigan, Arizona, New Mexico, California, Washington, Pennsylvania, Tennessee and West Virginia combine M.D.'s with D.O.'s (Doctors of Osteopathy).

2. Public Citizen Health Research Group tabulations are of the most serious disciplinary actions by State Boards (Revocations, suspensions and probations) and therefore do not include reprimands and other less serious actions. In addition, many such less serious actions were not reported to FSMB by every state in 1983. We also do not include voluntary surrender of license, approval or denial of requests for change in disciplinary status or actions taken as a consequence of actions by other states. FSMB included these "actions" in their tabulations.

3. Number of non-federal patient care doctors as of 12/82 from A.M.A.: Physician Characteristics and Distribution in the U.S.

Dangerous Doctors: Few Are Disciplined by Stat

Even the AMA has decided to back federal action

By Margaret Engel
Washington Post Staff Writer

States do such a poor job of regulating physicians that only a fraction of doctors who are dangerous, senile, alcoholic, drug-addicted or operating fraudulently are ever disciplined, according to congressional reports, medical critics and the states' discipline bank.

States disciplined 1,381 of the nation's 430,000 doctors last year, according to figures compiled by the Federation of State Medical Boards, a 73-year-old voluntary organization that has yet to achieve full reporting by all 50 states.

In 1983, the states revoked or suspended licenses or took other significant actions against 1,154 doctors, according to federation director Dr. Bryant Galusha.

The federation's figures on serious disciplinary actions represent only one of every 252 doctors who have had a malpractice case filed against them, according to a study by the Health Research Group, a Washington advocacy group.

"There is a tremendous and dangerous gap between the amount of malpractice and the amount of doctor discipline," said Dr. Sidney Wolfe, coauthor of the study, which urged an improvement in medical discipline as one solution to rising malpractice claims.

In addition to incompetent doctors, the American Medical Association estimates that 10,000 physicians in the United States are alcoholics and 4,000 are drug addicts. Between 5 percent and 10 percent of all U.S. doctors are impaired or are engaged in unethical practices that present a danger to patients, yet few are disciplined, according to congressional estimates.

A recent study by the New England Journal of Medicine noted, "Even the highest reported rates among the states are still less than 1 percent per year . . ," which lends "credence to popular suspicions that the medical boards have not been dealing effectively with this problem . . . ."

The relatively new problems of fake degrees and the lack of standard requirements for foreign medical practitioners are overwhelming medical boards that have problems simply issuing licenses every year.

Lax monitoring by state medical boards has surfaced over the past decade, prompting some legislatures to add staff and money to the boards. But the malpractice crisis, along with new concern by employers and their insurance companies over rapidly increasing health care costs, is prompting new attention.

Even the AMA, long a foe of federal action in state affairs, is endorsing a bill to give federal incentives to states that improve regulation of doctors.

"Lay the blame at the state boards," says Dr. James Todd, executive vice president of the AMA. "We're not seeing the ability of the state boards to handle" the need for increased reporting, he says. ". . . The AMA has been heading in this direction for so long."

There has been little change, however, in the secrecy, lack of public accountability and poor coordination among state boards, the AMA and other medical monitors.

Galusha says that in answering queries from state boards alone, the federation discovers about 30 disciplined doctors each month who have set up practices elsewhere. A recent General Accounting Office report on 181 doctors sanctioned in three states found that 33 of them moved elsewhere and continued to practice.

But Galusha says, "The net is tightening. Doctor-hopping has become a thing of the past."

However, because state boards are unable to stop the practice, private companies have formed to conduct credentials checks for client hospitals. "There's hardly a hospital in the United States that can keep track of the credentials of its doctors," says Dr. William Jacott, a member of the Minnesota Board of Medical Examiners. ■

'This meeting of the State Hos
now come to order. Is there ar
business? Do I hear a

9/12-13/85

Attachment XV

The *Journal of Health Politics, Policy and Law* seeks papers from scholars, policymakers and practitioners whose interests bear broadly on health. It welcomes concise, lively articles from any disciplinary perspective and from anywhere in the world.

Manuscripts should be submitted in *triplicate* to Lawrence D. Brown, Dept. of Medical Care Organization, School of Public Health, University of Michigan, 109 Observatory St., Ann Arbor, MI 48109-2029. Articles should be no more than 25-30 typewritten, double-spaced pages, with footnotes referenced in the text and listed at the back of the article. Footnotes and bibliographical citations should follow Kate L. Turabian, *A Manual for Writers*, University of Chicago Press. Since manuscripts are sent anonymously for editorial evaluation, author name and affiliation should appear on a separate title page only.

Books for Review should be sent to the attention of Deborah Stone, Department of Political Science, Massachusetts Institute of Technology, 77 Massachusetts Avenue, Cambridge, MA 02139. Authors interested in reviewing should correspond with the Book Review Editor before submitting manuscripts.

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Attachment XVI

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11. Editors, "Capitation: Stranglehold on Pharmacy," *National Association of Retail Druggists Journal* 103 (July 1981): 35-41.
12. See Note 1, supra
13. HCFA derives its authority to grant waivers from the amendments to the Social Security Act. Section 1115 of the Act deals specifically with demonstration projects and the waiver outlined in this section has thus become known as an 1115 waiver.
14. HCFA never formally or informally notified the DSS (or UI) before, during, or after the pilot study that administrative waivers were required, though it was aware of the pilot study.
15. DSS committed to the expanded project during its planning stage, but the implementation took place under another commissioner. In addition, other changes occurred in key posts within the department, and commitment and assurances had to be obtained again.
16. After the capitation experiment was in operation for a few months, the DSS Commissioner asked the System Development Corporation, the Medicaid fiscal intermediary, for an assessment of what capitation was costing or saving the state. SDC responded that despite the administrative cost overruns, the plan was saving money. However, one must consider a possible bias towards this conclusion, since the company profited by these additional administrative expenses and had a self-interest in perpetuating the program in its current form. Two other reports on the financial status of the experiment were received—one from the DSS staff and the other from the UI. The findings of both these reports conflicted with the SDC report.
17. DSS suggests that the early termination was due to financial problems exclusively. Others, including members of CIP, feel that their lobbying efforts moved the influential legislator to apply political pressure to DSS to terminate the project. As mentioned above, this occurred at a time when DSS was in the process of requesting supplemental appropriations from the state legislature.
18. D. Campbell and J. Stanley, *Experimental and Quasi-Experimental Designs for Research* (Chicago: Rand McNally, 1963).
19. R. S. Hanft, "Use of Social Science Data for Policy Analysis and Policy-Making," *Milbank Memorial Fund Quarterly/Health and Society* 59 (Winter 1981): 596-613.
20. P. Rossi and H. Freeman, *Evaluation: A Systematic Approach* (Beverly Hills: Sage Publications, 1982)
21. A. Kalunzy and J. Veney, *Health Service Organizations: A Guide to Research and Assessment* (Berkeley: McCutchan Publishing, 1980); J. McKinlay, ed., *Research Methods in Health Care* (New York: Prodist, 1973), D. Campbell and J. Stanley, *Experimental and Quasi-Experimental Designs for Research* (Chicago: Rand McNally, 1963), P. Rossi and H. Freeman, *Evaluation: A Systematic Approach* (Beverly Hills: Sage Publications, 1982).
22. H. Freeman et al., "Social Experiments," *Milbank Memorial Fund Quarterly/Health and Society* 59 (No. 3, 1981): 340-373.

State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment

Frank A. Sloan, Vanderbilt University

Abstract. Almost all states enacted legislation in response to the rapid rise in malpractice insurance premiums which occurred during the mid-1970s. After describing the types of statutory changes enacted, this study evaluates the influence of these changes on levels and growth of premiums paid by general practitioners, ophthalmologists, and orthopedic surgeons during 1974-78. The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums. Several explanations for this result are explored.

The medical malpractice "crisis" of the mid 1970s involved both a dramatic increase in premiums, and a reluctance on the part of many companies to write medical malpractice insurance policies. From 1974 to 1977, malpractice premiums almost doubled, following several years of relative calm.[1] The increased premiums were perceived by the public and their elected representatives as potential sources of medical care cost inflation, and it was feared that nonavailability of coverage might lead to nonavailability of certain types of needed medical services. As a result, virtually all states took some type of legislative action to ensure the availability of malpractice insurance at a reasonable price.[2] With isolated exceptions,[3] both the rate of premium inflation and availability problems have largely abated since this period of crisis.[4] Yet some observers have predicted that the late 1970s and early 1980s have been only a temporary calm before another storm.[5]

There is substantial variation in malpractice insurance premiums—among physician specialties and across states, as well as over time. In the mid-1970s, premiums in a high-risk specialty, orthopedic surgery, were about six times as great as those for the lowest-risk ("Class 1") specialists, including pediatricians and general practitioners who do no surgery.[6] The reason for such interspecialty variation in premiums is reasonably well understood: claims against physicians in surgical subspecialties in particular are much more frequent than in fields without a hospital orientation, such as general/family medicine and pediatrics.[7]

Partial support for this study came from contract #500-78-0018 between the U.S. Health Care Financing Administration and Vanderbilt University. The views expressed here are the author's, and do not necessarily reflect the view of either organization. The author is grateful to Nanette Fascher and Robert Hays for assistance in this research.

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Sources of interstate (and intertemporal) variation are much more complex. As an illustration of interstate variation in premiums within a specialty, premiums paid by orthopedic surgeons in 1974 varied from a high of $8,352 (in New York) to a low of $479 (in North Carolina), a more than seventeen-fold difference.[8] As will be discussed more fully below, the correlations in premiums paid for standard coverage levels by physicians in various specialties within a state are high, as are correlations among annual changes in premiums by specialty. Thus essentially the same degree of interspecialty and interstate dispersion has been preserved since 1974.

To date, no one has isolated the effects of specific legislative actions on either the price or availability of malpractice insurance. Statutory changes potentially affect the frequency of claims, the likelihood of judicial determination in favor of the plaintiff, and the size distribution of settlements. Expected payouts of insurers, as well as projected administrative costs and profit margins, are in turn reflected in premiums.[9] Thus, by affecting elements of expected payouts, statutory changes could have reduced premiums directly. Alternatively, the publicity effect surrounding legislative activity may have caused the public (and, for that matter, juries) to become more cost-conscious, when in fact the direct constraining impact of the laws themselves was rather minimal. Or the legislative initiatives may have unintentionally fooled insurers, by creating anticipations that both the frequency and magnitude of settlements would decrease when in fact these were not to occur.

The next two sections provide some pertinent conceptual and empirical background information on the malpractice insurance crisis of the mid-1970s, and describe specific legislative responses to the crisis at the state level. Empirical specification of premium regressions designed to assess the effects of these legislative responses, and explanation of empirical results obtained from this procedure, are provided in the third section, followed by a brief discussion of implications.

Background

Concepts. Insurers set premiums (P) to cover expected benefit payments (B) and administrative expense (A):

$$P = B + A . \tag{1}$$

Benefits payments can be expressed as the product of the number of claims (C), the probability of a decision favorable to the plaintiff (Q), and the mean dollar settlement if the plaintiff wins (X):

$$B = CQX . \tag{2}$$

Administrative expense consists of legal expenditures on behalf of medical defendants, other administrative expense (A_O), such as for marketing, and profit (π):

$$A = CY + A_O(N) + \pi , \tag{3}$$

where Y is the legal expense incurred by the insurer per claim, and N is the number of enrollees. To simplify, let $A^* = A_O(N) + \pi$, where A^* is a constant. This simplifying analytical assumption is justified since increased expense and profit rates are not generally considered to be reasons for the rise in malpractice insurance. Then, substituting (2) and (3) into (1), the premium equation becomes

$$P = C(QX + Y) + A^* . \tag{4}$$

Totally differentiating (4), it is apparent that the change in premiums depends on changes in the number of claims, in the probability of the plaintiff winning, in the insurer's legal cost per claim, and interactions among these changes, as well as changes in premium pricing policy as reflected in any change in A^*.

The number of claims filed by unsatisfied patients in a given state and year plausibly reflects the expected settlement net of legal fees ($QX - F$), patient relationships with physicians, and characteristics of such patients—including their degree of aversion to risk and to litigation. Legal fees per case depend, inter alia, on the number of lawyers per capita population. The probability of the plaintiff winning (Q) and the mean settlement size (X) would logically depend on the nature and extent of the iatrogenic injury, the defendant's conformance with medical standards in his/her local community, and characteristics of laws regarding malpractice in the state. Litigation (and presumably iatrogenic injury) is more likely when a surgical procedure has been performed. Apparently X also depends on patient income: patients with high opportunity costs of time have been found to obtain higher settlements, holding other factors constant.[10] But to the extent that affluent persons demand care from higher-quality doctors, Q should be lower. Thus, the effect of time cost—or its proxy, income per capita—on QX cannot be determined in advance of empirical research.

This brief discussion implies that empirical analysis should describe the type of medical procedures performed, variables from the lawyer's market pertinent to fee-setting, and patient characteristics (including income), as well as the legal environment. Ideally, one would also want to understand insurer pricing policy (which, in part, reflects elements of A^*), and how insurer expectations of future benefit outlays are formed. The latter phenomena, however, are difficult to measure empirically.

Previous empirical studies. Two published studies by economists have examined interstate variations in premiums and frequency of malpractice incidents. Using regression analysis, with states as observational units for years 1970 and 1972, Reder related the malpractice premium paid by surgeons to four explanatory variables: (1) operations per surgeon; (2) nonfederal attorneys per capita population; (3) number of "key doctrines" favorable to plaintiff adopted by the state; and (4) state per capita income.[11] Only two of the four independent variables showed statistically significant impacts on premiums: per capita income and legal doctrines. The positive effect of per capita income suggests that the effect of any tendency for higher-income persons to select higher-quality doctors is more than offset by a combination of effects of patient income on settlement size and on the propensity to sue.

Feldman assessed state differences in the number of malpractice incidents per 1,000 state population in 1970.[12] He included as explanatory variables surgical operations per 1,000 population, per capita income, lawyers' earnings, variables representing ten legal doctrines bearing on the processing or outcome of malpractice cases,[13] and (in one regression) a measure of defensive medicine. He found that the number of incidents rises with increases in surgical operations and in income, and falls with increases in lawyers' earnings. He also found that the plaintiff's return net of the payment for legal fees ($QX - F$) falls with increases in the lawyer's wage.

A legal variable constructed as the sum of the ten individual binary variables showed that states with laws more favorable to plaintiffs have more suits, a finding consistent with Reder's analysis; however, when the individual legal variables were included as separate explanatory variables, Feldman obtained few statistically significant parameter estimates. Feldman also expected that "defensive medicine" would reduce the occurrence of malpractice claims. He measured this factor with a variable defined as the weighted average of office visits by Medicare patients which entailed laboratory tests, x-rays, and consultations with other physicians. Feldman's results suggest more definite roles for income, frequency of surgery, and lawyer price-availability than for either legal doctrines or "defensive medicine" as determinants of interstate variation in the number of malpractice suits. Characterizing the nature of tort law by state at a given point in time, in terms of its relative impacts on plaintiffs versus defendants, is extremely difficult, and measurement errors could partially account for the legal variables' insignificance. A more accurate picture may be obtained by relating changes in incidents or premiums to changes in laws.

Dynamic factors. Many of the potential determinants of temporal change in malpractice costs and insurance premiums are not captured by analysis of a single cross-section; and of the dynamic factors, many are common to all specialties and states: technological change in the health field; rising patient expectations about the efficiency of medical care; loss of close relationships between providers and patients due to the rise in physician specialization; increased litigiousness of society; changes in quality of medical care; changes in attitudes of juries; and (for premiums, though not for malpractice incidents) returns on insurers' investments.

There is no consensus about the origins of the mid-1970s crisis, or, for that matter, why it passed. The industry justified substantial premium increases on grounds that insurers were losing money at their then-current malpractice insurance rates. However, profitability not only depends on loss ratios, but also on returns on investment of insurer reserves.[14] Insurers suffered paper losses in the 1974-75 stock market, and this development may have been contributory. Critics of the insurance industry, such as Law and Polan, have stated that—with a few exceptions, such as New York and California—insurance companies in the mid-1970s acted on the basis of events having little to do with their local

situations. Law and Polan argued that the broad-scale panic was due at least in part to the actions of a single company, Argonaut, which had responded decisively to its adverse loss experience in several markets.[15] Rather than assessing their own situation, other companies simply panicked. According to this psychological view of the crisis, matters eventually settled down after time allowed more objective assessments of the situation. Others have attributed the end of the crisis to fear of countersuits and lack of lawyer familiarity with the new state malpractice statutes, which might have the effect of delaying the filing of suits, even if the statutes themselves had no long term effects.[16]

State Legislative Responses

The crisis of the mid-1970s provided the impetus for numerous legislative proposals applying to actions alleging medical malpractice. Legislators assumed that, if new laws could reduce the number and dollar amounts of malpractice awards, insurers would be in a better position to predict recoveries, and therefore would maintain coverage at reasonable rates and assure availability of malpractice insurance. Statutory changes were quite narrowly focused on medical malpractice, and many of them were tested in the courts in the and early 1980s.[17] This section briefly describes most of the major legislative changes, the effects of which are to be evaluated below. These legislative provisions may be classified into three general categories: tort modifications, alternatives to trial, and insurance provisions.

Tort modifications

Limiting provider payments to plaintiffs. Several states enacted laws placing a dollar maximum on the amount providers are required to pay in medical malpractice cases. A limitation on provider liability was often imposed in conjunction with a limitation on plaintiff recovery. A ceiling on either the provider's liability or plaintiff's recovery potentially shifts some costs of damages to plaintiffs. Conversely, to the extent that awards had been "excessive" heretofore, particularly for such subjective items as "pain and suffering," the savings accrue to physicians and the public at large. Although these laws potentially reduce premiums, they will be successful only to the degree that settlements would otherwise have exceeded the ceilings, and/or that the initiation of malpractice suits is discouraged by a decline in ($QX - F$). Unfortunately, data are not available for comparing the frequency distribution of settlements to the ceilings in states which enacted these limitations.

In some states, patient compensation funds have been established to pay plaintiffs for damages incurred above the statutorily-determined limit on provider liability. These funds are financed by adding a surcharge to each physician's

premium—a surcharge often set so as to subsidize the premiums of physicians in high-risk specialties. The main effect of such funds, if any, is likely to be on amounts of insurance (i.e., liability limits) purchased by physicians, rather than on the premium for a specific amount of coverage (such as a $100,000/$300,000 policy).

Limiting use of the res ipsa loquitur *doctrine.* The doctrine of *res ipsa loquitur* applies when a plaintiff can show (1) that the event only could have occurred as a result of negligence, (2) that harm was caused while the instrumentality causing the injury was exclusively controlled by the defendant; and (3) that the plaintiff did not contribute to the injury.[18] This doctrine may be useful to plaintiffs when, for lack of specific information, the plaintiff cannot develop a prima facie case against the defendant.

Courts in a number of states expanded applicability of the doctrine of *res ipsa* in the early 1970s.[19] Since 1975, this trend has been reversed: state legislation has delineated situations in which *res ipsa* can be applied (e.g., to foreign objects left in the body, or radiation burns); and in some states (e.g., Washington), the use of *res ipsa* in malpractice cases has been virtually eliminated. A study of medical malpractice claims reported that plaintiffs were slightly more likely to win when the *res ipsa* doctrine was used,[20] hence limiting use of *res ipsa* may have had some but probably not a dramatic effect on premiums.

Tightening the statute of limitations. Statutes of limitations have received considerable attention in discussions of medical malpractice insurance. One reason is the lengthy time-lag which often occurs between the date an injury occurs and the date the claim is first made. Time-lags are particularly problematic in this area since malpractice insurance has typically been sold on an "occurrence" basis—that is, the insurer protects the provider against any claim that may eventually arise from a litigatable "event" that occurred during the policy years. Insurers have maintained that the persistent threat of a suit compels them to maintain substantial reserves; in any case, rate-setting is made more difficult by the possibility of delayed suits.[21]

Furthermore, there is empirical evidence that claims filed five years after the injury are more than twice as expensive as the average award.[22] Thus late claims represent a substantial risk to the insurer, and one can expect a risk premium to be charged for indemnifying physicians against such claims. State legislatures modified existing statutes of limitations to establish definite, presumably shorter, periods during which a medical malpractice action must be brought. However, the new limits contain exceptions which, in conjunction with interpretations of state courts, could have important implications for the effectiveness of the new limits.[23]

Clarifying informed consent. The doctrine of informed consent requires that a provider disclose information pertinent to the nature, purpose, and risks associated with a proposed medical treatment. Unfortunately, while the doctrine's intent is clear, whether patients were in practice properly informed is difficult to

document. During the mid-1970s, many experts held that ambiguity created by this doctrine was in itself a source of litigation, and several states added precision to the doctrine of informed consent to insure uniform definition and application.

Imposing contingent-fee regulation. It is often argued by physicians and others that payment of lawyers on a contingent fee basis for work on malpractice cases increases the total number of claims.[24] Assuming patients are risk averse, a plausible assumption for plaintiffs in the aggregate, economic theory supports this assertion.[25] Unfortunately, there is no empirical evidence on whether or not the method of lawyer compensation has an independent effect on the frequency of suits or on settlement amounts. Since 1975, several legislatures have limited attorneys' fees in medical malpractice cases either by empowering state courts to determine reasonableness of attorneys' fees, by statutorily fixing a percentage ceiling for contingent fees, or by adopting a sliding scale which bases the contingency-fee percentage on the amount of recovery. The latter two approaches at least have the potential of reducing lawyers' incentives to accept malpractice cases; the first is weakened by courts' reluctance to interfere with the attorney-client relationship.[26]

Adding collateral-source provisions. The collateral-source rule makes it impossible for the court to apply benefits received by an injured party from sources other than the defendant as an offset to compensation due from the defendant. Hence a medical malpractice plaintiff may collect benefits from a variety of sources, the sum of which may be substantially in excess of damages incurred. A number of states enacted legislation during the mid-1970s to limit such duplication of payments. Two types of laws have been enacted. One type permits introduction of evidence of payments received from collateral sources, allowing the jury to consider such evidence in determining the defendant's obligation to the plaintiff; the other approach requires that there be an offset.[27] These changes have been controversial. Proponents of the collateral-source rule have argued that the rule preserves patients' incentive to purchase insurance, and that the reduction in defendants' liability may reduce the deterrent effect of liability.[28]

Eliminating the ad damnum *clause.* The *ad damnum* clause is part of the plaintiff's initial pleadings, stating the amount of monetary damage incurred and the settlement requested. Although the *ad damnum* clause may be seen as no more than the presentation of an initial asking price, it may influence the jury to award a larger settlement. More recent legislation eliminates *ad damnum*; but some laws now also require that the defendant be informed during pre trial discovery of the precise amount of recovery sought by the plaintiff.[29]

Imposing a locality rule. Historically, health care providers have been expected to render care consistent with the general standard of care in their community. Because of improved communication and more uniform professional training, courts in many states have interpreted "community" quite broadly, encompassing regional if not national standards. There are two major reasons for dissatisfaction with this trend. First, many providers argue that this broad interpretation

leads to the use of "hired guns"—providers who specialize in testifying on the plaintiff's behalf. Second, adherence to regional and/or national norms may require that many physicians orient their practices to higher standards, which in turn results in more costly care. In response to this dissatisfaction, several states during the mid-1970s adopted rules requiring use of a local standard of care and/or of local expert witnesses.[30]

Alternatives to jury trial

Mandating use of a pretrial screening panel. During the mid-1970s, more than half of the state legislatures established pretrial screening panels to which cases must be submitted before they proceed to trial. Statutes vary substantially in terms of panel composition, procedural details, and admissibility of findings at subsequent trial. Virtually no other "reform" has elicited as much challenge in the courts as the concept of pretrial screening, principally because the panels are viewed as interfering with a plaintiff's right to a jury trial.[31]

Irrespective of the constitutional issues, there is some reason to believe that panels may not be effective in terms of reducing premiums. First, for any cases not settled during the pretrial hearing, and many are not, rather than substitute for the jury trial the panel adds another layer of proceedings. Second, although proceedings of the panels are less formal than a full-scale trial, substantial legal expenses may be incurred, especially in states where decisions of the panels are admissible at trial. Third, the existence of an informal and initially less expensive adjudication mechanism may in itself encourage the filing of claims.[32]

Allowing for binding arbitration. Binding arbitration differs from pretrial screening in that the decision of an arbitration board is final; unlike screening, arbitration is not followed by a jury trial. Proponents of arbitration argue that it reduces malpractice costs by resolving disputes in a less formal setting, through a panel of experts rather than a jury (which is both nonexpert and subject to emotionalism). These contentions are debatable.[33] Although, in principle, arbitration may be either compulsory or voluntary, no state to date has mandated compulsory arbitration, probably because of doubts about its constitutionality.[34]

Insurance provisions

Creating joint underwriting associations. Enabling legislation for the establishment of non-profit joint underwriting associations (JUAs) has been passed in the majority of states, but implemented in only a few. A JUA is a pooling arrangement composed of commercial liability insurers with business in the state. All JUA statutes require that premium rates be established on a self-sustaining basis: if losses occur, member companies may be assessed to cover the deficit. In some states, assessments may be recouped by subtracting the assessment due the state from the premium tax, or by instituting a surcharge on premiums paid by providers. JUA surpluses are to be used for premium reductions. Statutes normally expire two or three years after enactment; depending on state statute, the JUA may be the exclusive carrier, or may compete with others.[35] In some states where JUAs are monopolists, they have been subject to criticism by doctors for their high rates.[36] JUAs may be a better solution for the problem of malpractice insurance availability than for the cost problem.

Allowing formation of health care mutual insurance companies. A few states have recently enacted legislation authorizing creation of insurance companies owned and operated by associations of physicians. These firms assess physician members a one-time special charge (about one year's premium), which is refundable if the company succeeds.[37] Since these mutual companies are run by physicians, they presumably have a special incentive to control premium increases.

Empirical Specification and Results

Overview. The regression analysis presented here extends the work of Reder and Feldman.[38] It focuses on the role of legal variables during a period of rapid change in malpractice insurance premiums. The analysis is based on a time series of cross-sections covering the years 1974 through 1978, with the state as the observational unit. All continuous variables are expressed in logarithmic form; all binary variables enter linearly. Two alternative types of equations are specified: (1) premium levels, and (2) annual percentage change in premium levels. In the latter, the dependent variable is the difference in the logarithm of premiums in a given specialty between a year and the year immediately preceding it. This difference (multiplied by 100) yields a percentage change. When the premium equation is in difference form, the regressions span 1975–1978 (annual changes for 1974-75 through 1977-78). None of the previous studies have examined changes in premiums over time.

Dependent variables. The dependent variables refer to premiums paid by physicians in three fields—general practitioners who do no surgery, ophthalmologists, and orthopedic surgeons—deflated by a state price index that varies across states and over time (with 1967 = 1.0).[39] Premiums are defined for a policy offering $100,000/$300,000 coverage.[40]

Premiums for various specialties in a state are highly correlated: pair-wise correlations between general practitioners, ophthalmologists, and orthopedic surgeons based on these state data are all 0.92 or higher; correlations between annual percentage changes in premiums in the three fields are also high, all 0.91 or higher. These correlations imply either that all the physicians in a given state share the financial consequences of adverse experience of a few specialties, or that claim experiences among specialties within a state tend to move together. The former possibility is far more likely.

Table 1. Explanatory Variable Definitions, Means, and Standard Deviations

Variable Name	Definition	Mean	Std. Dev.
Y	Real per capita income	3717.0	503.0
OPSPOP	Surgical operations per 1,000 population	0.0812	0.0164
LAWPOP	Lawyers per 10,000 population	12.4	11.7
MDPOP	Patient care physicians per 10,000 population	13.0	4.4
LRECOV	Provider liability limited	0.18	0.38
LLIM	Recovery by plaintiff limited	0.23	0.42
PTCOMP	Patient compensation fund established	0.18	0.38
RESIPS	Use of *res ipsa loquitur* limited	0.22	0.41
ICON	Informed consent clarified	0.32	0.47
CONFEE	Contingency-fee regulation imposed	0.27	0.45
SLIM	Statute of limitations tightened	0.50	0.50
CSOUR	Collateral-source provisions added	0.24	0.43
ADDAM	*Ad damnum* clause eliminated	0.40	0.49
LOCAL	Locality rule imposed	0.22	0.41
SCREEN	Use of pretrial screening panels mandated	0.40	0.49
ARBIT	Binding arbitration provided	0.17	0.38
JUA	JUA major insurer in state	0.06	0.24
SELINS	Health care mutal insurance company implemented	0.08	0.28
T74	Year = 1974	0.19	0.39
T75	Year = 1975	0.20	0.40
T76	Year = 1976	0.20	0.40
T77	Year = 1977	0.20	0.40

Explanatory variables. The focus of the regression analysis is on the impacts of legislative changes on levels and rates of change in malpractice premiums. To isolate the impacts of legal influences on the dependent variables, it is necessary to consider the other possibly influential factors that were reviewed in the conceptual discussion above, such as patient income, availability of lawyers, and case-mix. The premium equations contain three control variables similar to those included by Reder and Feldman: per capita income (deflated by the state price index)—Y; surgical operations per 1,000 population—OPSPOP; and lawyers per 10,000 population—LAWPOP. In addition, the number of physicians primarily engaged in patient care (as opposed to administration, research, and/or teaching) per 10,000 state population—MDPOP—is included. Although a higher surgery rate may be expected to lead to a higher incidence of malpractice claims, a higher physician-population ratio may have the opposite effect, since patient access improves with increases in the physician-population ratio. More specifically, patients' office waiting time falls, and the length of time physicians spend with patients rises.[41] Thus, even if medically defined quality is not altered, patients may feel better about their doctors and thus be less prone to sue them.[42] As an alternative to MDPOP, a variable indicating physician availability in the specialty corresponding to the premium was entered as an explanatory variable. Results were virtually identical to those shown below.

When premiums are expressed as levels, it is appropriate to control for the legal environment prior to the mid-1970s. Preliminary regressions contained a legal variable to describe the application of tort law by state, as constructed by Feldman, and, alternatively, a legal index based on parameter estimates from Feldman's regression (which had malpractice claims frequency as the dependent variable).[43] Neither legal variable showed a discernible impact on premiums once other explanatory variables were included, and both were dropped from the regressions without having a consistent effect on the parameter estimates on the remaining variables. Binary variables representing each state were added to account for omitted state effects on premiums.

Variables depicting legislative responses to the malpractice crisis of the mid-1970s are shown in boldface in Table 1.[44] The variables ordinarily assume the value 1 for the year a malpractice "reform" was enacted by the state legislature and for succeeding years, and are zero otherwise. There is, however, one exception: when a reform was subsequently overturned by judicial decision, the variable assumes the value zero in the year in which the decision was reached and thereafter. Correlations among the "legislative response" variables are almost always positive, and most often in the 0.2 to 0.4 range. The highest correlation, not surprisingly, is between limitation on recovery and the patient compensation fund (0.63).[45]

Finally, time variables *T74* through *T77* represent time-related effects common to all states. Several alternative specifications were explored in order to gauge the time-phasing of responses to recent legislation and other explanatory variables, all using premium levels as the dependent variable. In one, a lagged dependent variable was included (Koyck lag specification). Results from these regressions imply that around 90 percent of the response to a change in an explanatory variable takes place in the year following the change, quite a rapid response. Alternatively, explanatory variables for both the current *and* the preceding year were included in the same regression. The resulting parameter estimates were very unstable because of multicollinearity.

Empirical results

Regressions with premium levels as dependent variables are presented in Table 2. The first, second, and fourth regressions also contain individual state binary variables, not shown. The state binary variables should account for factors responsible for any continued interstate differences in real premiums that are not explained by the first set of explanatory variables (from *Y* through *MDPOP*).

If legislative changes were effective, legislative change variables should dem-

Table 2. Premium Level Regressions

Explanatory Variables	Dependent Variables: 1. General Practitioner Premium		2. Ophthalmologist Premium	
	Coeff.	S.E.	Coeff.	S.E.
Y	0.42	(0.66)	0.44	(0.70)
OPSPOP	1.016[c]	(0.60)	1.11[c]	(0.63)
LAWPOP	1.020	(0.80)	1.31	(0.85)
MDPOP	-0.22	(0.87)	-0.49	(0.93)
LRECOV	-0.080	(0.088)	-0.027	(0.093)
LLIM	0.046	(0.093)	0.046	(0.098)
PTCOMP	0.039	(0.10)	0.0005	(0.11)
RESIPS	0.001	(0.094)	-0.037	(0.010)
ICON	-0.009	(0.085)	0.046	(0.090)
CONFEE	-0.011	(0.100)	0.013	(0.11)
SLIM	-0.047	(0.072)	-0.020	(0.077)
CSOUR	0.012	(0.094)	0.038	(0.099)
ADDAM	0.10	(0.087)	0.079	(0.084)
LOCAL	0.18[b]	(0.08)	0.11	(0.089)
SCREEN	-0.19[a]	(0.07)	-0.19[a]	(0.071)
ARBIT	0.26[a]	(0.09)	0.29[a]	(0.095)
JUA	0.13	(0.11)	0.080	(0.12)
SELINS	0.16[c]	(0.09)	0.048	(0.098)
T74	-0.21	(0.17)	-0.13	(0.18)
T75	0.074	(0.14)	0.063	(0.15)
T76	0.09	(0.11)	0.077	(0.11)
T77	0.065	(0.061)	0.070	(0.065)
Constant	5.16		6.37	
	R^2 = 0.87		R^2 = 0.84	
	$F(69,166)$ = 16.4		$F(69,166)$ = 12.4	

a Statistically significant at the 1% level (two tailed test).
b Statistically significant at the 5% level (two-tailed test).
c Statistically significant at the 10% level (two-tailed test).

onstrate negative effects on real premiums. But, as Table 2 shows, there are more positive than negative coefficients for the variables *LRECOV* through *SELINS*. The most consistently significant coefficients are for screening panels (*SCREEN*), arbitration (*ARBIT*), and, to a lesser extent, mutual insurance companies (*SELINS*). But of these, only the screening variable shows a negative impact on premiums.

The fact that the regression results are quite similar for the three specialties is not surprising, in view of the high simple correlations among premiums in the

Table 2, continued

Explanatory Variables	Dependent Variables: 3. Orthopedic Surgeon Premium*		4. Orthopedic Surgeon Premium	
	Coeff.	S.E.	Coeff.	S.E.
Y	0.28	(0.34)	0.51	(0.71)
OSPOP	-0.23	(0.44)	1.11[c]	(0.64)
LAWPOP	0.88[a]	(0.23)	1.04	(0.87)
MDPOP	0.25	(0.24)	0.17	(0.94)
LRECOV	0.019	(0.11)	-0.16	(0.09)
LLIM	0.11	(0.11)	0.024	(0.10)
PTCOMP	0.11	(0.12)	0.046	(0.11)
RESIPS	-0.088	(0.13)	0.052	(0.10)
ICON	0.28[a]	(0.11)	0.022	(0.091)
CONFEE	0.24[b]	(0.11)	-0.031	(0.11)
SLIM	0.016	(0.089)	0.0009	(0.078)
CSOUR	-0.15	(0.12)	-0.013	(0.10)
ADDAM	-0.15	(0.10)	0.13	(0.085)
LOCAL	0.069	(0.11)	0.093	(0.090)
SCREEN	-0.16[c]	(0.09)	-0.15[b]	(0.072)
ARBIT	0.25[a]	(0.10)	0.18[c]	(0.097)
JUA	-0.099	(0.16)	0.11	(0.12)
SELINS	0.31[b]	(0.14)	0.13	(0.10)
T74	-	(-)	-0.18	(0.18)
T75	-	(-)	0.15	(0.15)
T76	-	(-)	0.15	(0.11)
T77	-	(-)	0.090	(0.07)
Constant	4.69		6.63	
	R^2 = 0.36		R^2 = 0.86	
	$F(18,217)$ = 6.9		$F(69,166)$ = 14.0	

* Both time and state binary variables omitted from this regression.
a. Statistically significant at the 1% level (two-tailed test).
b. Statistically significant at the 5% level (two tailed test).
c. Statistically significant at the 10% level (two-tailed test).

three specialties. The only one among the first set of explanatory variables (from *Y* to *MDPOP*)[44] to show a significant impact on premiums in more than one regression is the surgery rate (*OPSPOP*), which loses significance when the time and state binary variables are omitted (regression #3). The size of the *OPSPOP* coefficient is about the same for GP premiums as it is for the surgical specialists,

Table 3. Annual Change Regressions

Explanatory Variables	Dependent Variables: 1. General Practitioner Premium		2. Ophthalmologist Premium		3. Orthopedic Surgeon Premium	
	Coeff	S.E.	Coeff.	S.E.	Coeff.	S.E.
LRECOV	−0.010	(0.064)	0.0001	(0.069)	−0.040	(0.070)
LLIM	0.040	(0.066)	0.018	(0.072)	0.027	(0.072)
PTCOMP	−0.012	(0.071)	−0.0003	(0.079)	0.014	(0.079)
RESIPS	0.043	(0.077)	0.040	(0.085)	0.089	(0.085)
ICON	−0.056	(0.067)	−0.055	(0.073)	0.057	(0.073)
CONFEE	0.0002	(0.06)	0.007	(0.071)	−0.018	(0.071)
SLIM	−0.006	(0.053)	0.019	(0.058)	0.012	(0.058)
CSOUR	0.007	(0.07)	0.030	(0.078)	0.018	(0.078)
ADDAM	0.050	(0.061)	0.039	(0.067)	0.053	(0.067)
LOCAL	0.032	(0.070)	0.012	(0.077)	−0.026	(0.077)
SCREEN	−0.071	(0.053)	−0.081	(0.058)	−0.044	(0.058)
ARBIT	0.11[c]	(0.06)	0.12[c]	(0.07)	0.074	(0.067)
JUA	0.034	(0.092)	0.026	(0.101)	−0.011	(0.10)
SELINS	−0.009	(0.082)	−0.065	(0.090)	−0.060	(0.090)
I75	0.38[a]	(0.07)	0.31[a]	(0.073)	0.45[a]	(0.073)
I76	0.19[a]	(0.06)	0.17[b]	(0.07)	0.21[a]	(0.07)
I77	−0.064	(0.060)	0.069	(0.066)	0.076	(0.066)
Constant	−0.070		−0.075		−0.081	
	$R^2 = 0.21$		$R^2 = 0.14$		$R^2 = 0.23$	
	$F(17,174) = 2.8$		$F(17,174) = 1.7$		$F(17,174) = 3.1$	

a. Statistically significant at the 1% level (two-tailed test).
b. Statistically significant at the 5% level (two-tailed test).
c. Statistically significant at the 10% level (two-tailed test).

implying that a doctor who does no surgery also is made to face a higher premium when the surgery rate rises. The coefficient for *LAWPOP* (the lawyer ratio) always exceeds its standard error, and it is statistically significant when the time and state binaries are dropped (regression #3).

One reason for the positive signs on the legislative response coefficients may be that states with a serious problem—i.e., those with high premiums—were more likely to enact remedial legislation. Analysis of the annual growth rate in real premiums, the dependent variable in Table 3, should be much less subject to this selectivity problem. But the legislative variables in this table, viewed collectively, have no impact on premium inflation. In fact, excluding the time variables, the *F*-statistic for the equation never exceeds 0.63, far below conventional levels of statistical significance. Regressions including changes in control variables *Y* through *MEDPOP*, not shown here, are similar to those reported in Table 3.

A Brief Discussion

Whereas many of the potential sources of premium inflation are national in scope, deliberate action has been undertaken mostly at the state level. The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums.[47] The publicity resulting from considerable legislative activity may have made juries and perhaps potential plaintiffs more aware of the cost consequences of malpractice suits. If so, this effect probably extended beyond the boundaries of any particular state.

Another possibility is that past frequency of claims and size distribution of settlements in a state are only weakly related to premiums in the state. Premiums are set on the basis of expected outlays, and insurers may not have based their expectations for the future on past experience. Unfortunately, state-specific data on claims frequency and dollar amounts of settlements are not available for 1974 and thereafter. However, correlations among 1974 premiums, claims filed, cases won by plaintiffs, and mean size of awards for 1970 are surprisingly low (0.3 or less).[48] Certainly, adverse insurer experience in a given year should be reflected in higher premiums in later years, so that higher correlations were anticipated. There is a need for more "hard" empirical evidence on how insurers *really* form expectations and set premiums.

Finally, lawyers are often held accountable for the increased tendency to seek legal recourse. Even though the lawyer variable is insignificant in regressions containing binary variables for states, the sign on the lawyer coefficients remains positive and substantial in size. Without the state binary variables (see regression #3, Table 2), the lawyer variable has a positive impact on premiums, significant at the one-percent level. Viewing the empirical evidence in its entirety, the notion that a 10 percent increase in a state's lawyer/population ratio leads to almost a like percentage increase in premiums, as the coefficients imply, is a distinct possibility.

Notes

1. See N. T. Greenspan, "A Descriptive Analysis of Medical Malpractice Insurance Premiums, 1974-1977," *Health Care Financing Review* 1 (Fall 1979): 65-71, for 1974-77 trends. Pre-1974 data on premiums are available from M. C. Kendall, "Expectations, Imperfect Markets, and Medical Malpractice Insurance," in *The Economics of Medical Malpractice*, ed. Simon Rottenberg (Washington, D.C.: American Enterprise Institute, 1978), p. 176.
2. There are numerous accounts of legislative responses, a few document court decisions in this area. See, for example, K. S. Abraham, "Medical Malpractice Reform: A Preliminary Analysis," *Maryland Law Review* 36 (No. 3, 1977): 489-531; American Arbitration Association, *Statutory Provisions for Binding Arbitration of Medical Malpractice Claims* (Washington, D.C.: U.S. National Center for Health Services Research, DHEW Pub. No. (HRA) 77-3165, October 1976); American Medical Association, "State Health Legislation Report," May 1977, American Medical Association, "Selected Important Court Decisions Relating to Medical Malpractice Legislation" (Chicago: AMA, Public Affairs Division, 1 December 1978); P. E. Carlin, "A Snapshot of State Legislative Enactments in the 1970 Sessions Relating to Malpractice" (Washington, D.C.: George Washington University, Intergovernmental Health Policy Project,

mimeo, 1980), Editors, *Duke Law Journal*, "Comment: An Analysis of State Legislative Responses to the Medical Malpractice Crisis," in *Medical Malpractice: The Duke Law Journal Symposium* (Cambridge, Mass.: Ballinger, 1977), pp. 241-92; B. J. Jacobs, "Overview of State Legislation Pertaining to Professional Liability of Physicians," *Clinical Obstetrics and Gynecology* 20 (March 1977): 25-54; S. Law and S. Polan, *Pain and Profit: The Politics of Malpractice* (New York: Harper and Row, 1978); A. J. Lipson, *Medical Malpractice: The Response of Physicians to Premium Increases in California* (Santa Monica, Calif.: Rand Corporation, #R-2026-PSEC, November 1976); Medical Liability Commission, *Legislative Index for Health Services Research* (Rockville, Md.: U.S. National Center for Health Services Research, December 1976); M. H. Redish, "Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications," *Texas Law Review* 55 (May 1977): 759-800; R. E. Stromberg, "Case Law Update" (San Francisco: National Health Lawyers Association, mimeo, May 1979); D. G. Warren and R. Merrin, eds., *A Legislator's Guide to the Medical Malpractice Issue* (Washington, D.C.: Georgetown University Health Policy Center, 1976).

3. *Medical World News*, "New York State Doctors are Threatened with Staggering Increases in Malpractice Premiums," 25 May 1981, pp. 18-19.
4. According to American Medical Association, *SMS Report* (Vol. 1, October 1982), malpractice premiums did not rise in real terms between the mid 1970s and the early 1980s. Also see E. K. Adams and S. Zuckerman, "Variation in the Growth and Incidence of Malpractice Claims," *Journal of Health Politics, Policy and Law* 9 (Fall 1984): 475-488.
5. See, for example, C. L. Rosenberg, "Why a New Malpractice Crisis is Coming," *Medical Economics*, 28 April 1980, pp. 109-14; and *Medical World News*, 1981.
6. Greenspan, "A Descriptive Analysis," p. 66.
7. U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims* (Washington: U.S. Department of Health, Education, and Welfare, Pub. No. HCFA 02108, 20 October 1978), Table 4-18; S. R. Henderson, "The Malpractice Insurance Situation and its Effects on Medical Practice," in *Profile of Medical Practice, 1978*, ed. J. C. Gaffney (Chicago: American Medical Association, 1979), p. 10; and American Medical Association, *SMS Report*.
8. The source is unpublished data from Nancy Greenspan, Health Care Financing Administration; premiums are for a "standard" $100,000/$300,000 policy.
9. See, especially, All Industry Medical Malpractice Insurance Committee, "The Problems of Insuring Medical Malpractice" (Hartford, Conn.: Aetna Life and Casualty, mimeo, November 1975), and Kendall, "Expectations."
10. H. W. Reder, "Medical Malpractice: An Economist's View," *American Bar Foundation* 1976 (No. 2, 1976): 311-63.
11. Ibid., and M. W. Reder, "An Economic Analysis of Malpractice," *Journal of Legal Studies* 5 (No. 2, 1976): 267-93. Although the direction of effect cannot be determined a priori, there are strong conceptual arguments for including per capita income. The role of operations per surgeon is much less clear. Since most suits may be traced to care rendered in the hospital, and a high proportion to surgery in particular, there is reason for including a variable representing hospital and/or surgical activity. See M. H. Rudov, T. I. Myers, and A. Mirabella, "Medical Malpractice Insurance Claims Files Closed in 1970," in *Appendix to Report of the Secretary's Commission on Medical Malpractice* (Washington, D.C.: U.S. Government Printing Office, DHEW Pub. No. (OS)73-89, 16 January 1973), pp. 1-25, and U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims*, several tables. However, the ratio of operations to surgeons may be high in states with few operations but with even a greater scarcity of surgeons. Also, since practice seems to make perfect, a high workload may be associated with higher rather than lower quality. See, for example, A. B. Flood, W. R. Scott, and W. Ewing, "Does Practice Make Perfect? Part I: The Relationship Between Hospital Volume and Outcome for Selected Diagnostic Categories," *Medical Care* 22 (February 1984): 98-114.
12. R. Feldman, "Determinants of Medical Malpractice Incidents: Theory of Contingency Fees and Empirical Evidence," *Atlantic Economic Journal* 7 (July 1979): 59-65.
13. Both Reder and Feldman took their legal variables from S. Dietz, C. B. Baird, and L. Bertal, "The Medical Malpractice Legal System," in *Appendix to Report of the Secretary's Commission on Medical Malpractice*, pp. 87-167.
14. J. F. Hastings, "Medical Malpractice Background Papers," in *An Overview of Medical Malpractice*, 94th Congress, U.S. House of Representatives, Committee on Interstate and Foreign Commerce (Washington, D.C.: U.S. Government Printing Office, 17 March 1975), pp. 3-49. All Industry Medical Malpractice Insurance Committee, "Problems of Insuring Medical Malpractice"; Law and Polan, *Pain and Profit*; P. Munch, "Causes of the Medical Malpractice Insurance Crisis: Risks and Regulations," in Rottenberg, ed., *The Economics of Medical Malpractice*.
15. Law and Polan, *Pain and Profit*, p. 171.
16. See, for example, Rosenberg, "Why a New Malpractice Crisis."
17. See, for example, American Medical Association, "Selected Important Court Decisions."
18. Editors, *Duke Law Journal*; "Comment", and Editors; *Northwestern Law Review*, "The Application of Res Ipsa Loquitur in Medical Malpractice Cases," *Northwestern Law Review* 60 (January-February 1966): 852-75.
19. Editors, *Duke Law Journal*, "Comment," p. 252; American Medical Association, "Selected Important Court Decisions."
20. U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims*, p. v-7.
21. All Industry Medical Malpractice Insurance Committee, "Problems of Insuring Medical Malpractice."
22. U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims*, p. v-6.
23. Exceptions are listed in Editors, *Duke Law Journal*, "Comment," pp. 254-5.
24. See, for example, Dietz, Baird, and Bertal, "Medical Malpractice Legal System"; and American Surgical Association, "Statement on Professional Liability, September 1976," *New England Journal of Medicine* 295 (2 December 1976): 1292-6.
25. Feldman, "Determinants of Medical Malpractice Incidents."
26. Editors, *Duke Law Journal*, "Comment," p. 268.
27. American Medical Association, *State Health Legislation Report*, p. 4.
28. Abraham, "Medical Malpractice Reform."
29. American Medical Association, *State Health Legislation*.
30. For further discussion, see Abraham, "Medical Malpractice Reform."
31. Recent court cases are listed in American Medical Association, "Selected Important Court Decisions." See A. R. Holder, *Medical Malpractice Law*, 2nd Edition (New York: John Wiley and Sons, 1978), pp. 403-18, for a description of screening panels.
32. Abraham, "Medical Malpractice Reform."
33. Ibid., p. 577. Arbitration panels may in fact be more lenient. See W. Wellington, "Alternatives to Litigation, IV: The Law of Arbitration in the U.S.," in *Appendix to Report of the Secretary's Commission on Medical Malpractice*, pp. 346-423. More favorable empirical evidence on cost-effectiveness of arbitration is presented in D. H. Heintz, "Arbitration of Medical Malpractice Claims: Is It Cost Effective?" *Maryland Law Review* 36 (1977): 533-65. Arbitration has encountered opposition from trial lawyers. See C. L. Rosenberg, "Which Malpractice Reforms Protect You Best?" *Medical Economics*, 28 April 1980, pp. 148-67.
34. Redish, "Legislative Response."
35. See American Medical Association, *State Health Legislation Report*, p. 10.
36. R. W. Rhein, "Malpractice: Grim Outlook for '76," *Medical World News*, 12 January 1976, pp. 71-83.
37. See American Medical Association, *State Health Legislation Report*, p. 11, and *Medical World News*, "Malpractice '77: 50-State Picture Improves," 10 January 1977, pp. 21-3.
38. See Reder, "An Economic Analysis"; Reder, "Medical Malpractice"; and Feldman, "Determinants of Medical Malpractice Incidents."
39. The state index is described in F. A. Sloan, "Physician Supply Behavior in the Short Run," *Industrial and Labor Relations Review* 28 (July 1975): 549-69.
40. Premium data came from the Telephone Survey of Malpractice Insurance Companies conducted by the Health Care Financing Administration. See Greenspan, "A Descriptive Analysis," for a brief description of the Survey. The first figure of the liability limit ($100,000 above) represents this annual limit per case, the second is the annual limit for all cases against the provider.
41. See F. A. Sloan and J. Lorant, "The Allocation of Physicians' Services: Evidence on Length-of-Visit," *Quarterly Review of Economics and Business* 16 (Autumn 1976): 85-103, and F. A. Sloan and J. Lorant, "The Role of Waiting Time: Evidence from Physicians' Practices," *Journal of Business* 50 (October 1977): 486-507.
42. It is also true that utilization rates rise. To the extent that some "unnecessary" care is given, patients may be more likely to sue.

43 Feldman's index is similar to Reder, "Medical Malpractice."
44 "Legislative Response" variables are based on sources listed in Note 2 above.
45 The correlations are presented in Vanderbilt University, *Analysis of Survey Data on Physician Practice Costs and Incomes* (Nashville: Vanderbilt University Health Policy Center, 1981, Final Report, Contract No. HCFA 500-78-0018 with the U.S. Health Care Financing Administration), p. 180.
46 Since Y through MDPOP are all continuous variables, associated coefficients are elasticities.
47 Many observers at the time were quite optimistic. See, for example, C. E. Welch, "Medical Malpractice," *New England Journal of Medicine* 292 (26 June 1975): 1372–76.
48 The 1970 data were used in Feldman, "Determinants of Malpractice Incidents." I am grateful to Roger Feldman for making these data available for my study.

State Rate-Setting and Its Effects on the Cost of Nursing-Home Care

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Abstract. The paper uses data from nursing-home cost reports to analyze the effectiveness of different approaches to nursing home reimbursement. Our research has produced considerable evidence on the effect of states' efforts to reduce the rate of increase in nursing home costs: First, homes in states with flat-rate reimbursement systems were found to have lower rates of increase than homes in other states, while there were no consistent differences between the results of prospective and retrospective systems. Second, efficiency incentives, inflation-projection methods, and the level of ceilings on rates appear to be very important, regardless of the general reimbursement method. For example, prospective systems with weak efficiency incentives, generous inflation adjustments, and high percentile ceilings have less cost-containment effects than prospective systems with stringent inflation allowances and low percentile ceilings. There is also evidence that the inherent weakness of the cost containment incentives in retrospective systems can be offset by low percentile ceilings and efficiency bonuses.

Introduction

Financing nursing-home care has been a major problem, both for individuals needing care and for state governments. National nursing-home expenditures more than doubled in the five years from 1976 to 1981, growing from $11.4 billion to $24.2 billion. Medicaid expenditures for nursing-home care grew by 18.6 percent from 1979 to 1980, and by 17.6 percent from 1980 to 1981.[1] The purpose of this paper is to examine the effects of public policy on the cost of nursing-home care.

Of the two public programs that pay significant amounts for nursing home care—Medicaid and Medicare—the Medicaid program has a much stronger effect on costs throughout the industry. Thus the principal issue is whether the reimbursement policies of state Medicaid programs significantly influence the rate of change in nursing-home costs. Since Medicaid programs pay for about 50 percent of the costs incurred by nursing homes, the program has a significant influence on the cost structure of individual nursing homes, and presumably a considerable influence on cost levels, and the rate of change in those levels, for the industry as a whole.

In order to analyze the determinants of rates of change in nursing-home costs,

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NATIONAL INSURANCE
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August 15, 1985

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INSURANCE COMPANIES "ON STRIKE"
NADER/NICO CHARGE:
FEDERAL SOLUTION SOUGHT

Washington, DC, August 15 - Ralph Nader today charged the insurance industry with "going on strike to extort excessive rates from the public." Nader also said that states were "failing to adequately protect consumers and stop the hemorrhaging." He called for federal action to make insurance available when insurers "abdicate their responsibilities."

Nader was joined by ex-Federal Insurance Administrator Robert Hunter, President of the National Insurance Consumer Organization (NICO). Hunter, an actuary, released a major NICO study of insurer profitability, stating that: "While insurer profits were low last year, a modest rate adjustment of about five percent was all that was needed to gain an acceptable profit level. Instead, we see massive cancellations and price increases of up to 1000% for day care centers, municipalities, environmental clean-up firms, fishing fleets, transit authorities, nurse-midwives and others. This is an unjustified raid on peoples' pocketbooks and the states are letting them get away with it," Hunter charged.

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9/12-13/85
Attachment XVII

NICO studies show auto premiums are skyrocketing at an 18.2% clip in 1985 and that premium increases of 300% to 1000% in the "distressed" lines of liability insurance are not uncommon. "This gouging has already skyrocketed insurer stock prices to record highs, at a rate of change double that of the Dow Jones Industrials," Hunter said.

Nader and Hunter called for a federal solution to the problem by: 1) federal review of the responses of state regulation to this crisis; 2) asking the Department of Justice to determine if illegal boycotts are being used by insurers; and 3) creation of federal pools to make insurance available to good risks who lose coverage through no fault of their own. "There is precedent in the FAIR Plans that kept insurance available in the cities of our nation when the riots of the late 60's occurred," Nader said.

NICO is a non-profit, public interest group that offers advice to help consumers buy insurance wisely and works for more equitable insurance laws and policies.

- 30 -

Good morning! I am Bob Hunter, President of NICO.

We are here this morning to discuss a mounting crisis in America, a crisis which involves every man, woman and child: the nation is losing its liability insurance. (See chart of headlines.) Day care centers are losing their insurance and are being forced to close, perhaps driving second breadwinners out of work or creating new latchkey children. Nurse-midwives are losing their insurance and the lower cost birthing centers are shutting down. Doctors are marching on state capitals because insurance is unavailable or costs have skyrocketed. Cities, Transit authorities, even whole states are losing their liability insurance. One of the leading auto insurers in the District of Columbia has pulled out. The list goes on and on.

And prices have skyrocketed. As this chart shows, the cost of insuring an auto in America has gone up at 9.1% for the first 6 months of 1985, exceeding the rate of change for all of 1984. 1/ The annualized rate of change is 18.2%

What is going on here? Are these practices of insurers justified?

The answer is "NO!" What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victim's rights.

Property-Casualty insurance has a cyclical profitability, as this chart shows. 2/ In 1984, if you accept the insurer's whopping reserve increases as valid (quite a large leap of faith), they earned a 3% rate of return on net worth (equity). That is too low. It would indicate that their premiums were about 5% short. If their premiums had been 5% higher, they would have earned a rate of return on net worth of about 15%, more than enough for an industry of the low to average riskiness of Property/Casualty insurance. 3/

A five percent premium shortfall is not a crisis. Yet we see all of the cancellations and mammoth price increases such as:

- A 70% increase for OB/GYNs in Maryland (totally unjustified -- per analysis, attached).
- 300% to 900% increases in lawyer and architect malpractice insurance premiums around the country.
- Increases of 200% to 500% for the day care centers who can get insurance. Many can't.
- 300% to 1000% increases for public transit authorities.

The statistics don't justify any of this!

What is going on?

If you look again at the cycle chart you will see that 1984 was a typical "bottom-of-the-cycle" year. The last time it happened was in the mid-1970's when I served as Federal Insurance Administrator. At that time, the country observed the twin crises of medical malpractice and product liability unavailability and skyrocketing premiums.

After insurers abandoned the medical and product manufacturer lines, the federal government reviewed the situation. I was fortunate to be part of the interagency working group that found that there was no justification for the insurer actions. 4/ We concluded that the insurers had just panicked from lack of data.

But look at what happened; their profits skyrocketed to all time record levels. They learned that the state regulators would, during the panic, give away the store in rate increases. They also learned that state legislators would act to reduce victims' rights in the wake of the panic (over half the states did so 5/).

They are applying the lessons they learned in the mid-1970's very well today -- to day care centers, to nurse-midwives, to doctors, to product manufacturers, and so on. They are petitioning Congress for product liability tort law changes and the states for changes in other tort systems.

Some property/casualty officials have made statements in the public record that; "It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures." (Journal of Commerce, 6/18/85) Reinsurance, a critical aspect of maintaining available and affordable insurance rates may not be available from overseas because syndicates would "simply not write reinsurance for the American casualty industry" in 1986. A representative of that overseas market was recently reported to have said that if a new policy form is not adopted by state regulators, reinsurance wouldn't be provided to American liability underwriters.

Wall Street knows what is going on. This chart shows that the property/casualty stocks have soared to record highs more than doubling the Dow Jones Industrial Average rise in 1985. 6/ Wall Street expects state regulators to allow excessive rate increases; Wall Street is right!

Insurers blame this crisis on the courts and the tort law and say the only way to fix it is to take away as many victims' rights as possible. They can point to such statistics as these:

> Of 28 insurers writing liability insurance for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, all have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it. 7/

Insurers will say this points to the need for tort reform, 8/ while admitting that data don't justify the action. 9/ I believe it shows joint action intend to create an atmosphere where rates can be put too high and legislators will be intimidated into action designed to take away victims' rights. Further, at the top of the cycle a few years ago, the now-dreaded liability insurance prices were being slashed wildly and even being sold after the insured event happened, such as in the case of the MGM Grand Hotel fire where liability coverage was written months after the fire. 10/ If tort reform was so desperately needed in 1974 and 1975, why not in 1981? Why again today? The crisis is within the insurance industry, not in the courts.

Now, insurance premiums represent 11.1% of the disposable income in this country. 11/ It is the fourth leading purchase Americans make (behind food, housing and federal income taxes, although we expect it to pass federal taxes this year).

In 1944, the Supreme Court found that insurance was interstate commerce and, thus, subject to anti-trust and other federal statutes. In 1945, under heavy insurer pressure, Congress passed the McCarran-Ferguson Act which uniquely exempts insurance from the federal anti-trust laws (except should intimidation, coercion or boycott occur). Congress delegated the authority to regulate insurance to the states with no standards for regulatory excellence and no ongoing congressional oversight. Indeed, the FTC cannot even study insurance under current law 12/ unless Congress specifically authorizes it in advance. (Their power was revoked because they had the audacity to point out that whole life insurance was not a wise purchase for most Americans. The fact that the FTC was right did not alter their fate.)

The immensely important McCarran-Ferguson Act was adopted by Congress without benefit of a hearing. The legislative history makes it clear that President Roosevelt wanted only a short, two or three-year moritorium after which anti-trust laws would fully apply. 13/ That is, in fact, what both houses of Congress adopted but their language was somewhat different, requiring a conference. Mysteriously, the conference committee reported back a bill that continues in effect today.

Every independent study of insurance concludes that the states have failed mysteriously in their attempts to regulate this giant industry. 14/

The states have allowed this crisis to happen. Had they been equipped to keep prices to statutory standards (all states require that the rates be "not excessive, not inadequate, not unfairly discriminatory") we would not be in the mess we are in today with clearly excessive prices going into effect routinely around the nation and unfair cancellations rampant.

What Should We Do?

(1) We call today upon Congress to review the McCarran-Ferguson Act to determine if it is working to protect America. The quality of state regulation is documented to be inadequate; the insolvency funds are a "Maryland S&L Crisis Waiting to Happen." Congress should act now.

(2) NICO also believes that the approach enacted at a previous bottom, 1968/9 is worthy of consideration by the Congress: The Urban Property Protection and Reinsurance Act of 1968 was a response to the unavailability of insurance in the inner cities in the wake of the riot situation of the late 60's. 15/

To be sure, the predicate for the withdrawal of riot insurance was strong, given the very serious situation extant in the country at the time. But the finding of the President's Panel on the Insurance Crisis is just as valid for the day care provider community today as it was for the inner city communities of the late 60's: "Communities without insurance are communities without hope." 16/ Providers will have to shut down, possibly forcing spouses to decide among themselves which one will have to stop working, or the latchkey situation will be exacerbated, or other undesirable results will be forced on parents. Some families may even have to give up a home for loss of the second income, situations not unlike the loss of mortgage following loss of insurance in inner city areas plagued by riot almost two decades ago.

The federal government agreed to reinsure (insure the insurance companies -- a sort of lay-off bookie arrangement) the insurers against the specified peril of riot and civil commotion in return for a reinsurance premium and a commitment to participate in a pool to make sure insurance is available to all residents whose homes met reasonable standards of insurability.

The federal government made $125 million writing this reinsurance!

The cities were saved from the sure death that no insurance brings in twentieth century America!

The program worked well.

I think that a program of stand-by authority should be prepared to take care of the day care and nurse-midwives current problem (and, perhaps some of the others). The authority should be granted to cover future crises as well, to stabilize the insurance profit cycle's harsh symptoms.

When a line of insurance became severely distressed, representatives of those purchasers could appeal to the agency given authority to reinsure. The agency would make a finding as to the extent and cause of the dislocation. If a distressed situation is certified, then the agency could offer reinsurance to insurers who would agree to make a market in the line. Following meetings with the insurers, the agency head would determine what the cause of distress was and would offer only to reinsure that cause (e.g., only reinsure the peril of child abuse for day care liability if that is the finding). Insurers would pay a reinsurance premium designed to be self-sufficient.

Insurers, the administrator of the program and representatives of the distressed industry would meet to set standards for insurability under which those who qualify are assured of an insurance market.

Studies will be undertaken to determine if other longer range action (risk management, tort reform, etc.) is also needed to resolve underlying problems.

Funding for this program would come from reinsurance premiums. I also envision a small surcharge, perhaps one-quarter of one percent of premiums written by all p/c insurers, to back up the program. This is in case premiums are insufficient over a short period or if it is determined by Congress that some short term subsidy is required to stabilize a distressed line sometime in the future.

The one-quarter of one percent surcharge would cost only 81 cents on the average private passenger car premium but would yield over$300 million this year. Over a ten year cycle, with a 10% growth in premiums and a 10% interest rate, $7 billion would flow into the Treasury. I would envision these funds being used in the general revenue area, but carefully accounted for to be available to the agency head when needed.

(3) Finally, NICO has today asked the Department of Justice to review the evidence to see if a conspiracy to boycott insureds has occurred in Day Care insurance and other lines, the intent of which is to intimidate state regulation into granting excessive rate increases and to intimidate state and federal legislators into passing unjustified tort law modifications which will maximize insurer profit levels.

Such boycotts and intimidations are not exempt from federal review under the provisions of the McCarran-Ferguson Act.

Conclusion

America deserves a better deal on its insurance. The federal government cannot sit idly by and let the insurance industry hold day care providers hostage in a large game beyond the providers' control. The terrorist tactics of insurers every 10 years at cycle bottom must be dealt with in a systematic way that adds the stability to our economy that insurance is meant to deliver. It is time the Congress began to look at the delegation it made to the states in 1945 to see if we are, as a nation, getting the most we can out of that twelve percent of our disposable income we pay into insurance premiums. A good place to start is solving the day care crisis that exists only in the minds of a few underwriters on John Street in New York City.

FOOTNOTES

1/ CPI data on "auto insurance", Bureau of Labor Statistics.

2/ Source of data: Citybank Economics and Insurance Services Office.

3/ For a discussion of risk in the property/casualty insurance business, see Investment Income and Profitability in Property/Casualty Insurance Ratemaking, J.R. Hunter and J.W. Wilson, 1983, Chapter 5.

4/ Hearing on December 3, 1975, Subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Among the interesting data supplied by ISO at that hearing were exhibits that showed that the average claim cost ISO used for ratemaking significantly exceeded the limit of liability, clearly ratemaking that had run amok. That led to this exchange:

Sen. Laxalt: Is malpractice always a loser as far as carriers are concerned?

Mr. Hunter: If they charge these rates, they could not help but win. (Page 141.)

In John Guinther's book, The Malpractitioners, Anchor Press, 1978, Guinther cites this exchange at page 169 in a chapter entitled "They Could Not Help But Win." In the following chapter, called "They Won," Guinther reviewed the later experience.

Final Report, Product Liability Task Force. Report on Product Liability Ratemaking, Product Liability and Accident Compensation Task Force, US Department of Commerce, 1980. At page ix the Report states that "overly subjective ratemaking practices were one of the principal causes of the product liability insurance problem."

5/ St. Louis Post Dispatch, Section B, P.3, 4/14/84.

6/ Source of data: Best's Property/Casualty Stock Index, A.M. Best and Company, Oldwick, NJ.

7/ "The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985.

8/ "Any permanent solution (of the day care insurance crisis) will require significant changes in the tort system." Testimony of Frank Neuhauser, Vice-President and Actuary for AIG (a leading insurer of day care centers) before the House Select Committee on Children, Youth and Families, July 30, 1985.

9/ "The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office . . . appears to conform with the current loss experience for the majority of commercial insurance lines . . . (these data) do not suggest that insurers should abandon the market." Testimony of James L. Kimble, Senior Counsel, American Insurance Association, before the House Select Committee on Children, Youth and Families, July 30, 1985. The testimony was also endorsed by the Alliance of American Insurers.

10/ See, for instance, the National Underwriter, 11/20/81, page 1, where it says:

> A large commercial umbrella (liability) risk came up for renewal and was rated at $105,000, about the same as the previous year. But the insured was not satisfied. Aware of the aggresive rate competition in the commercial lines market today, he decided to shop around. He approached a second agent, who submitted the very same risk to a different company, which offered to write it for just $20,000.
> But the insured was still not happy. He continued shopping and eventually the original company, which originally wanted $105,000 came back and took the business for $5,000. That's right, $5,000. (Emphasis added.)

11/

Item	1984 Amount Spent in Billions a/	Column (1) - 1984 Disposable Income of $2,578.1 Billion a/
Food	444.3	17.2%
Housing	397.8	15.4
Personal Income Taxes	302.6	11.7
INSURANCE b/	287.1	11.1

a/ Source: US Department of Commerce, Bureau of Economic Analysis.
b/ Source: Bests Management Reports, December 31, 1984, page 1.
Life Insurance Fact Book, page 56.
Blue Cross Association, Telephone call of 1/25/85.

12/ The law was euphemistically entitled the "FTC Improvements Act of 1979."

13/ See Statement of Honorable Claude Pepper before the Subcommittee on Monopolies and Commercial Law on the Insurance Industry's Antitrust Exemption, April 11, 1984; found at page 5 of the Subcommittee's report, Competition in the Insurance Industry.

14/ See, for instance, Issues and Needed Improvements in State Regulation of the Insurance Business, General Accounting Office, 1979; Invisible Bankers, Andrew Tobias, Linden Press, 1982; The Life Insurance Game, Ronald Kessler, Holt, Rinehart and Winston, 1985;"Protection for Sale: The Insurance Industry," NBC-TV Nes, 1981; Risk, Reality and Reason, the Conference of Insurance Legislators, September, 1983.

One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.
There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabeling them to be "Fellows" in the Casualty Actuarial Sociaty. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]
Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

Source of data: American Academy of Actuaries 1985 Yearbook and Directory of Members by Business Affiliation.

15/ Public Law 90-448, 82 Stat. 476; 12 U.S.C. 1749bbb, 42 U.S.C. 4011.

16/ Meeting the Insurance Crisis of Our Cities, A report of the President's National Advisory Panel on Insurance in Riot-Affected Areas, January, 1968, p. 1.

NATIONAL INSURANCE
CONSUMER ORGANIZATION

5 Rocky Mt. States Lose Liability Cover

6/27/85

The Colonial Penn Insurance Co. has "non-renewed" a liability insurance policy for the entire state of Colorado.

Unless the state can come up with coverage by Sept. 15, a the state will be its auto and

"We've been the three thousand companies country, only them are willing governmental entities

Midwives Facing Loss of Insurance

NY TIMES 7/13/85

By CAROL LAWSON

THE problems that doctors across the country are having with malpractice insurance are also being felt by nurse-midwives. About a third of the 2,500 in practice have been notified that they will soon lose their malpractice insurance, meaning that they might have to give up their profession unless another insurer will cover them for professional liability.

Birthing Centers Face Shortage of Cover

By C.A. CARPENTER

Birthing centers, one of the least expensive places to have a baby, have become threatened by the same medical - ice system that encoura development.

7/12/85

Insurance Premiums Sink Fishing Fleet

7/5/85

GLOUCESTER, Mass. — Sam LoGrasso was sitting outside the St. Peter's Club on Rogers Street here, basking in the sun. He would rather have been fishing.

But Mr. LoGrasso, 44, is one of more than 30 Gloucester commercial fishermen who in the last two weeks have been forced to let their trawlers sit idle because their insurance has been canceled.

Transit Systems Fa Liability Shortage

By JUS

The

transit
some difficul-
insurance, ac-
American Public

the group's mem-
ng rates increase by as
,000 percent.

7/12/85

The loss ratio for publ transportation systems has remained constant, yet members are experiencing premium increases from 300 percent to 1,000 percent.

Fireworks Makers Face Loss of Insurance

7/2/85

By JAMES NOLAN

NEW YORK — A Fourth of July without as evening of "ahs" — boom — ahh" is unthinkable.

But the way things are in the casualty insurance industry, the Fourth next year might very well be quiet, indeed.

Day Care Insurance Imperiled

Policies Canceled
House Hearing 'Ic

7/15/85

Rate hikes, capacity crunch seen with July 1 renewals

THE 1985 INSURANCE CRISIS

WHAT'S GOING ON HERE?

By Sandra Sugar

Alyce M. Chessance told a gressional committee yesterd that she has been providing child care in Burke, Va., for eight years. But this year the care will end, be cause her insurance has been can celed.

Karen E. Sloan testified that she also will have to close her day care business at her home in Falls Church, because her insurance policy has been canceled.

Auto Insurer To Discontinu Service in D.C.

7/10/85 By Sandra Evans

Dairyland Insurance Co., the N writer of auto insurance in th trict, informed the city govern it yesterday that it is discontin insurance for all of its District ypolders by the end of this year use of high losses it has had

About 16,000 customers, most of them high-risk drivers with month-to-month policies, will have to scramble to get insurance from oth-

Risky Business

Liability Insurance Is Difficult to Find Now For Directors, Officers

7/10/85

Suits by Shareholders Cause Premiums to Skyrocket;

The worst is yet to come, reinsurers, brokers predict

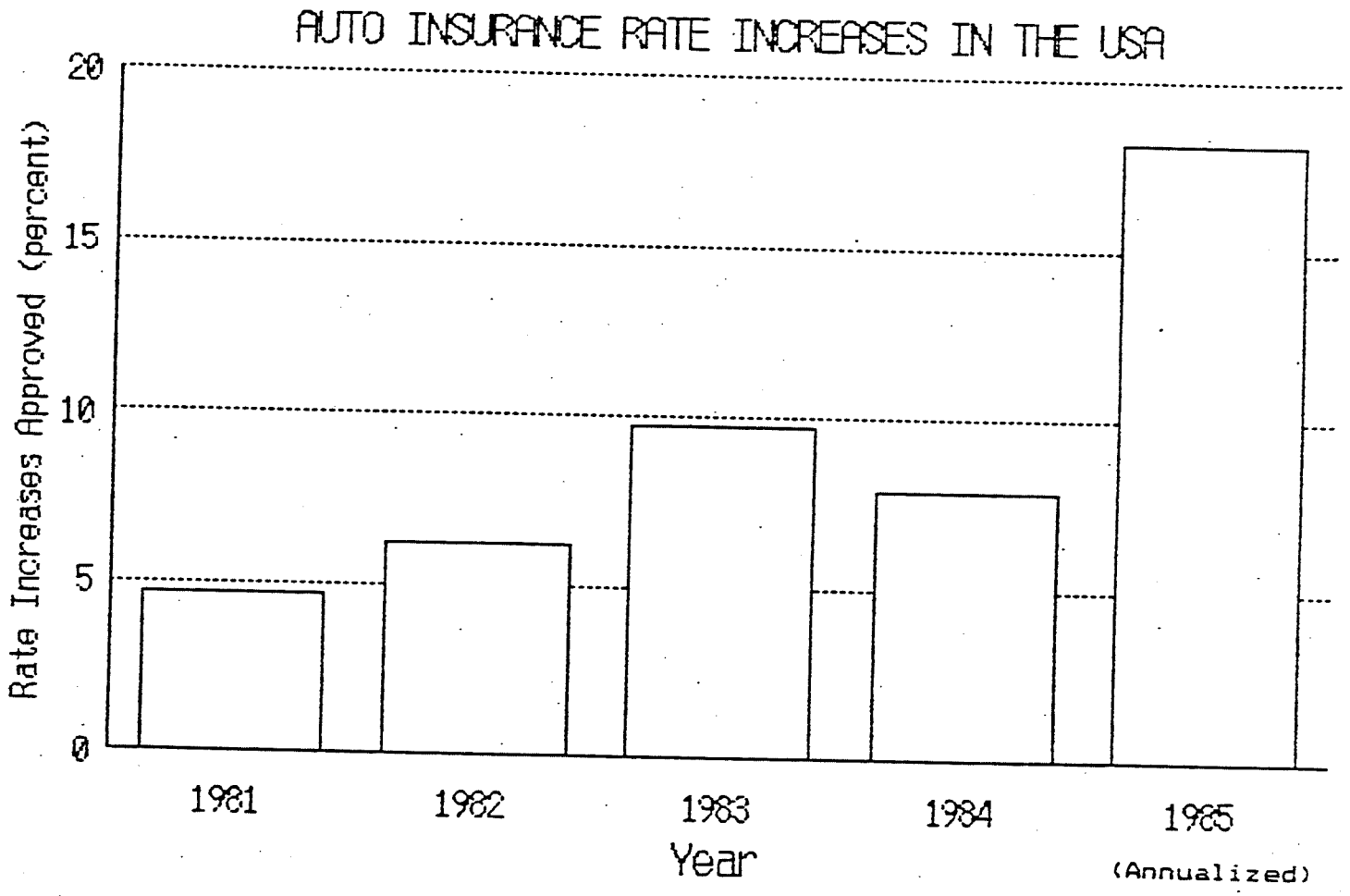
By DOUGLAS McLEOD 7/5/85

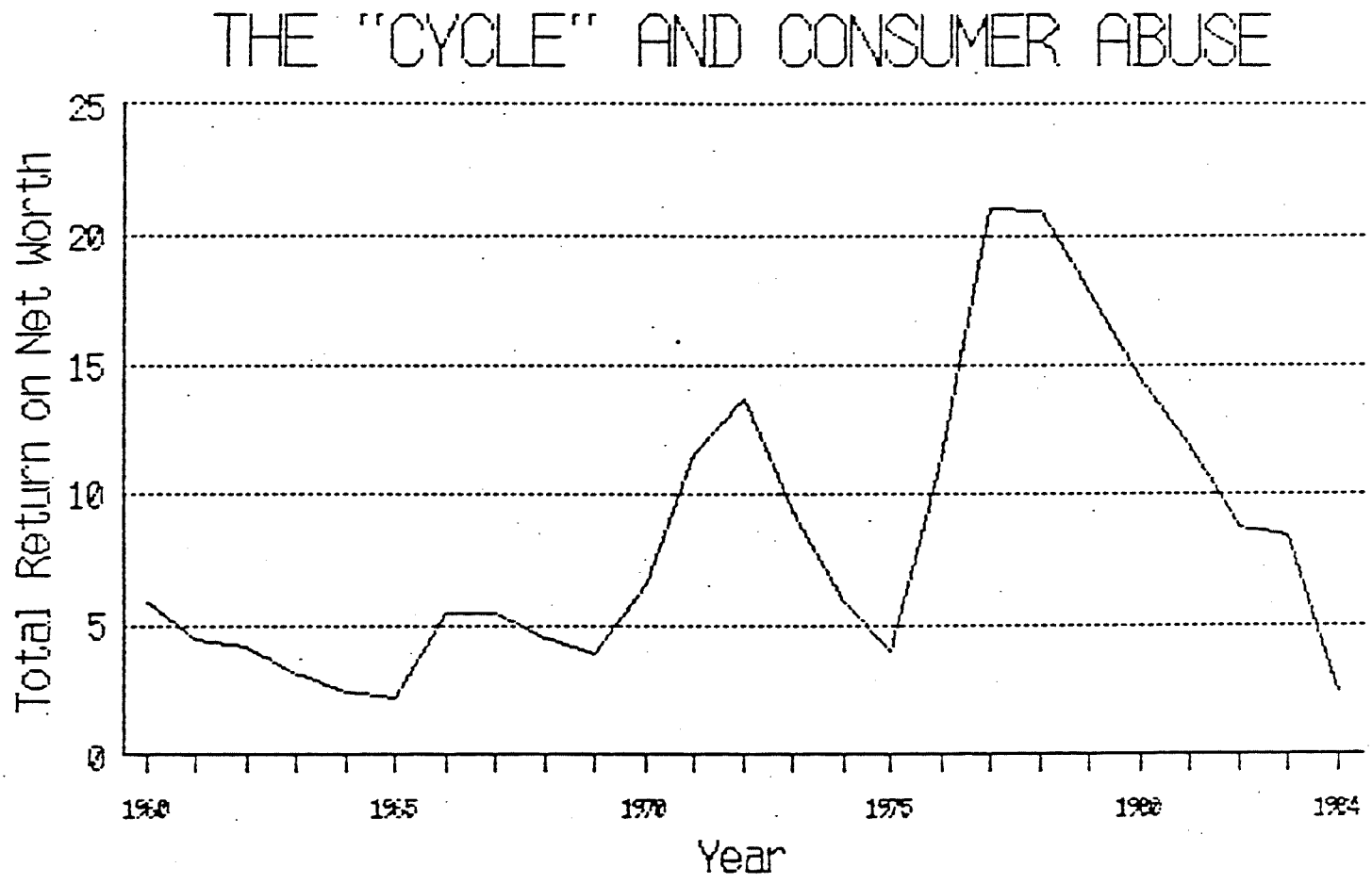
It's summertime, but the living is far from easy for reinsurance buyers.

After being clobbered during last January's renewals with rate hikes, capacity shortages and more-restrictive policy terms, ceding companies were hit even harder during July 1 renewals.

And, there is no relief in sight as next January's renewal season approaches, brokers and reinsurers predict.

"I think it's going to be a bloodbath," said an underwriter at Constitution Reinsurance Corp. in New York, referring to next January's renewals, which brokers will


AUTO INSURANCE RATE INCREASES IN THE USA
Rate Increases Approved (percent)
20
15
10
5
0
1981
1982
1983
1984
1985
Year
(Annualized)


THE "CYCLE" AND CONSUMER ABUSE
Total Return on Net Worth
25
20
15
10
5
0
1960
1965
1970
1975
1980
1984
Year

Analysis of Rate Filing of

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

Filing Date: May 16, 1985 Effective: July 1, 1985

J. ROBERT HUNTER

Fellow, Casualty Actuarial Society
Member, American Academy of Actuaries
President, National Insurance Consumer Organization
Former Federal Insurance Administrator

BACKGROUND

On May 16, 1985, the Medical Mutual Liability Insurance Society of Maryland (MMLIS) filed for an increase in malpractice premiums of +29%. The filing also requested changes in the relativities between classes, the most notable of which was a one-third increase in Class 8 (OB/GYN Surgery). The total impact of the overall rate change of +29% and the class relativity change of +33.3% on OB/GYN surgeons was to increase their rates by 66.7%. For the highest rated territory, these doctors had their rates raised from $25,429 to $42,393. This did not please the OB/ GYN community.

WAS THE OVERALL 29% RATE INCREASE JUSTIFIED?

In my opinion, there was no justification for an overall rate increase of 29%. Indeed, I believe that the filing supports a reduction in premiums rather than an increase. Here's why:

- The filing incorrectly assumes that the yield on investments that the MMLIS will earn is 5%, an unrealistically low assumption, and

- The filing incorrectly assumes that inflation in the future will be at double-digit levels.

When proper assumptions are made on just these two items, even accepting other major assumptions (such as their reserves are accurate), a rate reduction of 10.5% is indicated.

HOW SHOULD INVESTMENT INCOME BE FACTORED IN?

To do the job properly, a full blown total return analysis should be undertaken. The National Association of Insurance Commissioners adopted the total return approach at their June, 1984 meeting, and issued a report detailing several approaches. Under a total return approach, all income is analyzed to determine what overall profit the company will make under a given set of rates and a comparison of that potential earning power to the needed margin to attract risk capital is undertaken. It is a sophisticated, highly desirable approach that should be used in Maryland, as the NAIC recommended for all regulated lines.

In that the filing was woefully short of the data needed to undertake total return analysis, I decided to accept, for review purposes, the MMLIS approach to discounting the cash flows (their Exhibit 5, my Exhibit "A", attached). On my exhibit, you will see the MMLIS approach as typed and mine in

handwriting. MMLIS discounted the losses based on a distribution of losses paid by time. Presumably this is based on their Maryland experience, the filing does not identify that.

The average claim takes a bit over 7 years to pay. This means that MMLIS holds the money in reserve for that long before they pay the average claim. Obviously this means that the reserves, which are fully funded today under statuatory accounting rules, will produce a significant amount of investment income.

The MMLIS approach assumes that they will earn 5% on their invested reserves. This is obviously too low. MMLIS has earned, according to their 1984 Annual Statement, the following yields on their total assets (including assets not invested or used for business--such as properties) the following:

1982	9.1%
1983	8.9%
1984	9.3%

Other filers recognize that the yield is not so absurdly low. For example, on May 17, 1985 the leading writer of medical malpractice insurance in the country, St. Paul submitted a filing in South Carolina in which it used a 10.5% yield to discount that state's cash flow. (see my Exhibit "B")

I have chosen to use a 10% discount rate, which is reasonable for fully invested assets of MMLIS. That change is shown on Exhibit "A". It results in a discount for investment income of 43% rather than 26% based on the unjustified 5% yield assumption. If that change is carried through to the rate level itself, the rate filing would have been for a <u>reduction</u> in rates of 1.4% rather than an increase of 29%. The calculation of the reduction is found on Exhibit "C", attached.

TREND

MMLIS displayed its own Maryland data for trend on its Exhibit 4, my Exhibit "D". It carefully analyzed the data and concluded that the range of results were between an annual trend of +7.8% based on straight line projection, and +9.3% based on exponential line projection. The data are company specific and Maryland specific andthrough the most recent year, 1983.

For some reason, the filer then displays data for other insurers, for other states, that is old data. (See Exhibit

"E"). This experience is from a period of high inflation and is not relevant, in my opinion to the case at hand. For one thing, the federal government has reported that medical inflation rates in the nation are below 10%, certainly no where near the 16% figure that the irrelevant data produce. These data should not be given weight, in my estimation.

I selected a trend of 9% for the purposes of this review. It gives weight to the fact that the exponential line has a slightly better "fit" to the data and is within the range as calculated by MMLIS, but near the exponential side. I also chose to apply the trend exponentially (this gives a higher answer than using a straight line).

Looking again at Exhibit "C", the use of the amended trend, coupled with the 10% yield assumption produces an indicated rate level reduction of 10.5%

SENSITIVITY ANALYSIS

If we used a yield of only 9% (less than MMLIS earns, even on all assets including cash) and use a trend of 10% (ehich is more than that realized by MMLIS and more than that in the nation today) the indicated rate would be a reduction of 0.9%.

ANALYSIS OF CLASSIFICATION CHANGES

Incredibly, there is absoultely no justification for the changes in the classification differentials employed by MMLIS contained in the filing. The entire "justification" for the change is found on Exhibit "F", attached.

There are other, more minor changes made without a shread of evidence, such as the territorial relativity changes, and the increased limits changes.

BALANCE SHEET

MMLIS is as solid an insurer as there can be. Their 1984 balance sheet shows that the company enjoys a premium/surplus ratio of 1.2 to 1. This company appears to be over-capitalized. If the ratemaking has followed the current filing approach, it is no wonder.

CONCLUSION

This filing is not justified. An overall rate level decrease of 10.5% is needed, not a 29% increase. The class changes which so sharply impact the OB/GYN surgeon group is not justified in the filing, although their may be experience somewhere that supports that change. The filing should have been disapproved. It is particularly abusive to observe a 66.7% increase for OB/GYN surgeons with no justification. On the basis of the filing, the OB/GYN rate should have been decreased by 10.5%. This means that the OB/GYN surgeons in Maryland may be paying about 85% too much.

Exhibit "A"

MEDICAL MUTUAL LIABLITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW - OCCURRENCE COVERAGE

PRESENT VALUE OF PAID MEDICAL MALPRACTICE CLAIMS

(OCCURRENCE BASIS)

Time Interval	Cum. Paid	% Paid Losses By Interval	Years of Discount (n)	Vn (5%)	10%	Present Value	
Up to 12 mos.	0.0%	0.0	0.5	.976	.954	-	
24	2.0	2.0	1.5	.929	.867	1.858	1.7
36	7.0	5.0	2.5	.885	.788	4.425	3.9
48	19.0	12.0	3.5	.843	.716	10.116	8.5
60	35.0	16.0	4.5	.803	.651	12.848	10.4
72	53.0	18.0	5.5	.765	.592	13.770	10.6
84	68.0	15.0	6.5	.728	.538	10.920	8.0
96	79.0	11.0	7.5	.694	.489	7.634	5.3
108	87.0	8.0	8.5	.661	.445	5.288	3.5
120	92.0	5.0	9.5	.629	.404	3.145	2.0
132	95.0	3.0	10.5	.599	.368	1.797	1.1
144	97.0	2.0	11.5	.571	.334	1.142	.6
156	99.0	2.0	12.5	.543	.304	1.086	.6
168	100.0	1.0	13.5	.518	.276	.518	.2
						74.547%	

Avg 7.1 yrs

5%

Exhibit "B"

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Physicians and Surgeons Professional Liability

Exhibit C
Loss and Loss Expense
Payout Patterns

Year	Cumulative Annual Payout	Incremental Annual Payout	Present Value*
1	.061	.061	.059
2	.275	.214	.187
3	.496	.221	.175
4	.668	.172	.124
5	.786	.118	.076
6	.869	.083	.049
7	.910	.041	.022
8	.952	.042	.020
9	.976	.024	.011
10	1.000	.024	.009
		1.000	.732

* Discounted claims payments at 10.5% pre-tax.

EXHIBIT "C"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 Professional Liability Rate Level Review - Occurrence Coverage

Total Limits Rate Level Indication -- $000's

(1) Calendar/ Accident Year	(2) E. P. at Current Rate Level (Exh. 3)	(3) Ultimate Incurred Loss & ALAE (Exh. 2)	(4) Trend Factor to 7/1/86 at 11% 9%		(5) Losses Trended to 7/1/86 (3)x(4)		(6) Loss Ratio at Current Rate Level (5)/(2)	
1979	33,395	24,688	1.826	2.076	51,255	45130	1.535	1.351
1980	35,732	25,235	1.677	1.870	47,200	42319	1.321	1.184
1981	33,872	25,904	1.539	1.685	43,649	38,866	1.289	1.177
1982	28,984	25,414	1.412	1.518	38,580	35,885	1.331	1.238
1983	18,203	18,854	1.295	1.368	25,785	24,416	1.417	1.341
	150,185				206,470		1.375	
					187,816		1.249	

Annual Trend Factor: 11.0%
(Exhibit 4)

a)	Five year loss ratio at current rate level:	1.249	1.375	
b)	Discount for investment income at 5.0%: (10%) (Exhibit 5)	.570	0.745	.570
c)	Discounted loss and ALAE ratio (a) x (b):	.712	1.024	.784
d)	Provision for Unallocated LAE (Exhibit 6)	1.05	1.050	
e)	Discounted loss and LAE ratio (c) x (d):	.748	1.075	.823
f)	Permissible discounted loss and LAE ratio: (Exhibit 6)	.835	0.835	
g)	Indicated rate level increase (e) / (f):	-10.5	1.288	-1.4%
h)	Selected rate level increase	—	1.290	

INVESTMENT INCOME AND TREND CHANGE

ONLY INVESTMENT INCOME CHANGE.

Exhibit "D"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 RATE LEVEL REVIEW - PROFESSIONAL LIABILITY - OCCURRENCE COVERAGE

TREND IN TOTAL LIMITS LOSS RATIOS AT CURRENT RATES

($000'S)

(1) Calendar/ Accident Year	(2) Earned Premium at Current Rate Level	(3) Ultimate Incurred Loss and ALAE	(4) Loss Ratio at Current Rates	(5) Linear Fit	(6) Exponential Fit
1979	33,395	24,688	.739	.672	.683
1980	35,732	25,235	.706	.748	.747
1981	33,872	25,904	.765	.825	.816
1982	28,984	25,414	.877	.901	.893
1983	18,203	18,854	1.036	.978	.976
			Average Annual Trend:	+ 7.8%	+ 9.3%
			r :	.899	.906

(2) Exhibit 3

(3) Exhibit 2

(4) (3) / (2)

ISO COUNTRYWIDE TREND (Exh. 4A): 16% ← Irrelevant

Selected Trend Factor: 11%

I'd use 9.0%

EXHIBIT "C"

INSURANCE SERVICES OFFICE

EXHIBIT 4A

COUNTRYWIDE#

Professional Liability Insurance
Calculation of Annual Trend Factor
Based on Basic Limits Loss Ratios at Present Rates

PHYSICIANS, SURGEONS AND DENTISTS

Basic Limits

(1) Policy Year Ending	(2) $100,000 Basic Limits Incurred Losses*	(3) Premium At Present Rates	(4) (2)÷(3) Actual	(5) Exponential Curve of Best Fit
			Average Loss Ratio at Present Rates	
12/31/75	$167,810,058	$615,020,250	.273	.232
12/31/76	139,176,608	524,225,850	.265	.271
12/31/77+	181,630,098	638,830,853	.284	.316
12/31/78+	251,848,210	700,894,098	.359	.369
12/31/79+	280,590,219	717,382,127	.391	.430
12/31/80+	332,612,672	705,726,416	.474	.502
12/31/81+	426,038,352	684,461,050	.622	.585
12/31/82+	497,532,513	666,499,516	.746	.683

Average Annual Loss Ratio at Present Rates Trend.....16.6%

Excluding Texas and Massachusetts

* Losses include allocated loss adjustment expense and are developed to an ultimate settlement basis.

+ Includes Claims Made Data.

Selected Annual Trend 16.0%

TS-PR-84-11
12/20/84

Exhibit "F"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW

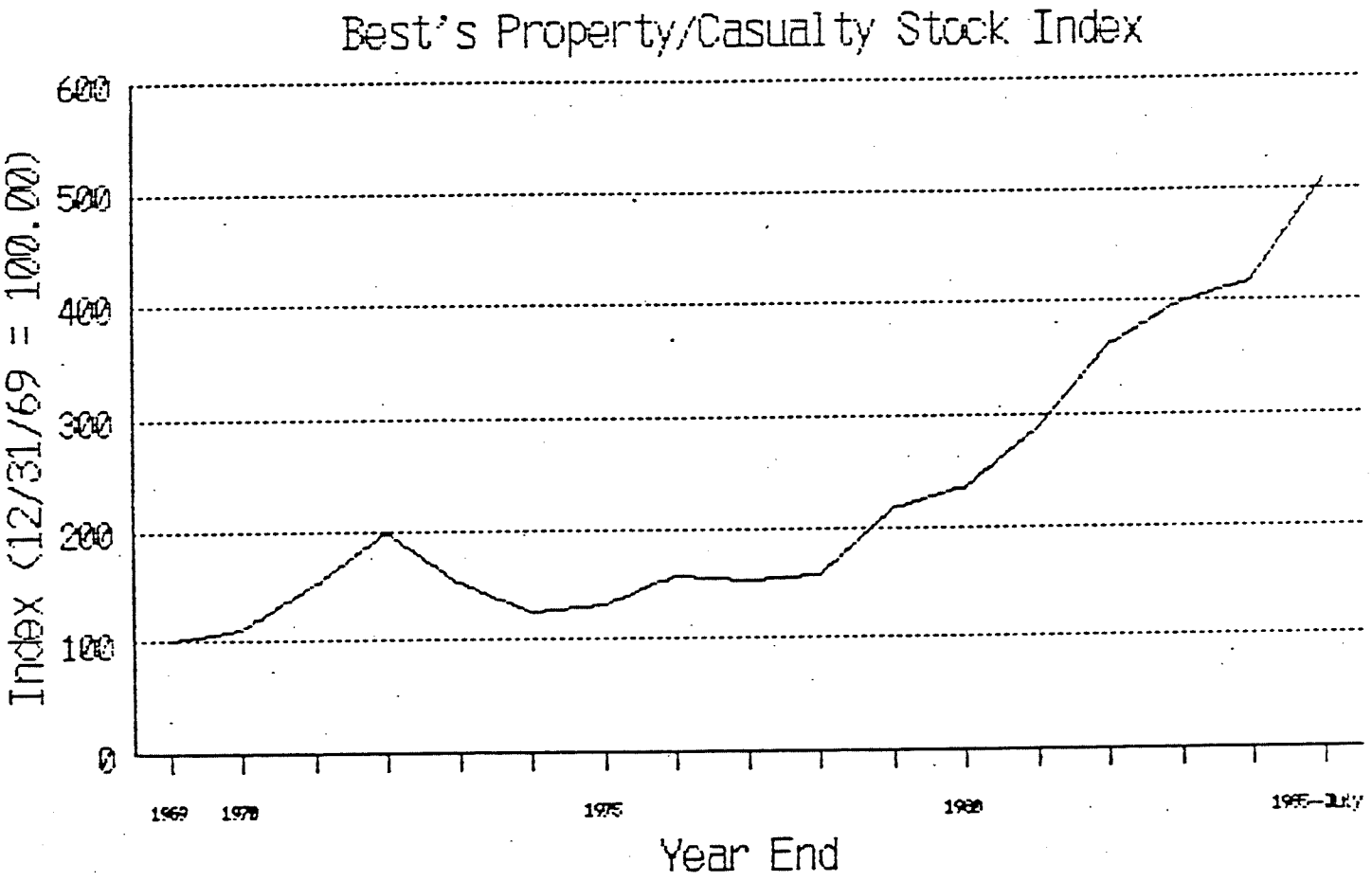
Effect of Proposed Classification Changes

Specialty	Description	Distribution Of Total Limits Premium	Present Relativity	Proposed Relativity
80240	Forensic Medicine	0.0 %	.75	.65
80232	Hypnosis	0.0	.75	.65
80248	Nutrition	0.0	.75	.65
80263	Ophthalmology-No Surgery	0.2	.75	.65
80235	Physiatry and Physical Medicine	0.2	.75	.65
80249	Psychiatry	0.3	1.00	.65
80250	Psychoanalysis	0.0	1.00	.65
80251	Psychosomatic Medicine	0.0	1.00	.65
80266	Pathology-No Surgery	0.5	1.00	.65
80261	Neurology-No Surgery	0.8	1.00	1.20
80253	Radiology-Diagnostic-No Surgery	0.5	1.20	1.80
80280	Radiology-Diagnostic-Minor Surgery	0.1	2.10	2.80
80145	Surgery-Urology	3.0	3.00	3.60
80155	Surgery-Plastic-Otorhinolaryngology	1.5	6.00	5.00
80156	Surgery-Plastic-N.O.C.	2.5	6.00	5.00
80141	Surgery-Cardiac	0.0	5.00	6.50
80150	Surgery-Cardiovascular	0.0	6.00	6.50
80153	Surgery-Obstetrics/Gynecology	8.0	9.00	12.00
80168	Surgery-Obstetrics	0.1	9.00	12.00
	All Other	82.3		
		100.0%		

Effect: +2.8%

Current Average Relativity: 2.15

Projected Average Relativity: 2.21


Best's Property/Casualty Stock Index
Index (12/31/69 = 100.00)
600
500
400
300
200
100
0
1969
1970
1975
1980
Year End

UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

ADDRESS

BY

NATWAR M. GANDHI

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BEFORE THE

AMERICAN RISK AND INSURANCE ASSOCIATION

VANCOUVER, B.C.

August 20, 1985

9/12-13/85

Attachment XVIII

I am pleased to present our views on taxation of the property/casualty insurance industry. We, at the General Accounting Office, have had an active interest in this area for the past 6 years. In 1981 we submitted a report to the Congress on taxation of life insurance companies. Earlier in 1985 we issued to the Senate Finance Committee a report on taxation of the property/casualty insurance industry. Today, I will focus on the latter.

Mr. Chairman, we believe that the Congress should reexamine several aspects of the tax code dealing with property/casualty insurance companies. These aspects include the deduction for loss reserves, the deduction for acquisition expenses, and the protection against loss account. Before explaining why we believe certain parts of the tax code should be reexamined, I would like to provide some background information on property and casualty insurance company pricing strategies, a financial overview of the industry, and the impact on the industry of certain current tax provisions.

PROPERTY/CASUALTY COMPANY PRICING STRATEGIES

A property/casualty company derives its income from underwriting gains (the excess of premiums over claims and expenses) and investment gains. Because of investment gains, a property/casualty company can still have net income even though its premiums alone are not large enough to cover claims and expenses.

Thus, even though a company has a ratio of claims and expenses to premiums in excess of 100 percent, which normally would indicate the company had suffered an operating loss, it may well have a positive net income.

The ability to offset underwriting and investment income has played an important role in a company's pricing strategy--that is, the amount of premiums it charges for the lines of insurance that it offers. For a number of years the companies have been willing to charge lower premiums to compete for certain insurance lines, even though they will have ratios of claims and expenses to premiums in excess of 100 percent. (For example, in some major lines of business, such as medical malpractice and other liability, these ratios have been more than 150 percent.) The companies expect to make up the premium shortfall through investment income. Through the incremental volume of premiums resulting from this pricing approach, companies are able to generate a larger amount of net cash flow which they can then invest to earn additional investment income. For instance, in 1983 when the industry had a combined ratio of claims and expenses to premiums of about 112%, which produced an underwriting loss of about $11 billion dollars, it still had a net gain of about $9 billion and generated a total of about $12.1 billion in net cash flow, as reported by Best's Management Reports.

While in past years investment gains have exceeded underwriting losses by a fairly wide margin, in more recent years the gap has narrowed. For example, in 1984, underwriting losses for

the industry were $20.5 billion, while investment income and realized capital gains were $20.8 billion. As the margin has narrowed, many companies have reacted by raising premiums. Given this, it does not seem unreasonable to expect the gap to widen again as companies within the industry implement new pricing strategies.

FINANCIAL OVERVIEW OF THE PROPERTY/CASUALTY INDUSTRY

We developed a financial overview of the property/casualty insurance industry by studying financial data for stock and mutual companies for the 10-year period 1974 through 1983. We obtained these data from Best's Aggregates and Averages. While Bests' reports omit figures for many small and/or new companies, we believe that the data are sufficiently representative of the overall financial results of the property/casualty industry.

In tables 1 through 5 we show sources of income, broken out by underwriting gains, investment gains, and total gains. We also show disposition of income, broken out by the increase in surplus, dividends to stockholders, and the combined total. Federal income taxes are also shown.

We show in table 1 that, while property/casualty companies had about $28 billion in underwriting losses from 1974 through 1983, they had about $100 billion in investment gains during this period, resulting in a total gain of about $72 billion for those years. From 1974 through 1983, property/casualty companies paid $1.3 billion in federal income taxes, an amount equal to about 2 percent of the industry's total gains for the period.

Table 1

All P/C Companies - Consolidated Basis
1974 through 1983
(in billions of dollars)

Underwriting gains	Investment gains	Total gains	Federal income tax	Percentage of federal income tax to total gains
($28.4)[a]	$100.7[b]	$72.3[c]	$1.3[d]	1.8

[a]Positive gains in 1977 78, 79, negative in other years.
[b]Negative gain in 1974; positive in other years.
[c]Negative total in 1974; positive in other years.
[d]Negative taxes in 1974-75; 1982-83; positive in other years.

Table 2 shows that about $44 billion of property/casualty companies' income from 1974 through 1983 went to an increase in surplus, and about $17 billion to stockholders in the form of dividends. These two items totaled about $61 billion, and the $1.3 billion paid in federal income tax during this time equal 2 percent of this total.

Table 2

All P/C Companies - Consolidated Basis
1974 through 1983
(in billions of dollars)

Increase in surplus	Dividends to stockholders	Total	Federal income tax	Percentage of federal income tax to total
$44.3[a]	$17.0	$61.3[a]	$1.3	2.1

[a]Negative in 1974; positive in other years.

The figures in tables 1 and 2 refer to mutual and stock companies combined. Since only stock companies give dividends to stockholders, we developed table 3 to show some ratios solely for stock companies.

We show in table 3 that from 1974 through 1983, stock companies had total gains of $59 billion and, as we previously mentioned, distributed about $17 billion to stockholders as dividends. During this period, stock companies paid $200 million in federal income taxes, an amount equal to 0.3% of their total gains and to 1.2% of their dividends paid.

Table 3

Stock Companies
1974 through 1983
(in billions of dollars)

Total gains	Dividends to stockholders	Federal income tax	Percentage of federal income tax to total gains	Percentage of federal income tax to dividends to stockholders
$59.0	$17.0	$0.2	0.3	1.2

We also wanted to see how the 20 largest companies compared with the other companies. Tables 4 and 5 provide results separately for stock and mutual companies.

Table 4

Stock Companies
1974 through 1983
(in billions of dollars)

	Total gains	Federal income tax	Percentage of federal income tax to total gains
20 largest companies	$19.8	($1.0)	(5.1)
All other companies	39.2	1.2	3.1
All companies	59.0	0.2	0.3

Table 5

Mutual Companies
1974 through 1983
(in billions of dollars)

	Total gains	Federal income tax	Percentage of federal income tax to total gains
20 largest companies	$17.2	$0.9	5.2
All other companies	5.6	0.4	7.1
All companies	22.8	1.3	5.7

Tables 1 through 5 have shown that from 1974 through 1983 the industry as a whole, in spite of its underwriting losses, had positive net gains yet paid a small percentage of these gains, 1.8 percent, in federal income taxes. For stock companies, the percentages of taxes paid were lower than for mutual companies--0.3 percent for stock companies and 5.7 percent for mutual companies.

For large companies, the percentages of federal income taxes paid were lower than for smaller companies. For stocks, the 20 largest companies had an income tax rate of -5.1 percent as compared with 3.1 percent for the smaller companies. For mutuals, the 20 largest companies paid 5.2 percent as compared with 7.1 percent for the smaller companies.

As previously mentioned, tables 1 through 5 each cover the 10-year period ending in 1983. Information is not yet available for updating all of the tables through 1984. However, preliminary information shows that the property/casualty companies had a record underwriting loss in 1984 and, as we indicated, investment gains (including capital gains) were approximately equal to the underwriting losses.

Using data from our table 1 and from the preliminary information that has been published for 1984, we constructed table 6 to cover the 10-year period 1975 through 1984.

Table 6

All P/C Companies - Consolidated Basis
1975 through 1984
(in billions of dollars)

Underwriting gains	Investment gains	Total gains	Federal income tax	Percentage of federal income tax to total gains
($47.0)	$119.1	$72.1	($0.063)	(0.1%)

These figures show that from 1975 through 1984 the investment gains exceeded the underwriting losses by over $72 billion while taxes were a negative $63 million, a rate of -0.1% of the total gains.

IMPACT OF CURRENT TAX PROVISIONS

Our analysis of the foregoing financial data gives insight into how current tax policy affects the property/casualty insurance industry. As a result of certain tax advantages, many property/casualty companies have not paid federal income taxes for a number of years, and, in fact, have qualified for refunds or the ability to carry back or carry forward losses for tax purposes. In addition to the tax deferrals resulting from the treatment of loss reserves, the treatment of acquisition expenses, and the protection against loss account, property/casualty companies can also use tax provisions available to other taxpayers. These include excluding interest income from tax-exempt securities and deducting eighty-five percent of the dividends received from domestic corporations. Between 1975 and 1982, about 40 percent of the gross investment income of all property/casualty companies was tax-exempt investment income. The dividends received deduction during this period represented about 20 percent of the gross income of the companies.

While we presented and discussed these facts in our report, we did not recommend any changes in the application of the exclusion of tax exempt interest or the dividend received deduction to property/casualty companies. We limited our study to those provisions of the tax code which applied only to property/casualty companies.

AREAS OF PROPERTY/CASUALTY INSURANCE TAXATION NEEDING CONGRESSIONAL REEXAMINATION

We indicated in our report on the taxation of the property/casualty insurance industry that the Congress should reexamine three areas of the tax code. These areas are

--the deduction currently allowed for loss reserves;

--the practice of currently deducting all of the expenses associated with the sale and renewal of insurance policies; and

--the protection against loss account, which defers a portion of a mutual company's income to provide a cushion for catastrophic loss.

Our conclusions and recommendations in each of the three areas were as follows:

First, we concluded that the present practice of deducting in the tax year the full (undiscounted) amount of future estimated settlement costs overstates the loss reserve deduction. Since the assets underlying loss reserves are invested pending final settlement of claims, the firm actually needs to set aside only that amount which, together with subsequent investment earnings, would equal expected subsequent claims. We suggested that the Congress consider amending the tax code to provide that for tax purposes loss reserves be discounted in calculating the loss reserve deduction. We further stated that the discount rate should be based on a moving average of each company's pre-tax net return on its investment portfolio.

We estimated discounted loss reserve levels at several discount rates for 1980-82 (holding all other factors constant) and the additional tax liability that would have resulted. The higher the discount rate used, the greater the reduction in the loss reserve deduction and the greater the increase in tax liability. If a hypothetical discount rate of 7 percent had been used by all companies in 1982, the deduction taken would have been reduced by about $1.3 billion, and tax liabilities would have been greater by about $613 million.

Second, we concluded that the present treatment of acquisition expenses fails to match expenses and revenues. Currently, the tax code permits all acquisition expenses to be deducted immediately, even though the premiums associated with these expenses are spread over the life of the contract. In this case we suggested that the Congress consider amending the tax code to provide that acquisition costs be allocated over the life of related contracts so that these costs are matched with premium payments generated by the contracts.

If acquisition expenses were allocated when revenue is recognized, then taxable income would increase. We estimated the additional tax liability that would have accrued for the years 1980-82 if this change had been made and everything else had remained the same. Based on these assumptions, the additional tax liabilities would have been approximately $164 million in 1982.

We must mention that for both the changes in the tax code the Treasury in 1982 would have received only a portion of these amounts in additional current taxes. Some companies were showing losses for tax purposes. Furthermore, companies might shelter more of their investment income and thereby mitigate any increases in taxes. This could be done through increasing their holdings of tax-exempt securities or equity securities of domestic corporations.

Third, we concluded that the protection against loss account may not protect mutual companies against catastrophic losses because the money in the account is not earmarked for that purpose. Thus, if a catastrophic loss were to occur, the account does not necessarily ensure the company's ability to satisfy its contract obligations. In this case, we recommended that the Congress consider whether or not this special tax preference for mutual property/casualty insurance companies should be retained in its present form.

CONCLUSION

In conclusion, Mr. Chairman, the financial information we have presented indicates that the property/casualty insurance industry has paid a relatively small share of its net income in federal income taxes in recent years. While we are not in a position to comment on what might be an appropriate federal tax burden for the industry, we do believe that the Congress should consider amending the tax code along the lines suggested in our

report. In our view, the changes would result in a better match of the industry's revenues and expenses and represent a more rational approach to its taxation.

This concludes my prepared remarks.

Omnibus Reinsurance Act of 1985

PROBLEM: Many insureds are facing crises in availability and affordability of liability insurance. States, municipalities, environmental concerns, product manufacturers and medical professionals are among the hardest hit. Most day care centers and nurse-midwives cannot find coverage and if they are lucky enough to do so, the cost is prohibitive.

The twin crises of availability and affordability of liability insurance may force manufacturers and service providers out of the normal course of their business. If day care centers close, some families with marginal incomes might lose their homes as well as a second paycheck. Lower cost, high quality care birthing centers may be forced to close, as indeed some have. Products which are safe and beneficial might be kept from markets and physicians or surgeons may quit practice because of unavailable or unaffordable liability insurance. Society cannot function properly when its commerce is so disrupted.

SOLUTION: A federally sponsored reinsurance program to ease availability and affordability of liability insurance in distressed lines of property/casualty insurance.

PRECEDENT: In the late 60's the federal government set up a riot reinsurance program. The federal government agreed to reinsure carriers for the specific peril of concern (riot) in exchange for their forming pools to assure full coverage (including fire, liability, etc.) in distressed areas. The federal government collected reinsurance premiums (and made $125 million) and also required insurers to impose certain safety requirements upon risks they undertook. (See, 12 USC 1749bbb, 42 USC 4011 (1968)).

IMPLEMENTATION: Legislation would have to be passed to give some federal agency stand-by authority to declare certain lines of property/casualty insurance "distressed" and eligible for reinsurance from the federal program. The "distressed" determination would have to be made upon application or at the agency's discretion. Initial funding would be from borrowing authority from the Treasury, later paid back through the collection of reinsurance premiums and a surcharge upon all property/casualty premiums paid. A surcharge of .25 percent upon all premiums paid would generate about $300 million per year and with interest would make almost $6 billion available to reinsure distressed lines at the bottom of the next underwriting cycle.

OUTCOME: Distressed lines of property/casualty insurance will be stabilized against the vagaries of the underwriting cycle. Reasonably safe risks like most day care centers and nurse-midwives will be able to obtain essential insurance. Society will not be faced with the lack of products or services because of unavailable or unaffordable insurance.

9/12-13/85 Attachment XIX

OMNIBUS REINSURANCE ACT OF 1985

Section -[1]-(a) Within 30 days after the receipt of an application by any manufacturer, service provider or any group or association representing such manufacturers or service providers, the Commission shall conduct a hearing on the reasonable availability and affordability of adequate commercial general liability insurance and other lines of insurance for that manufacturer or service provider or the members of any group or association of manufacturers or service providers.

(b) The Commission may in its discretion hold hearings to investigate the reasonable availability or affordability of commercial general liability insurance and other such lines of insurance as from time to time become unavailable or unaffordable thereby threatening the health, welfare or commerce of the United States and the various states by making some manufactured good or provided service unavailable or available only at an unreasonable cost.

(c) Within 30 days after the hearing required under subsection (a) or conducted under subsection (b) the Commission shall determine in writing, based upon the record of the hearing conducted pursuant to subsection (a) or (b), whether the insurance described in subsection (a) or (b) is , and will be, reasonably available or affordable to affected manufacturers, service providers or the members of any group or association representing manufacturers or service providers to cover anticipated claims. Such determination, and the basis therefore, shall be published in the Federal Register.

(d)(1) If the Commission determines at any time that:

(A) the insurance described in subsection (a) or (b) is not available or reasonably affordable from the private sector to applicants under subsection (a) or the affected parties described pursuant to subsection (b) to cover anticipated claims;

(B) in order for an applicant under subsection (a) or affected party described pursuant to subsection (b) to have regular operations in the United States, assistance under any of the programs authorized under sections [2] or [3] is necessary; and

(C) the availability of such goods or services from that applicant under subsection (a) or affected party under subsection (b) is essential to promote the public health, welfare or the general commerce of the United States, the Commission is authorized to implement the insurance pool described in section-[2]- and the reinsurance coverage described in section-[3]- with respect to such goods or services. If at any time the Commission determines that one or both of the programs provided for in section -[2]- or -[3]- reasonably assures the availability or affordability of such goods or services in the United States, the Commission may implement the operation of the programs described therein.

(2) to further the purposes of this act and in recognition of the critical situation facing both day care centers in insuring for the specific peril of child abuse and nurse-midwives in obtaining medical malpractice insurance, the Congress makes the necessary determination for the Commission to implement section [2],[3] or both and any other pertinent section under this title for these affected parties. Affected party eligibility under section [1](d)(2) shall not be subject to review by the Commission until 90 days after the enactment of this title.

(3) To the extent feasible, the programs provided for under this title shall be implemented in a manner to insure that:

(A) such programs will not act as a disincentive to improvements in product safety or safe service delivery, and shall operate to promote product safety and safe service delivery through the establishment of models for risk management as may be agreed upon by the Commission, the insurers and the insureds as a prerequisite for eligibility for any of the programs under this title.

(B) each manufacturer or service provider which benefits from such programs will agree that such goods or services shall remain available to the public during the period in which such product manufacturer or service provider or the insurer of such product manufacturer or service provider participates in such programs.

(C) each insurer which benefits from such programs will agree that such insurance as is written during the period in which such insurer or its insured product manufacturer or service provider participates in such programs shall have premiums which are based upon an experience rate.

Section-[2]-(a) After making findings under section [1], the Commission shall encourage and otherwise assist any insurance companies which meet the requirements of subsection (c) and any others set out in this title to form, or otherwise join together in insurance pools for the purpose of assuming, on such terms and conditions as may be agreed upon, such financial responsibility as will enable such companies and other insurers, with federal financial and other assistance under this title, to assume a reasonable portion of responsibility for the adjustment and payment of claims arising from product or service induced injuries, disabilities, illnesses and deaths.

(b) Funds from such insurance pools shall be available only to pay claims resulting from product or service related actions in excess of such amounts as are established each year by the Commission. The Commission may establish differing amounts for each manfacturer or service provider or insurer and each good or service based upon the needs of the manufacturer or service provider or insurer and other relevant factors.

(c) any insurer licensed to operate as such by any state, territory or possession of the United States shall

be eligible for participation in such insurance pools.

(d) Such insurance pools may be funded by premiums paid by manufacturers or service providers to insurers approved by the Commission. If the Commission finds, after notice and public hearing, that the premiums charged by such insurance pools make the insurance from such insurance pool unavailable for manufacturers or service providers, the Commission may amend the terms and conditions of reinsurance under this title to lower premiums to be paid by such manufacturers or service providers.

Section [3](a) In order to further the purposes of this title, the Commission may take such action as may be necessary to make available,to the insurance pools formed or otherwise created under section [2], reinsurance coverage under this section to any insurer or pool for losses assumed by such insurers or pools in accordance with the agreements entered into under subsection (b).

(b)(1) Following the date of enactment of this title, the Commission is authorized to enter into any contract, agreement, treaty, or any other arrangement with any insurer or pool for reinsurance coverage, in consideration of payment of such premiums, fees or other charges by insurers or pools which the Commission deems to be adequate as required under Section-[5]- of this title to obtain aggregate reinsurance premiums and charges for deposit in the Omnibus Reinsurance Fund established under Section-[5]- in excess of the estimated amount of insured product or service induced losses in 1985, and thereafter the Commission may increase or decrease such premiums or charges if it is found that such action is neccessary or appropriate to carry out the purposes of this title.

(A) Reinsurance offered under this title shall reimburse an insurer or pool for its total proved and approved claims for covered losses resulting from product or service induced injuries, disabilities, illnesses and deaths during the term of the reinsurance contract, agreement, treaty, or other arrangement, over and above the amount of the insurer's or pool's retention of such losses as provided in such reinsurance contract, agreement, treaty, or other arrangement entered into under this section.

(B) Such reinsurance contracts, agreements, treaties, or other arrangements may be made without regard to section 3679(a) of the Revised Statutes of the United States (31 USC 665(a)), and shall include any terms and conditions which the Commission deems necessary to carry out the purposes of this title. The terms and conditions of such contracts, agreements, treaties, or other arrangements with insurers or pools, throughout the country, in any one year shall be uniform: Provided, that where necessary to further the purposes of this title, pro rata and other such forms of reinsurance may be included in such terms and conditions.

(C) Such reinsurance shall be provided upon such terms and conditions , and subject to such deductibles

and other restrictions and limitations, as the Commission deems appropriate, but no reinsurance shall be available to a product manufacturer, service provider, insurer or pool of insurance which the Commission determines to be uninsurable or to any product manufacturer, service provider, insurer or pool of insurance with respect to which reasonable protective measures to prevent loss, consistent with standards established by the Commission under section [1](d)(3)(A), have not been adopted.

(D) Any contract, agreement, treaty, or other arrangement for reinsurance under this section shall be for a calendar year.

Section 4(a) The Commission shall take such action as is necessary or appropriate to make reinsurance available directly to insurers which participate in pools created under this title for that portion of their business which is related to any distressed line as determined under section [1](d) which is written and not within a pool created pursuant to section [2] of this title.

(b) Such reinsurance may be made pursuant to contract, agreement, treaty, or other arrangement, and pursuant to such regulations as may be reasonably prescribed by the Commission.

Section 5(a) To carry out the programs authorized under this title, the Commission may establish in the Treasury of the United States an Omnibus Reinsurance Fund which shall be available without fiscal year limitations--

(1) to pay reinsurance claims under the reinsurance coverage provided under section [3]; and

(2) to pay reinsurance claims under section [4]; and

(3) to pay such administrative expenses as may be necessary or appropriate to carry out the purposes of this title; and

(4) to repay to the Secretary of the Treasury such sums, including interest thereon, as may be borrowed from him for purposes of such programs under section [5](b).

(b) The reinsurance fund under this section may be financed by:

(1) such amounts as may from time to time be advanced to the fund from the general fund of the Treasury in order to maintain the fund in an operative condition adequate to meet its liabilities; and

(2) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [3]; and

(3) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [4]; and

(4) such amounts as may be raised by the establishment of an uniform surcharge upon premiums paid to

property and casualty insurers.

(A) the Treasury shall, no later than 120 days after the enactment of this title, collect a .0025 (.25 percent) surcharge upon all premiums paid to property and casualty insurers which revenues shall go to maintain the reinsurance fund created under this section in an operative condition adequate to meet its liabilities.

(5) interest which may be earned on investments of the fund; and

(6) receipts from any other source which may, from time to time, be credited to the fund.

Section [6](a) If at any time the Commission makes the determinations described in section [1](d), the Commission may, in carrying out its responsibilities under this title, utilize--

(1) insurance companies and other insurers, insurance agents and brokers , and insurance adjustment organizations, as fiscal officers of the United States,

(2) officers and employees of the Federal Trade Commission, and such other officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree upon, on a reimbursement or other basis, or

(3) both of the alternatives specified in paragraphs (1) and (2), or any combination thereof.

Section [7](a) The Commission may in the interest of furthering the purposes of this title delegate authority to administer any portion of this title to other appropriate officers and emloyees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree: Provided that any action taken by any such agency officer or employee shall not be inconsistent with any portion of this title.

(b)(1) The Commission through its Bureau of Competition shall periodically review each plan under this title and the methods and practices by which such plan is actually being carried out in order to--

(A) Assure that such plan is effectively making commercial general liability and other essential lines of liability insurance readily available to such product manufacturers and service providers as is intended and is otherwise carrying out the purposes of this title, and in order to identify any aspects of the operation or administration of such plan which may require revision, modification , or other action to carry out such purposes.

(B) Report to the Congress at least once a year the findings of any such investigation under subsection b(1)(A), or from time to time as may be requested by the Congress to report on the current status of all programs under this title.

Section [8](a) Within 90 days after the enactment of this title and before implementation of the programs contained therein for the benefit of any applicant, affected party , insurer or pool of insurance, the Commission shall prepare and transmit a report to the Congress which shall--

(1) indicate the nature and extent of anticipated use of the insurance industry in the delivery under this title of reinsurance to product manufacturers, service providers, insurers, and pools of insurance.

(2) identify anticipated costs of provision of such reinsurance to product manufacturers, service providers, insurers, and pools of insurance under this title.

(3) identify any potential applicant which has made query to the Commission about such programs as have been authorized under this title and, in the case of affected parties, those which preliminarily might benefit from participation under the programs authorized under this title.

Section [9](a) The Commission, or any agency officer or employees which administer portions of this title as authorized under section [6] and [7], in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Commission or its delegated agent.

(b) No action or proceeding brought under this section may be brought for any amount in excess of that lawfully payable by any insurer to the Commission or its delegated agent and any such action shall be brought within five years of when the right to such payment accrued, except where any false or fraudulent conduct warrants, the claim shall not be deemed to have accrued until its discovery.

(c) Any recovery had pursuant to any action or proceeding under this section shall be deposited to the credit of the reinsurance fund created under this title.

LANDSMAN & LASTER

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JOHN L. LASTER
RON M. LANDSMAN

August 14, 1985

Hon. Rick Rule
Acting Assistant Attorney General
Antitrust Division
United States Department of Justice
Tenth and Constitution Avenues, N.W.
Washington, D.C. 20530

Dear Mr. Rule:

I am writing on behalf of the National Insurance Consumer Organization to bring to your attention evidence of concerted anticompetitive conduct within the property casualty insurance industry that is not exempt under the McCarran-Ferguson Act.

The industry is now going through one of its periodic capacity scares. As in previous incidents, the public suffers severe and economically debilitating dislocations. After a period of glut, when premiums drop to a fraction of their prior fixed-price levels, underwriting tightens like a vise and important major manufacturing and service industries find themselves unable to purchase insurance protection at any price from any company.

To be sure, much of this pattern may reflect nothing more than the operation of the business cycle in an industry not under reasonable and effective regulatory oversight at the national level. The extremely aggressive price competition in commercial property/casualty lines in the late 1970s, and perhaps the subsequent price increases as well, appears to reflect such market forces. Some of the industry's responses may also reflect the mindless herd instinct which so distinctively marks the insurance industry. This is perhaps to be expected in an industry with a long history of price-fixing and other cooperative anticompetitive arrangements under state regulation that from the consumers' perspective ranges from lax to impotent, but so be it.

But the response of the industry to recent developments in their customer industries -- and the statements of industry leaders explaining their conduct -- suggest that something more is occurring.

Spokesmen for the reinsurance industry have told state regulators that they plan to withdraw en masse if they -- the regulators -- do not approve new insurance policy forms jointly developed by the reinsurers and the industry price-fixing agency (Insurance Services Office, Inc.). These new policy forms severely

9/12-13/85 Attachment XX

narrow the protection provided to the insurers' commercial customers, changes about which they are, to say the least, extremely unhappy. See Attachment A. Along the same lines, a well-known insurance company executive has justified the mass departure of insurers from medical, toxic waste, and directors' and officers' liability lines by "the social good" in "let[ting] the pressures build in the courts and the state legislatures" to change laws respecting their customers' -- and the insurers' -- liability. See Attachment B.

There is, finally, irrational market conduct that goes beyond even this industry's herd instinct. They have withdrawn from lines for risks with experience ranging from good to excellent and which even the insurers admit could and should be written. See Attachment C.

Boycotts to force action by state and federal officials, be they judges, legislators, or regulators, are illegal. The McCarran-Ferguson Act specifically does not exempt boycotts from federal antitrust enforcement. In St. Paul Fire and Marine Insurance Co. v. Barry, 438 U.S. 531 (1978), the Supreme Court held that the term boycott was broadly applicable to joint action to deny coverage to customers. Nor is there protection to be had under any of the familiar non-statutory exemptions. The Noerr-Pennington doctrine does not exempt "an express or implied agreement ... that the participants will jointly give up their trade freedom, or help one another to take away the trade freedom of others through ... boycotts ... ." Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127, 136 (1961). And Parker v. Brown, 317 U.S. 341 (1943), does not exempt joint product-fixing absent state statutes authorizing such joint action. The debates on the McCarran-Ferguson Act reflect absolutely no consideration of agreements respecting products, and the state laws enacted in response to it by and large do not adopt such joint action as state policy. Southern Motor Carriers Rate Conference v. United States, --- U.S. ---, 53 U.S.L.W. 4422 (March 27, 1985).

Property/casualty insurance industry conduct, as explained by industry leaders themselves, may be but a prelude to a larger campaign to force major industries, from the chemical and drug manufacturers to physicians and others, to bend to the interests and will of insurers. If their means include non-exempt joint anticompetitive action, however, then you may hold the key to important public protection. I urge you to investigate to ascertain whether the federal antitrust laws are being violated.

Yours truly,

Ron M. Landsman

Ron M. Landsman
Counsel, National Insurance

Appendix A

JCC 6/18/85

Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

WOODBRIDGE, N.J. — The insurance industry should quit covering doctors, chemical manufacturers and corporate officers and directors. And the sooner the industry quits such lines of business, the sooner it will free itself from its bondage to a court system "that has run amok."

This was the message delivered to a meeting of actuaries here Monday by John J. Byrne, chairman and chief executive officer of Geico Corp., the Washington-based personal lines insurance company.

Mr. Byrne said that the single thread running through such lines of business for underwriters was that they have fallen under the sway of the courts.

"There will be no problem with insuring homeowners or autos in the coming years," he said. "But anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a zany judge or jury out in California. To my mind, he is absolutely stupid."

Mr. Byrne's comments came in the midst of a discussion at a meeting of the Casualty Actuaries of New York about what kinds of insurance products might be available in the future.

The touchstone for the discussion was a presentation by the Insurance Services Office Inc., an industry-rating and data-gathering service. The ISO estimates that in the next few years the insurance industry will suffer a $62 billion shortfall in capacity. This means that corporate America will not be able to buy all the insurance it needs because insurers ability to cover them will fall short by that amount.

'Anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a zany judge or jury out in California.'

Mr. Byrne said the industry was responding to these issues in precisely the right way by refusing to cover lines of business that are hostage to court interpretations. "It will be best for the social good to let society know that the problem is not one for the insurance industry but for society as a whole. It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures," Mr. Byrne said.

He said he saw little hope for reform in such things as the federal program for Superfund, a toxic waste cleanup measure. He said the vast amount of money thus far spent by Superfund was to "educate lawyers on how to refine their suits brought on the part of plaintiffs against industry."

"Anybody who leaves his private capital where the courts can grab it has not done the right thing for his owners," Mr. Byrne said.

On a related score, Thomas A. Greene, president of his reinsurance brokerage firm in New York, said that still more pressure would be brought to bear on the American property and casualty industry by underwriters at Lloyd's of London. Mr. Greene said that beginning in 1986, Lloyd's syndicates would "simply not write reinsurance for the American casualty industry, especially in the lines mentioned by Mr. Byrne." He said further that reinsurance underwriters would virtually dictate to the ISO about a proposed commercial general liability form. He said the domestic reinsurance industry will not write treaties unless the industry adopts the new CGL form.

As to the stability of the insurance companies suffering through this trying period, at least one of the actuaries said that current measures of company solvency used by the National Association of Insurance Commissioners were less than adequate.

Kevin M. Ryan of the National Council of Compensation Insurance urged the actuaries to model industry solvency judgments on a study done by the Aetna Life & Casualty Co. a few years ago.

Aetna studied the financial data of companies that had actually failed and the resultant ratios were absolutely realistic, Mr. Ryan said.

(1)

EPA Chief Deems It Necessary To Keep Toxic Liability Powers

By LEAH R. YOUNG
Journal of Commerce Staff

WASHINGTON — The Environmental Protection Agency must keep the authority allowing it a wide choice of whom to sue for cleaning up toxic waste sites, Administrator Lee M. Thomas said.

While acknowledging that the market for all kinds of environmental insurance is drying up, Mr. Thomas insisted in an interview that the EPA cannot give up the "strict, joint and several liability" powers that courts have given it.

The insurance industry has been arguing that it cannot insure and collect premiums from individual companies when a court can require one or a few companies to pay all the costs of cleaning up a site.

That is especially true, insurers add, when many of the policies being interpreted by state courts never were intended to pay for hazardous waste cleanup.

But Mr. Thomas pointed out that he is responsible for getting such sites cleaned up while ensuring to the extent possible that the polluter, not the federal government, bears the costs.

The insurance industry would like to divide liability so that its clients are held responsible only for their share of damage, but the EPA finds that in most Superfund waste cleanup sites substances are mixed and records are poor.

When the EPA tried to apportion responsibility — an approach that is surfacing again among some congressmen at the behest of the insurance industry — it became "just as controversial among the private parties as utilization of joint and several" liability, Mr. Thomas said.

The EPA tried to base responsibility on the volume of waste, he said, but the companies fell into long debates over whose waste was more toxic.

However, as adamant as he is that strict, joint and several liability must be part of any Superfund program, Mr. Thomas opposes attempts by House Energy and Commerce Subcommittee Chairman James Florio, D-N.J., to write it into the pending Superfund bill.

"We don't think it should be specifically mandated," Mr. Thomas said. "Trying to get language in the statute has the potential of opening up the whole issue again to litigation."

But Rep. Florio argues that while he is "heartened" by the district court rulings to date, "this principle could be gutted by a specific district court or by the Justice Department."

He wants to make sure that industry cannot convince the administration to abandon this unwritten interpretation.

Rep. Florio lost a battle in his subcommittee on the issue to a group headed by Energy and Commerce Committee Chairman John Dingell, D-Mich.

In spite of the setback, Rep. Florio has vowed to continue his fight on the issue, and for other provisions the subcommittee rejected, in the full committee and on the House floor.

His rejection in subcommittee is no reason for rejoicing by the insurance industry. Many who opposed Rep. Florio support the views of Mr. Thomas.

Rep. Jim Slattery, D-Kan., explained that injecting joint and several liability into the legislation could lead to a situation in which the provision was either stricken or filibustered in the Senate.

That would create legislative history that might convince state courts that such liability is not part of Superfund.

While Mr. Thomas is determined to keep joint and several liability in spite of evidence of growing insurance problems, Mr. Thomas does not have any recommendations to alleviate the burden on the insurance industry.

He pointed out that a lot of the problems are not related just to Superfund, but rather to the general economic situation in the property-casualty insurance industry.

He noted that the European reinsurance market is drying up for environmental policies. There has been poor experience with asbestos, and a general desire to "establish a less risky base of insurance."

Under such circumstances, he said, he has been unable to win from the insurance industry any assurances that particular steps taken on the federal level will result in a return to the environment market.

Instead, insurance industry spokesmen will only say that if some steps are not taken "there is a chance we won't get back in the market," Mr. Thomas said.

It is possible that there is a need for federal involvement in the environmental liability field, but the debate has not reached the point where he thinks he can draw any conclu-

In the meantime, EPA recognizes that many hazardous waste sites being licensed under the Resource Conservation and Recovery Act may not prove financial responsibility on Nov. 8 as required.

Without insurance, some facilities may use their own net worth, Mr. Thomas said, but others may just be forced out of business.

Fewer facilities will require companies that are generating wastes to modify their procedures to incinerate or otherwise minimize waste that until now was cheaper to send to land disposal facilities.

It is too soon to analyze the impact of this scenario, he said, in light of the congressional decision to encourage companies to move away from land disposal.

The only thing he is at all sure of now is that solving the problems of insuring hazardous waste facilities would not solve the entire insurance dilemma.

The House subcommittee did vote against one provision that disturbed the insurance industry. Congressmen rejected an amendment to permit citizens to sue private parties if they perceived a dangerous situation being ignored by the Environmental Protection Agency.

Only one Florio amendment was attached to the Superfund bill that goes to the full Commerce Committee.

That provision requests that the House Ways and Means Committee revise as part of the taxing scheme an import fee to reduce the share of general federal revenues envisioned in the bill from $250 million to $110 million.

The idea is to tax imported feedstock derivatives equally with domestic feedstock components in order not to give an advantage to foreign derivatives.

Mr. Thomas said the administration still opposes new Superfund taxes.

Appendix B

JOC 6/18/85

Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

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(1)

In Day-Care Crisis Cited

Official Criticizes Insurance Firms

By Sandra Sugawara
Washington Post Staff Writer

Maryland Insurance Commissioner Edward J. Muhl said yesterday that "hysteria" had caused insurance companies to discontinue coverage of day-care centers and that Maryland officials had blocked an attempt by one California firm to cancel 242 day-care policies.

Muhl also said that state officials were studying a wide variety of options, including the creation of a mutual liability insurance fund in Maryland similar to the one created in 1974 by the General Assembly to help physicians hit by an insurance malpractice crisis.

Muhl testified yesterday before the House Select Committee on Children, Youth and Families, which is holding hearings on the nationwide insurance crisis in the day-care industry. Muhl, who appeared on behalf of the National Association of Insurance Commissioners, critized insurance companies for wholesale cancellation of day-care policies, saying the insurance industry was overreacting to news accounts of sexual abuse and court suits involving some day-care centers.

Muhl said a California insurance carrier canceled policies at 242 Maryland day-care centers before they were to expire. He said he recently ordered that firm to revoke the midterm cancellations, although he said the company does not have to renew the policies.

Muhl said he was sympathetic to the plight of the insurance industry, which had its worst year ever in 1984. He said the Association of Insurance Commissioners expects the industry to sell $67 billion less in insurance this year than last year.

Muhl said he has signed 20 notices of insolvency for Maryland insurance firms this year. Those firms have gone out of business or must stop writing policies because of financial problems.

Insurance industry executives testified yesterday that the industry was in a slump and urged Congress

EDWARD J. MUHL
... testifies before House committee

gress would be forced to get involved if the insurance industry failed to take immediate action to prevent the closing of thousands of day-care centers.

Insurance industry representatives have said the financial slump was caused by excessively low rates that companies charged during the late 1970s, when they were trying to increase business. They tried to make up the losses through investments, but were hurt by falling interest rates, according to Marvis A. Walter, senior vice president of Insurance Services Offices Inc., which compiles statistics and rate information for the industry.

Because of the financial problems, insurance firms began dropping high-risk industries, and they place the blame on the high awards given in liability cases.

"The potential for multimillion-dollar judgments exists even though no such award has yet been paid in a child-abuse case, said Frank Neuhauser Jr., vice president of AIG Risk Management Inc., an insurance group based in New York. "Many of us believe we are living under a tort system that is completely out of control."

But J. Robert Hunter, former head of the Federal Insurance Administration during the Ford and Carter administrations, said that the insurance industry is using the courts "as a scapegoat."

"It's a self-inflicted problem, and to take it out on day-care centers is wrong," said Hunter.

Mike Causey is on vaca-

(3)

ısurers Urge doption f New Policy

By JAMES NOLAN
Journal of Commerce Staff

CHICAGO — The very fate of the ıerican liability insurance indus- hangs on state regulatory ap- ıval of new liability insurance ms.

An array of insurance industry ɔkesmen argued this position in blic hearings Thursday before a nel of insurance regulators from states.

The industry representatives pre- ted further that American busi- ss and industry in all likelihood uld go unprotected by insurance ainst liability claims on their as- ts unless the regulators approve a oposed uniform commercial gen- al liability form for use by Jan. 1, 86.

The hearings were organized by llinois, New York and Texas insur- ıce commissioners after a meeting the National Association of Insur- ıce Commissioners in Kansas City June.

The commissioners at that time ıld they felt they wanted to hear om the industry in a single presen- ıtion, rather than taking testimony ı a state-by-state basis as is usually ıe case when insurers seek approv- l for a new policy form.

Illinois Insurance Director John . Washburn, chairman of the regu- ıtor panel, grouped supporters of ıe new policy in the morning and fternoon session.

Opponents, such as the Risk and nsurance Management Society, the oice of corporate insurance buyers, were to present their case later in the day and continue this morning.

Speaking in support of the new policy John C. Morrison, a senior vice president at Cigna Corp., said the use of the new commercial gen- [illegible] Insurance Services Office, an industry policy-making group, "will help to forestall a very serious threat to the financial solvency of some members of our industry.

"Without approval of the new ISO program, there will likely be an unacceptable number of insurer insolvencies — and this problem could have disastrous consequences for the general public."

The ISO in a statement said the industry's existing "occurrence" policy would be replaced by a "claims-made" version.

An occurence policy covers the insured for injury and property damage that happen during the policy contract year.

The claims-made policy covers the insured only if a claim is made for the damage during the year the policy is in force.

Christopher C. Mansfield, vice president and general counsel, Liberty Mutual Insurance Co. said that "unless we act positively, our industry may not be able to provide the risk shifting and loss distribution capacity which our customers require and society demands."

Fred R. Marcon, ISO executive vice president and chief operating officer, said, "There has been a complete breakdown in confidence on the part of risk takers: confidence in the predictability of loss, the efficacy of the underwriting process and the ability of insurers to control their own financial destinies."

Supporters of the new policy were united in placing the major share of the blame for the crisis on the judiciary system.

Industry officials say almost with one voice that it is the courts redefinition of policy contract language that has led to awards in pollution liability, product liability and medical malpractice that are bankrupting liability underwriters.

Gerald Wakefield, chief executive, North American reinsurance division of C.T. Bowring & Co., presented the views of Lloyd's of London reinsurers, vigorous supporters of the new policy.

Mr. Wakefield conceded that Lloyd's cannot dictate to American regulators on policy approval, but he wryly said that if the new form is not approved, Lloyd's will not reinsure American liability underwriters.

"Worldwide reinsurance capacity at this juncture is so short that further erosion could cause a fundamental change in the fabric of the U.S. insurance industry's mode of operation." He concluded: "ISO's proposed new claims-made form certainly goes a long way toward the retention of such reinsurance market support which currently looks so tenuous."

The industry spokesmen returned to the hearing table later in the day for questioning by the insurance commissioners.

Claims Made Vs. Occurrence

Journal of Commerce Staff

CHICAGO — The casualty insurance industry and its biggest customers, corporate America, are having problems with words.

Three words in particular.

The words occurrence and claims made refer to that most important facet of the insurance business, the payment of claims and the question of who will make the payment.

To put it as simply as is possible, no small thing in a sea of policy language complexity, when you buy an occurrence insurance policy, your claim is good for damages you sustained in the period for which you paid the premium; usually one year.

You may not discover the damage until years later, but still your claim is valid and the underwriter who sold you that occurrence policy must pay the claim.

If you bought a claims made policy, your claim is good only if you file the claim during the [illegible] in which the policy contract

So if you are a doctor or make your living by making anything from cookie tins to insect spray, you most assuredly want that occurrence coverage. Who knows what you did 10 years ago to lay yourself open to a claim?

Now we get to the sticky part.

It is the occurrence policy and the way law courts are defining the words therein that is bleeding the casualty industry white, industry leaders say.

The insurance industry, therefore, wants to sell only claims made coverage beginning in January 1986.

In the process, the coverage afforded by the occurrence policy as it is understood by the corporations who buy it would be no more.

Understandly, then, the Risk and Insurance Management Society, the voice of insurance buyers for America's corporations, is, to a

lew Liability

By JAMES NOLAN
Journal of Commerce Staff

HICAGO — Major state insur- regulators were openly skepti- last week about the proper- asualty industry's plans to use a commercial general liability dard policy form.

hearings convened by the Illi- Insurance Department, regula- from New York, Texas, Con- icut and Illinois said time and n that the insurance industry s intent on reducing the amount ability coverage corporations buy beginning in January.

rther, the regulators argued industry representatives during hours of intense questioning the proposed policy was much omplex for corporate insurance rs to understand.

fore than a dozen industry repre- tives countered with arguments the new policy form was an lute necessity for the survival of ndustry.

he burden of the industry's case carried by delegates from the ance Services Office, an indus- unded policy-making body, h has fashioned the new policy s.

l of the industry arguments ran hread that casualty underwrit- ave been suffering catastrophic in recent years.

Lloyd's of London delegate who over expressly for the meeting that unless the U.S. industry permitted to adopt the new , the Lloyd's reinsurance mar- would discontinue backing Amer- underwriters forthwith. Such n would severely limit the U.S. stry's ability to buy reinsurance, spreading risks on major disas- such as a supertanker sinking, ffshore oil well disaster and the ming claims associated with the pal, India, gas leak catastrophe killed more than 2,000 and in- l tens of thousands more less a year ago.

Lloyd's has had a substantial position for generations in supporting American primary underwriters with reinsurance for product liability, pollution and environmental impairment coverages, directors and officers liability and medical and other professional malpractice coverages.

The industry forum was organized by commissioners from Illinois, Texas and New York. They were joined by commissioners and staff regulators from 14 other states after they found they were reacting in a piecemeal fashion to pleas from the industry, state by state, for permission to adopt the new system.

Although the commissioners protested that they were open minded about the issues, their questioning showed mounting skepticism.

For example, Peter Gilles, Connecticut commissioner, said that traditionally the industry position on a new policy filing has been that policy contract language is virtually cast in bronze and should not be changed.

"The purpose of this whole exercise is to avoid litigation. But aren't we going to just march lock step into court on this issue?" Mr. Gilles said.

"When the industry does not want us to approve something in a policy form the argument is made that if you change it, we will have to go and litigate. And you know what this means in the courts, so for God's sake, don't do that to us.

"Now you are asking us to approve a form which is going to make some very dramatic changes in a whole host of areas. How do you avoid the courts?" Mr. Gilles said.

Richard Savage of the ISO said that the danger of litigation was lessened because the new contracts were worded most carefully.

To put the kindest face possible on the matter, the response drew laughter from the regulator's table.

Later, Fred R. Marcon, ISO executive vice president, conceded that the possibility of new litigation had been much on the mind of those who shaped the new form. But, he added, the property/casualty industry has no other course if it is to survive.

At another point, Gerald H.C. Wakefield, chief executive, North American reinsurance division of C.T. Bowring at Lloyd's of London, employed an extended anecdote to explain the genesis of a legal liability principal.

He said that a British court had ruled in the days of Queen Victoria that if a householder was "fool enough to keep a tiger in the back garden, the householder was liable for damages the tiger did when he got out.

At a later moment in the proceedings, Mr. Wakefield sought permission to address the panel on a point.

"Fine," said James P. Corcoran, New York insurance superintendent, "but, please, no lions and tigers."

Outright hostility to the new policy forms was repeated at the meeting by a delegation from the Risk and Insurance Management Society, an organization of some 3,800 corporate insurance buyers.

William Flick Jr. of the Allen Group, a New York auto parts maker, and spokesmen for the society, said the group stood fast on the position it took in public hearings before the New York Insurance Department in May.

The society then accused the ISO of "an abuse of the antitrust exemption granted to insurers by the McCarran Ferguson Act," and that the new policy had been fashioned "with little or no concern as to the impact these changes will have on the insured or potential claimants."

APPENDIX C

STATEMENT OF THE AMERICAN INSURANCE ASSOCIATION

BEFORE THE

HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

CONCERNING

CHILD CARE AND INSURANCE

JULY 30, 1985

American Insurance Association

The American Insurance Association is a national trade organization of casualty insurance

The American Insurance Association (AIA) is a trade association which represents 172 property and casualty insurance companies. The member companies of the Association provide a majority of the commercial line insurance coverages written throughout the United States. Some of AIA's members provide general liability coverage to professional day care centers. Liability insurance is provided to some family day care homes through the application of the "business pursuits" endorsement which removes the business exclusion from the homeowner's policy.

Professional day care centers and family day care homes are currently experiencing a liability insurance availability and affordability problem. To the extent that state law mandates the acquisition of general liability insurance coverage as a prerequisite for doing business, the availability/affordability situation is exacerbated. Current insurance market conditions for professional day care centers suggest a market in transition rather than chaos. The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office, Inc. (ISO) for advisory ratemaking purposes for day nurseries appears to conform with the current loss experience for the majority of commercial insurance lines. If expense factors are built into the loss and loss adjustment data for day care nurseries provided by ISO, the combined ratio approaches the aggregate general liability combined ratio of 152. Although these losses clearly indicate the need for increased rates, they do not suggest that insurers should abandon the market.

Insurance availability and affordability problems are not confined to the day care industry. Societal litigiousness and our legal system's movement

"The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985. The Commissioner went on to point out these statistics for Maryland, remarkable action by many companies given the lack of statistical justification for such a move:

> Of 28 insurers writing liability insurance for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, <u>all</u> have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it.

PLASTIC SURGERY

A course entitled "Eighth Annual Practical Plastic Surgery for Practitioners" will be held in Tapatio Springs in Boerne, Tex., April 17–20. The fee is $275.

Contact Medical School Continuing Education Services, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Dr., San Antonio, TX 78284; or call (512) 691-6295.

SUICIDE

The American Association of Suicidology will hold its 18th annual meeting entitled "Suicide — A Critical Perspective" at the Sheraton Centre in Toronto, April 18–21.

Contact Julie Perlman, American Association of Suicidology, 2459 S. Ash, Denver, CO 80222; or call (303) 692-0985.

COCAINE SYMPOSIUM

The University of Wisconsin-Extension, the Wisconsin Institute on Drug Abuse, and the National Institute on Drug Abuse will sponsor a program entitled "Cocaine: A Symposium" at the Marriott Hotel in Milwaukee, April 17–19.

Contact Saran Z. Aslakson, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53705; or call (608) 263-2356.

UNIVERSITY OF PENNSYLVANIA

The University's Department of Anesthesia will sponsor a conference entitled "Start Up and Management of a Day Surgery Unit: Anesthesia, Nursing and Administrative Considerations" in Philadelphia, April 19–21.

Contact Dr. John H. Lecky, Hospital of the University of Pennsylvania, 3400 Spruce St., Philadelphia, PA 19104; or call (215) 662-3733.

CALL FOR ABSTRACTS

Abstracts are now being accepted for the European Society of Pneumology's Fourth Congress, entitled "Bronchitis and Emphysema," to be held in Milan and Siena, Italy, September 22–28. The deadline for receipt of abstracts is April 20.

Contact Dr. Rosaria Marmo, Masson Italia Congressi, Via Statuissera, 4-20129, Milan, Italy; or call (02) 223404.

ECHOCARDIOGRAPHY

Yale University School of Medicine will hold a conference entitled "The Clinical Value of Echocardiography in the Adult, State of the Art Symposium" in New Haven, Conn., April 15 and 16. The fee is $150.

Contact the Office of Graduate and Continuing Education, Yale University School of Medicine, 333 Cedar St., P.O. Box 3333, New Haven, CT 06510; or call (203) 785-4578.

ONCOLOGY CONFERENCE

The Alta Bates Hospital will hold a conference entitled "Frontiers in Oncology: for Oncologists and Primary Care Physicians" at the Hospital in Berkeley, Calif. on April 20. The fee is $75.

Contact Alta Bates Medical Education Dept., 3001 Colby St., Berkeley, CA 94705; or call (415) 540-1420.

INTERNATIONAL CLINICAL HYPERTHERMIA SOCIETY

The Society will hold its sixth annual meeting on Kiawah Island in Charleston, S.C., April 21–26.

Contact Dr. Harry LeVeen, Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29425; or call (317) 266-2524.

ANESTHESIOLOGY

The Dartmouth–Hitchcock Medical Center and the Neurological Institute-University of Munich will sponsor a symposium entitled "Cancer Analgesia with Intrasonal Narcotics" at the University of Munich, Germany, April 24–28. The fee is $80.

Contact Dr. Dennis Coombs, Dartmouth-Hitchcock Medical Ctr., Hanover, NH 03755; or call (603) 646-5922.

SPECIAL REPORT

THE ETHICS OF PROFESSIONAL REGULATION

CHAPTER 458 of the Florida Statutes (The Medical Practice Act) begins: "The Legislature recognizes that the practice of medicine is potentially dangerous to the public if conducted by unsafe and incompetent practitioners. The Legislature further finds that it is difficult for the public to make an informed choice when selecting a physician and that the consequence of a wrong decision could seriously harm the public health and safety. The sole legislative purpose of enacting this chapter is to ensure that every physician practicing in this state meets minimum requirements for safe practice. It is the legislative intent that physicians who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state."

Most states have medical-practice laws with similar preambles. Intertwined in the regulation of the medical profession by states are two purposes that have not always been compatible. The ethical conflict in professional regulation involves the rights of the profession as opposed to the rights of the government and its citizens. The profession seeks to maintain its integrity and independence from bureaucratic control, and the state seeks to protect its citizens from incompetent practitioners and from monopolistic behavior, such as the exclusion of new practitioners and the control of fees.

According to sociologist Elliot Freidson,* members of professions make three claims that distinguish them from other types of workers. First of all, they claim to possess such an unusual degree of skill and knowledge that nonprofessionals are not equipped to evaluate or regulate the members of the profession. Secondly, they claim that the professional is responsible and can be trusted to work conscientiously without the supervision that is necessary for other types of workers. Thirdly, they claim that on the rare occasion when a member is found to be incompetent or unethical, the profession itself can take proper regulatory and disciplinary action, without outside interference.

Professions have been likened to the medieval guilds from which they evolved. Their members generally believe that the professions are doing an excellent job of maintaining high standards and regulating their members. Professions change slowly because they tend to perpetuate the status quo.

The public once believed Freidson's definition and allowed the profession to follow the rule he described. Few members of the public did possess enough education and skill to challenge the integrity of the profession, and the regulation of members was carried out in

*Freidson E. Profession of medicine: a study of the sociology of applied knowledge. New York: Dodd, Mead, 1970:170.

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private, creating the appearance of a conspiracy of silence.

Over the past quarter century, however, it has become increasingly evident that society wishes to change its definition of professionals, especially as that definition relates to physicians. Public opinion has changed for a variety of reasons, including the increasingly common belief that physicians, far from being divine, are not basically different from other people. The press has been quick to report the many cases of physician incompetence and the allegations of conspiracy that were made when the profession was allowed to regulate itself in secrecy.

It should be evident to all observers that the medical profession can no longer live up to its own definition of a profession, as interpreted by Freidson. First of all, physicians no longer possess such unique knowledge and skill that only other physicians are capable of judging their work and competence. Many other health-care workers, including nurses and technicians, have achieved high levels of sophistication in specialized areas of medical practice. The general public itself is more educated and sophisticated and can often tell when a physician is guilty of medical incompetence or fraud.

The second claim, that professionals can work unsupervised, has been impugned by the many documented instances of medical incompetence. There have been estimates that as many as 5 to 15 per cent of doctors are not fully competent to practice medicine, either from a deficiency of medical skills or because of impairment from drugs, alcohol, or mental illness.

The third claim, that the profession can be trusted to discipline members on the rare occasions when misconduct has occurred, is also no longer acceptable to society. Numerous examples of attempts to cover up professional misconduct have been documented by the media.

Professional regulatory boards were developed as a mechanism for meeting society's need to have professional groups licensed and disciplined, in order to protect its citizens from harm. The state governments, beginning with Virginia in 1639, took on the power of licensing authority and with it the responsibility of policing those who were licensed. As in the case of other licenses, states resisted federal intervention in the process.

For many years, state professional boards were controlled to a great extent by the professional medical association of the state, which offered names to the governor when there were vacancies on the board. This "old-school-tie" system continued as the mechanism of professional regulation under the guise of state control. Executive directors of medical boards and state board chairmen were virtual lords, completely controlling the granting of medical licenses and the imposition of medical discipline. Individual physician members of the boards also wielded great authority in determining who would get a medical license and who would be charged with a statutory violation.

In Florida, a period of drastic change began in 1979. The *Miami Herald* had published a series of articles that documented the fact that doctors who had harmed patients and who had violated the law had continued to practice because the state medical board had been unable or unwilling to perform its disciplinary role effectively.

At the same time, Florida's Medical Practice Act was terminated under the provisos of the state's "sunset law," which terminates all state regulatory boards and their governing legislation on a periodic basis, usually about every five to six years.

A new governor was elected in Florida at the same time, and he used the opportunity offered by the passing of a new medical-practice act and the public demand for change to appoint all new board members. I was appointed then as one of the nine physician members of the board.

The legislature completely revamped the regulatory process by empowering the Department of Professional Regulation (DPR) to oversee the licensing and discipline of 27 different regulatory boards and their 750,000 licensees, including physicians. The secretary of the DPR is a member of the governor's cabinet.

Under the old system, the medical board had great autonomy and power. Board members and their staff handled all complaints filed against medical licensees and initiated an investigation when it was deemed appropriate. Board members then decided whether probable cause existed, and a member also served as the hearing officer in the disciplinary trial of the accused licensee. The full board itself, with one public member, ultimately determined findings of fact, conclusions of law, and an appropriate penalty on the basis of the hearing officer's recommendation at the trial.

There were charges that individual board members had too much authority in cases involving violations of the medical-practice act, often serving as the investigator, hearing officer, and final judge. Individual physicians who seemed to have been guilty of gross statutory violations were acquitted of all charges and allowed to practice without restraint or any requirement that they improve their competence.

Under the present system, the individual professional boards, including the medical board, share the responsibility for licensing and discipline with the DPR. DPR complaint analysts receive and analyze all telephoned or posted complaints, and together with a prosecuting attorney, who is employed by the state as an assistant attorney general, determine whether the complaint has merit and is worthy of an investigation.

The investigation is handled by DPR investigators who are assigned to medical-board activities. The investigative file is then presented to the Probable Cause Panel, which is composed of physician members of the medical board, and they analyze the case with a DPR

attorney. If probable cause is found, DPR issues an administrative complaint against the respondent, who is provided with an election-of-rights form on which he or she can admit guilt, seek out a full disciplinary hearing, or seek to plead his or her case directly before the medical board without having a disciplinary hearing before a hearing officer. Due process is best served by the hearing process.

The hearing officer is employed by the Division of Administrative Hearings of the state's separate Department of Administration, and is an attorney and a judge. The respondent is entitled to be represented by counsel, and the state is represented by a prosecuting attorney from the attorney general's staff who handles only medical matters.

The hearing officer issues his findings of fact, conclusions of law, and a recommended penalty on the basis of his interpretation of the testimony of witnesses and other evidence presented at the hearing. The documents from the hearing are then presented to the 11 members of the medical board, who review the file and interview the respondent at a public meeting of the board. These meetings are scheduled six times a year and last three days each. The board may not alter the hearing officer's findings of fact, since board members were not present at the hearing to observe and cross-examine witnesses. The board may, however, differ with the hearing officer's conclusions of law and recommended penalty. This occurs quite often because the hearing officer, who is an attorney, may not perceive the statutory violations in the same manner as do the physician members of the board, or even the public members. A licensee who is unhappy with the board's decision in a disciplinary action against him or her may seek relief from the District Court of Appeals. The court may issue a stay of the board's final order pending a full appellate review.

The board is statutorily composed of nine physicians and two public members, and they represent a cross-section of Florida's multiethnic population, from both rural and urban areas. Members serve for four years and may serve an additional four if they are reappointed by the governor.

Under the "sunshine law," Florida's government is required to give public notice of all its activities and to carry them out in public view. Some states do not have sunshine laws, whereas others, like Colorado, exempt the activities of medical disciplinary boards from the rules. All medical-board meetings in Florida and all subcommittee meetings, including those of the Probable-Cause Panel, are open to the public and press. Board members are forbidden by law to discuss state business in private with other board members, and they may not meet at any time in any official capacity without proper notice to the public.

The state's DPR and the professional members of the board share responsibility for the system. The rights of the profession are protected to a great degree by the nine physicians, whereas the rights of the citizens are protected by ensuring that no conspiracy of professionals seeks only to protect its members.

If a complaint is determined to be frivolous and without merit, it will be dismissed before it is made public. If probable cause is found for a justified complaint, an administrative complaint is issued within 10 days and made known to the press and public. A physician licensee is therefore spared the public condemnation and notoriety that may result from a frivolous complaint, but his or her misdeeds are publicized if a statutory violation has truly occurred.

The presence of 9 physicians on the 11-member board guarantees that misconduct by physicians can be properly evaluated by colleagues who understand the stresses of practicing medicine in our state. The profession is responsible for its own discipline and may set guidelines for the level of professional competence and morality required of physicians in the state. High standards can be maintained by strict enforcement of the statutes and by putting dishonest and incompetent practitioners on notice that inferior medical care will not be tolerated.

According to the Federation of State Medical Boards, Florida carried out 147 disciplinary actions against physician licensees in 1982 (Table 1). Since reorganization in 1979-1980, the board has revoked the licenses of 58 physicians, suspended those of 46 more, and accepted the relinquishment of another 51. This represents a threefold increase in the number of disciplinary actions as compared with the four-year period before 1979.

In the same year, California disciplined 144 physicians at a time when over 50,000 licensed physicians practiced in that state. New York, with over 40,000 licensed physicians, disciplined only 51. Five states did not discipline a single physician in 1982 (Table 1). These data refer to actions reported to the Federation and may have minor inaccuracies due to deficiencies in reporting.

It would be naive to suggest that the relative number of physicians disciplined by a state regulatory board should be the sole indicator of the effectiveness of the disciplinary system in maintaining high professional standards. However, few other objective criteria can be used. It is difficult to believe that in any given year any state or territory would not have at least one physician per thousand who posed a threat to the health and safety of its citizens, and yet in 1982, 14 states reported less than that number of disciplinary actions. Has the balance of interests in these states tipped too far in the direction of protecting the profession to the detriment of its citizens? Almost everyone will concede that physicians are not saints, are capable of error, can be evaluated to some degree by nonphysicians, and have been guilty, at times, of trying to cover up the misdeeds of their colleagues or themselves. The only way to deal with these facts is to do the best possible job of protecting the profession, while at the same time protecting the public from dangerous doc-

tors. The overwhelming majority of physicians are competent and honest professionals. By identifying and disciplining the few who are not, we meet our public and professional responsibilities.

State medical boards must share responsibility for medical licensing and discipline with agencies of their state governments. All states and territories currently have medical regulatory boards that are state financed and mandated by state law. Medical disciplinary meetings should be held in public view to dispel myths about cover-up. Public members should continue to serve on boards to offer a nonphysician's perspective on the disciplinary process and to allay public anxiety.

These boards, however, must continue to include a majority of physicians, who can better understand the doctor's position. They can empathize with sick colleagues, and they can mete out strict discipline to incompetent and dishonest physicians when it is appropriate. The single overriding goal of state medical boards must continue to be the protection of the public from incompetent and unethical doctors. A second goal, and one of increasing importance in the past decade, is the rehabilitation of the impaired physician.

State medical boards can serve as the arbiters of medical practice in their states by defining minimally acceptable levels of conduct and practice. In so doing, they must adhere strictly to the statutes that govern the practice of medicine in their state.

Florida, California, and many other states periodically publish newsletters that are distributed to all physician licensees, hospitals, county medical societies, and other interested parties. In Florida, the newsletter is used to educate physicians about the medical laws of the state so that ignorance of the law will not lead to statutory violations. The newsletter, published four times a year, also lists the names and addresses of doctors who have been found guilty of breaking the law and have been disciplined by the medical board. The newsletter has been well received and has served as an invaluable asset in identifying physicians who may have to be more closely watched by hospitals, colleagues, and patients.

We realize that some physicians who have lost their medical licenses in Florida, because of revocation, suspension, or voluntary relinquishment in the face of impending discipline, will travel to other states in which they still possess a valid medical license. They may practice there until the new state is notified of their administrative difficulties in Florida and chooses to initiate an investigation. The board in Florida attempts to find out in which other states a physician is licensed to practice medicine and notifies those states of its action by mailing a copy of the board's final order. Reports of all disciplinary actions are also sent to the Federation of State Medical Boards, which has the responsibility of notifying all other states and territories. Each state will usually look into the reason that a physician was disciplined in another state and act appropriately.

Most states use similar applications for a medical license to be granted on the basis of an examination given in another jurisdiction. These applications contain questions about prior disciplinary actions in other states, and an affirmative response is always investigated before a license is granted.

Table 1. Disciplinary Actions Taken against Medical Doctors in 1982.*

State	No. Licensed M.D.s (in State)	No. Disciplined per 1000 M.D.s
Florida	20,100	7.4
Arizona	5,000	7.0
Nebraska	2,500	6.8
Mississippi	3,000	6.0
South Dakota	842	5.9
Iowa	4,000	5.5
Wyoming	663	4.5
South Carolina	4,500	4.4
Georgia	7,500	3.3
New Mexico	2,400	3.3
Idaho	1,200	3.3
New Jersey	22,000	3.1
Kansas	2,957	3.1
Louisiana	6,500	3.1
Missouri	9,000	3.0
Oklahoma	4,000	3.0
Utah	2,000	3.0
Wisconsin	4,500	2.9
West Virginia	3,500	2.9
California	51,500	2.8
Minnesota	7,000	2.6
Maine	1,500	2.6
Alaska	411	2.4
Indiana	6,000	2.3
Nevada	1,300	2.3
Maryland	11,000	2.0
Michigan	14,500	1.9
Virginia	10,000	1.9
Oregon	5,270	1.9
Colorado	6,500	1.8
Alabama	4,380	1.3
Hawaii	1,900	1.6
Tennessee	7,000	1.4
Illinois	20,000	1.2
Washington	7,850	1.2
New York	45,000	1.1
Kentucky	5,250	1.1
Montana	1,000	1.0
Texas	24,500	0.9
Ohio	19,000	0.9
Vermont	1,160	0.9
North Carolina	8,500	0.8
Massachusetts	17,500	0.7
New Hampshire	1,546	0.6
Rhode Island	1,782	0.6
Pennsylvania	30,000	0.5
Connecticut	6,500	0.3
Arkansas	3,100	0.0
Delaware	752	0.0
District of Columbia	3,500	0.0
North Dakota	939	0.0
Puerto Rico	4,057	0.0

*Source: Federation of State Medical Boards. Data represent the number of reported actions and are only approximations because reporting may be incomplete in some states.

3361 S. Miami Ave.
Miami, FL 33133

RICHARD JAY FEINSTEIN, M.D.

To: The Legislative Interim Committee;

I understand that you folks are studying whether legal guidelines should be set to standardize actual damage awards in medical malpractice cases. It is my belief that definite standards should be set. The situation has gotten out of hand and we are all having to pay. For example, I have had to undergo 170 dollars worth of unnecessary medical care because my doctor was afraid that I might sue him if he didn't. Where was my opinions or feelings considered, or did it matter that I didn't feel that I could afford this care? NO! And the ones who are truely reaping are the lawyers. Let's face it. People are greedy and doctors are fallible, so let's make some sense out of this mess and draw up some reasonable guidelines.

It should be proven without a doubt that the doctor was negligent. The duration of the patient's suffering should be considered. Will the patient be suffering a short time or will care be needed lifelong? Then restetution can be awarded accordingly.

Let's remember that doctors and insurance companies do not have an unlimited amount of money, and especially those of us everyday people who pay higher doctor bills to help pad the pockets of those who seem to wish to make money off of the suffering of others.

Sincerely,

Mrs. Joseph A Vaughn
Box 52
Bird City, Ks. 67731

9/12-13/85

Attachment XXII

RISK MANAGEMENT IN A CHANGING LIABILITY ENVIRONMENT (PEER REVIEW PROCESS)

PRESENTATION ON BEHALF OF
KANSAS MEDICAL SOCIETY
BEFORE THE
SPECIAL COMMITTEE ON MEDICAL MALPRACTICE
KANSAS LEGISLATURE
SEPTEMBER 13, 1985

BY

DANIEL K. ROBERTS, M.D., PH.D.
Professor and Chairman, Department
of Obstetrics & Gynecology at
Wesley Medical Center
University of Kansas School of
Medicine - Wichita

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Attachment XXIII

RISK MANAGEMENT IN OBSTETRICS

I. HISTORY

II. CLINICAL SCREENING SYSTEM
"RISK MANAGEMENT"

A. CLINICAL SCREENING SERVES TO:

1. IMPROVE CLINICAL RISK MANAGEMENT

2. DATA SOURCE FOR QUALITY ASSESSMENT

B. GENERIC OUTCOME SCREENING CRITERIA

- "THE EXPECTED"

- FLAGS "THE UNEXPECTED"

C. DEFINE

1. PCE

2. QOCI

D. RECOMMENDATIONS

1. RISK TREATMENT

2. RISK PREVENTION

E. QUESTIONS TO BE ANSWERED

1. IS THERE EXPOSURE ?

2. HOW MUCH ?

3. WHOSE ?

4. WHAT CAN BE DONE TO MINIMIZE IT ?

5. WHAT SHOULD BE DONE TO AVOID SIMILAR EVENTS IN THE FUTURE ?

6. WHAT ARE THE BEST DEFENSES IF A CLAIM IS ASSERTED ?

F. CLINICAL SCREENING SYSTEM

IS REPORTING, RECORDING AND ANALYZING UNEXPECTED PATIENT CARE MANAGEMENT EVENTS.

III. DEPARTMENTAL CLINICAL SCREENING

A. GENERIC OUTCOME SCREENING CRITERIA

1. MATERNAL

L-M-1. DEATH

L-M-2. CARDIAC OR RESPIRATORY ARREST

L-M-3. TRANSFUSION DURING OR WITHIN 24 HOURS OF DELIVERY

L-M-4. ADMISSION/TRANSFER TO ICU

L-M-5. UNPLANNED RETURN TO DELIVERY ROOM OR OPERATING ROOM

L-M-6. INCORRECT SPONGE, NEEDLE, INSTRUMENT COUNT

L-M-7. MID FORCEPS DELIVERY WITH RESULTING INJURY

L-M-8. HIGH FORCEPS DELIVERY

L-M-9. COMPLICATION OF REGIONAL ANESTHESIA

L-M-10. UNPLANNED REMOVAL OR REPAIR OF AN ORGAN OR BODY PART

2. INFANT

L-I-1. DEATH

L-I-2. UNPLANNED TRANSFER TO CONTINUING CARE NURSERY

L-I-3. NECESSITY FOR ASSISTED VENTILATION IN LDR

L-I-4. UNPLANNED ADMISSION OR TRANSFER TO NICU

L-I-5. INFANT INJURY (E.G., SKULL FRACTURE, BRACHIAL PALSY, PARALYSIS, FRACTURED CLAVICLE, MASSIVE HEMATOMA)

L-I-6. CONGENITAL ANOMALIES

L-I-7. APGAR SCORE _ 7 AT 5 MINUTES

L-I-8. DISMISSAL DIAGNOSIS OF ASPHYSIA

L-I-9. MID FORCEPS DELIVERY WITH RESULTING INJURY

B. QUALITY ASSESSMENT DEPARTMENT

1. EVENT REPORTING

A. POLICY

ANY UNEXPECTED PATIENT CARE MANAGEMENT EVENT LISTED AS A CLINICAL SCREEN IS REPORTED ON A TIMELY BASIS TO THE DEPARTMENT OF ASSESSMENT ACTIVITIES BY THE RESPECTIVE NURSING UNIT/ CLINICAL SUPPORT SERVICE SUPERVISOR.

B. CLINICAL ANALYSIS WORKSHEET

CLINICAL ANALYSIS WORKSHEET

ate Screened:_____

creen Code:_____

hysician:_____

rovide Factual Account of Event - include date - time - location

Date_____ Referred By:_____

2. QUALITY ASSESSMENT COORDINATOR FOR LOSS PREVENTION

A. POLICY

THE QUALITY ASSESSMENT COORDINATOR FOR LOSS PREVENTION OBTAINS ADDITIONAL INFORMATION AS NEEDED FROM THE MEDICAL RECORD TO CLASSIFY THE EVENT AND REFERS THE CASE, WHEN INDICATED, FOR PHYSICIAN ANALYSIS.

B. WORKSHEET

OBJECTIVE CLINICAL FINDINGS

1. PRE-EVENT - PATIENT INFORMATION:

2. POST-EVENT - PATIENT INFORMATION:

3. CONDITION OF PATIENT:

DISPOSITION: STORE/DISPLAY ( ) PHYSICIAN ANALYSIS ( ) SR. VICE PRESIDENT

4/84 DATE _____ PREPARED BY: _____

3. CLINICAL RISK MANAGEMENT COMMITTEE - PHYSICIAN ANALYST

A. POLICY

THE CLINICAL RISK MANAGEMENT COMMITTEE (CRMC) REVIEWS THE PERTINENT FINDINGS, EVALUATES THE COMPLETENESS OF THE MEDICAL RECORD AND FORMULATES ALTERNATE HYPOTHESES AS TO THE CIRCUMSTANCES PRECIPITATING THE EVENT. THE CASE IS REFERRED TO THE CLINICAL CHAIRMAN WHEN INDICATED.

B. WORKSHEET

CLINICAL RISK MANAGEMENT DATA

Monthly or Year To Date

Clinical Area	# of Patients	# of Events	# of Phys.	P.A.	Q.C. & Screen Codes	PCE & Screen Codes
LDR - Maternal	Deliveries					
LDR - Infant	Births					
Total						

Legend:

# of Events = Number of Referred Events

P.A. = Events requiring Physician Analysis

Q.C. = Events representing Quality of Care Issues

PCE = Potentially Compensible Events

Screen Code = Specific Screen Code for Clinical Area

# of Phys. = Number of Individual Physicians

5. FINALIZATION

A. POLICY

THE CLINICAL ANALYSIS WORKSHEET AND ALL SUPPORTING DOCUMENTATION IS CONSIDERED CONFIDENTIAL INFORMATION, SHALL NOT BE DUPLICATED EXCEPT ONE (1) COPY TO THE SENIOR VICE PRESIDENT; AND IS MAINTAINED IN A LOCKED FILE CABINET. AS APPROPRIATE, THE DATA ARE AGGREGATED AND DISPLAYED, IN A NON-IDENTIFIED MANNER, FOR USE BY THE RESPECTIVE MEDICAL STAFF COMMITTEES.

B. CLINICAL RISK MANAGEMENT DATA TO

1. CLINICAL CARE EVALUATION COMMITTEE
2. PCE & QOCI REPORTED INDIVIDUALLY
3. OTHER COMMITTEES AS INDICATED

DEPARTMENT CHAIRMAN ANALYSIS:

1. DO YOU CONCUR WITH THE ABOVE? YES ( ) NO ( )
   COMMENT:

2. WAS THE CARE RENDERED DIFFERENT THAN WHAT WAS EXPECTED? YES ( ) NO ( )
   COMMENT:

3. WAS THE EVENT UNFORSEEABLE AND UNPREVENTABLE? YES ( ) NO ( )
   COMMENT:

4. DOES THE CLINICAL EVIDENCE SUGGEST:
   A. POTENTIAL EXPOSURE? YES ( ) NO ( )
      COMMENT:

   B. QUALITY OF CARE ISSUE? YES ( ) NO ( )
      COMMENT:

ACTION:

DATE_____ PREPARED BY_____

4. CLINICAL SERVICE CHAIRMAN

A. POLICY

THE CLINICAL CHAIRMAN REVIEWS THE PERTINENT FINDINGS, COMPLETE THE ANALYSIS AND DOCUMENTS WHAT ACTION IF ANY, WAS TAKEN

B. WORKSHEET

PATIENT IDENTIFIER #_____

PRELIMINARY PHYSICIAN ANALYSIS:

1. ANY RESULTING IMPAIRMENT OF PHYSICAL/MENTAL FUNCTION THAT IS POSSIBLY OR ARGUABLY RELATED TO THE EVENT? YES ( ) NO ( )
   COMMENT:

2. LIST ALL POSSIBLE REASONS WHY THE EFFECT MAY BE UNRELATED TO THE EVENT:

3. IS THE MEDICAL RECORD COMPLETE AND DOES IT APPEAR TO ADDRESS THE ISSUE?
   YES ( ) NO ( ) COMMENT:

4. REFER TO DEPARTMENT CHAIRMAN? YES ( ) NO ( )
   COMMENT:

DATE _____ PREPARED BY _____

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Presentation to
The Special Interim Committee
on
Medical Malpractice

State Capitol Building
September 12, 1985

Mr. Chairman. Members of the Special committee. My name is Ron Smith, and I am Legislative Counsel for the Kansas Bar Association. It is a privilege to be here on this subject today.

I'm not going to take much of your time, nor get very complicated. You've been very patient, and with all of the memos this summer, I've already discussed several issues. Let me try to summarize.

You've asked for summation remarks from KBA's perspective. To do that, I must make some general statements about the evidence and testimony that has been presented to you thus far in the summer's proceedings. Some of the missing pieces to this jigsaw puzzle are important. Those pieces are still missing.

1. We've heard from vice presidents of medical insurance companies about the Indiana medical malpractice plan. We've not heard from other interested groups, including malpractice plaintiffs in Indiana, whether they think this is a good plan.

2. We've heard horror stories about the large, unnecessary verdicts rendered in Kansas, about 91-year old women who get $10 million verdicts. Where are the details of those verdicts? You don't have the facts to know whether those verdicts are reasonable.

3. We've heard physicians say the big verdicts are the problem, and those big verdicts must be capped. We're talking about 12 verdicts in 10 years large enough to require payments from the Health Care Stabilization Fund. How can you determine whether the verdicts are reasonable without that information?

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4. You've asked the Insurance Department for actuarial data on how much of the current premium surcharge is due to the fact that for 3 years health care providers received unlimited insurance coverage without paying a surcharge premium. Do you have that information?

5. You've asked the Insurance Department for actuarial data on various changes to the overall tort system, and what each change would mean to reduce premiums. Do you have that information?

6. You've asked for information on health care providers with repeat claims so you can see whether severely restricting the activity of a handful of physicians would help the solvency of the fund. Do you have that information?

7. What percent of these high malpractice premiums can you directly attribute to 1984 SB 507's requirements of larger amounts of commercial insurance, and making the Health Care Stabilization Fund solvent?

8. What percent of these Fund surcharges are directly related to 1976 legislative actions which made the fund actuarially unsound. The doctors came to the legislature and said if they must have mandatory insurance, they didn't want to pay more than is necessary, and they asked the legislature make the surcharge zero as long as the fund was above $10 million. Is the tort system to be radically altered because of this fact?

9. What reliable assurances do you have that radical change in the tort system will result in immediate, significant lowering of medical malpractice premiums by commercial insurance companies?

I submit the answers to these questions are important. The answers create the perspective from which you draw conclusions. If your perspectives are too narrow, your decisions may not be appropriate.

In sum, the important work of this committee is not yet complete. Yet today, interest groups are beginning the summation phase of the interim hearings, and tomorrow you're scheduled to begin making decisions.

I've heard all the testimony this summer and for the better part of a year I've listened to a great deal of unnecessary and uninformed lawyer-bashing. There is plenty of blame for everybody. Every interest group is part of the problem and part of the solution. Each must shoulder appropriate responsibility for the present situation. So far, all I've seen is attempts to shift responsibility.

Radical Surgery to the Tort System?

Medical consumers facing elective surgery often are encouraged to seek second opinions. One physician may recommend radical surgical treatment for a cancer, while more cautious colleagues recommend chemotherapy or radiation treatments. The reasons are sound. Once you

take certain radical surgical steps, the patient's body is no longer the same.

That cautious approach must also apply to legislative solutions with regard to medical malpractice insurance problems, and the tort system. This caution is doubly well advised when insurance representatives and physicians and their support groups begin telling you the only problems with medical malpractice are with a tort system that is too costly and doesn't work any more.

I wish this complex problem could be reduced to such simplistic terms. We are dealing with an economic problem of insurance that is not the result of the tort system's application to medical malpractice actions. The tort system is remedial in nature, and we've heard no evidence that the tort system is a significant cost driver in the medical malpractice problem. Rhetoric is not evidence.

If I can leave you with one fact that I'd like you to remember from today, it is this: according to figures supplied by the bureau of the census, and the Kansas Health Care Stabilization Fund, if medical malpractice premium growth had equaled the growth in the Medical Care Index of the CPI from 1977 to 1985, the Fund would now be operating with a surplus -- even if you don't figure in investment income!

From that fact you must answer this question: is it inappropriate to believe if the medical sector's goods and services grows at an annual average rate of 10.2% from 1977 to 1985, that premiums to insure that part of the economy's liability should not rise at the same pace?

KBA believes before radical surgery is performed on the tort system, the Kansas public has the right to see clear evidence that such change will help the overall problem, yet preserve a meaningful system of justice. We haven't seen that evidence yet. Rhetoric is not convincing evidence.

Last Friday, I had the privilege of hearing The Right Honorable Owen Woodhouse, a justice on the Court of Appeals of New Zealand speak about medical malpractice systems in New Zealand. In discussing the deterrent value of the American tort system towards a physician's negligence, he made a statement that I wrote down:

> "It is a strange argument to say doctors must be fearful of courts in order to practice better medicine."

But he's wrong. We are a nation of laws, not men. In our society, one's status in life does not depend on birth, or professional status. If the law is to govern us, it must govern individuals equally. It is the law against which every person's conduct is measured to determine equality, and what is right or wrong. Dr. Woodhouse was advocating a separate system of justice for physicians solely because of economic factors. To say that the tort system should be redesigned so that one segment of society need have little fear of the consequences of its negligence is wrong.

The primary sponsors of radical reform make the peculiar argument that in order to save the medical system, the public must agree that

the most seriously injured persons from medical negligence may be left less than fully compensated -- that the law no longer protects the individual when the individual conflicts with the economic interests of powerful professions.

I'm just enough of an idealist that I'm not ready to adopt that theory.

KBA believes, and we are dedicated towards, fine-tuning the present tort system so that, when combined with major, important legislation passed in 1984 and 1985, the resulting system should speak to the physician's economic problems, and provide some rate relief.

What major legislation?

a. 1984: Moving the Health Care Stabilization towards fiscal solvency. This change involves financial pain for health care providers, and you saw a lot of that pain this morning;

b. 1984: Giving major new powers to the Board of Healing Arts, and the Board of Governors of the Health Care Stabilization Fund.

c. 1985: Creation of a new exception to the collateral source rule;

d. 1985: clarifying the circumstances under which punitive damages can be awarded;

What do I mean by further fine-tuning of the tort system?

(1) Repeal of the excessive post-judgment interest rate which each day further adds to the burden the Health Care Stabilization Fund must pay. Tie that rate to the T-bill rate.

(2) Let's look at requiring the proof of present value of future damages through the use of special verdicts. This will keep truly injured plaintiffs from receiving a windfall, without artificially limiting the compensation to which the jury says they are entitled.

(3) We can restructure screening panels to make them do what they're intended to do: screen out medical malpractices cases of questionable liability when one attorney or the other cannot find good medical advice on medical negligence from local sources or expert medical witnesses. We don't need them to become biased, expensive procedural hurdles which must be leaped before appropriate use of the tort system can begin.

(4) This fine-tuning should treat the plaintiff and the defendant equally in the eyes of the law. No single side should receive the upper hand in the process.

Together with proposals for medical peer review and education, proposals for continued good long-term positive management of the Health Care Stabilization Fund, and the effects which will flow from changes in previous law, this "economic" problem facing Kansas physicians may quickly stabilize -- without the radical surgery being proposed.

This approach to fine-tuning the present tort system is responsible reform.

Physicians often prescribe "time" as the best healer. I also know that an argument can be fashioned that time benefits one interest group or another. I've been around the legislative process 11 years. The most unnatural instinct of a legislator is to listen to his constituents, and then say, "I don't think we should do anything at this time. Let current law handle the situation."

You are <u>not</u> under any requirement to recommend radical reform of the tort system. You <u>are</u> under an obligation to do what is best for <u>all</u> citizens of this state -- even those who are not represented here today.

Based on hard evidence presented to this committee thus far, time and some fine-tuning of the current system may well be the best thing the doctor can order for this patient.

TESTIMONY TO THE SPECIAL COMMITTEE
ON MEDICAL MALPRACTICE

September 12, 1985
Kathleen Gilligan Sebelius

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE:

I am Kathleen Sebelius, Executive Director of the Kansas Trial Lawyers Association, a voluntary bar association with approximately 900 members in Kansas. This issue of malpractice is one which is debated with great emotion, from all sides. This morning you heard eloquent pleas from doctors for some relief from the burden of high premiums for medical malpractice insurance. Since Kansas is one of the states which requires doctors to purchase insurance in order to practice medicine, the only way to avoid the cost is to stop being a doctor. The lack of access to health care would be a serious problem for Kansas citizens.

This afternoon some citizens spoke to you about their personal experiences. They came as volunteers to plead for a public policy which would not restrict a citizen's right to adequate recovery and redress for a wrong. While the stories they tell are not particularly pleasant, they are real; and, the lives of these people and their families and friends have been shattered by acts of negligent doctors.

The medical malpractice issue is not a debate between lawyers and doctors, although we come before you frequently with opposing views. The fundamental decisions on this issue involve public policy choices for the 2.5 million citizens in Kansas who are deeply affected by this debate. Kansans are

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health care consumers and they are potential victims of medical negligence. They want access to affordable, high quality health care, but also rely on the system which protects them from harm and compensates innocent victims for injuries received.

We feel that there is a delicate balance which must be preserved between the recent financial burden felt by doctors and the fundamental rights of all of the citizens in this state. You are being asked to arbitrarily restrict the rights of victims of medical negligence to be fully compensated for their damages. Health care providers would be treated as a special class, not held to the same standard of accountability as other citizens of Kansas. The most severely injured citizens would be asked to carry the financial burden to reduce insurance premiums for doctors.

This is a major public policy decision, one which is as large in magnitude and future impact as any you may ever make as a legislator. It is so fundamental that if the citizens of Kansas were before you today, they would demand that you apply one standard or test to your deliberations. They would demand that you pledge not to modify their legal right to full recovery for wrongful damages which they may suffer from medical negligence, unless and until you are decided there exists no other available remedies to resolve this problem.

We do not believe that the current medical malpractice crisis meets that test. In fact, we will suggest several steps which can be taken, which will begin to alleviate the problem. Some are absolutely guaranteed to have positive results.

Before suggesting solutions it is important at this phase of the Committee's deliberations to define the nature and cause of the problem. Malpractice insurance premiums have risen sharply in the last few years, and for some doctors, in various surgical specialties, the costs are becoming prohibitive. This is an economic problem, not one rooted in the legal system. The cause is our statutory system by which we mandate and provide insurance coverage.

While there is still much confusion over the pricing and rate setting of liability insurance, a few items are relatively clear. The economic problem is national and not local, and all rates have risen in spite of a wide variety of state laws. The insurance crisis is not limited to health care providers, but is affecting rates for diverse groups from pesticide workers to nurse-midwives, from municipalities to day care centers.

There are numerous national studies, including ones from the United States General Accounting Office and A.M. Best's Casualty Loss Reserve Development, which recognize that the role of investment income in the medical malpractice insurance industry has caused tremendous fluctuations in the market. Malpractice claims are paid relatively slowly, and with high interest rates in the early 80's, the investment gains on premiums was substantial. Consequently, many believe that the product was underpriced to encourage purchase and investment capital.

The rapid decline of interest rates shook the property/casualty insurer because the premium was suddenly too low and investments were not yielding the high returns. This has

caused enormous malpractice premium increases being imposed on unsuspecting doctors from coast to coast.

Thus are insurance "crisis" created: overly competitive and fiscally careless insurers; virtually unregulated and untaxed, keep premiums low during times of high investment yield, only to be forced to overcompensate with enormous premiums increases and limited or non-existent underwriting in riskier lines. All in the name of a non-existent increase in losses.

In addition, the fundamental cause of medical malpractice claims is medical carelessness. While, by and large, the quality of health care in this country is the finest in the world, a few health care providers are causing too many serious injuries to health care consumers, while the rest of the medical profession and taxpayers are left with the bill. With the exception of the tort system, there are too few effective mechanisms to discipline this small percentage of frequently careless doctors and hospitals.

Far from being too high, experts all agree that malpractice claims represent only a fraction of real medical negligence. Estimates vary from Rand's study of "one in ten incidents of malpractice resulting in a claim", to HEW's number of only one in fifteen severe injuries resulting in a claim.

According to Insurance Commissioner Bell's 7/1/85 report on the Health Care Stabilization Fund, there have only been 940 claims filed in 9 years. That's an average of slightly over 100 claims per year in a state of 2.5 million citizens. In that same period of time only 135 payments have been made.

The real costs of malpractice are the shattered lives and pocketbooks of victims of medical carelessness, many of whom never receive any compensation through our current tort system. Recent Congressional testimony by economist Patricia Danzon (Labor and Human Resources-Senate-7/10/84) estimates the financial costs of uncompensated injury from medical negligence to be $24 billion in lost jobs and health care. The deterrant value of the current system promoting increased medical care is well worth the insurance dollars.

A further tragedy in the malpractice situation is that a small number of health care providers is responsible for a large share of the malpractice suits. This is true in Kansas and has been confirmed in every state which has conducted a major study, including Washington State, Florida and recently in Pennsylvania.

After hand tabulating over 700 case files in Kansas we found that 31 doctors, less than 1% of the medical population were multiple repeaters and responsible for 16% of the claims filed during that period. Unfortunately, the Insurance Commissioner's Office has either been unwilling or unable to provide the dollar figures to determine the amount of claims paid for these frequent offenders, but our estimates are that these suits account for 30-40% of the money paid out of the Fund. This means that all of the Kansas doctors are paying for the errors of a few colleagues.

The Medical Society has proposed a radical solution - to restrict the rights of Kansas citizens to recover for their damages. We feel that this legislation should never be pro-

posed unless there are no other alternatives available, and unless you are convinced that you have adequate information to determine that the insurance rates are justified. Neither of these situations exists in 1985 in Kansas.

But, we urge you to take some positive steps to ease the financial burden on the majority of Kansas doctors who do not deserve these exhorbitant rates. These solutions reward careful and contientious providers as well as protecting the rights of victims of medical negligence.

I. Steps to Reduce and Eliminate Frivolous Claims and Lawsuits.

The justifiable purpose of a screening process is to "screen out" frivolous claims, not to preempt the jury by deciding the case. The health providers recommend a mandatory screening panel for every claim and lawsuit whose membership would be comprised exclusively of medical peers of the defendant provider. Their conclusions would be admissable in any subsequent litigation.

Such a procedure would not only be incredibly costly and time consuming, but would substantially bias the trial of the case. Merely ask yourself whether you would feel disadvantaged by having a jury comprised entirely of doctors if you were a victim in a malpractice case.

We would recommend that a number of alternative steps could be provided under the law which would serve the same end of eliminating frivolous suits but with a far higher degree of fairness to all the parties concerned. These would include:

a. A requirement that with every case filed in court, the claimant's attorney would have to file an affidavit, as required by the new Illinois law, setting forth that a medical expert had reviewed the claim and found it to be meritorious.

b. In the alternative, if no affidavit was filed or no expert was available, the claimant would be required to proceed with a screening panel comprised in the manner set forth under current law. Under this procedure if the claimant lost both before the screening panel and in litigation, the defendants costs and attorney fees could be assessed against the claimant.

c. Sanctions would be set forth in the law for any findings by the court of any false statements in the affidavit.

d. Mandatory settlement conferences would be required in every medical malpractice case within the first 90 days to be conducted by a judge other than the trial judge.

e. Encourage trial judges to educate attorneys on the use of the current frivolous lawsuit statute, which imposes court costs and fees on an attorney and a litigant (K.S.A. 60-211).?????

These proposals will serve to discourage and eliminate frivolous activity, as well as to prompt reasonable settlement negotiations at an early date in a significant case.

II. <u>Steps to Reduce the Insurance Premium Burden on Non-Negligent Providers</u>:

The real medical malpractice problem for the non-negligent providers is the rising cost of their liability insurance.

The providers recommend that the only mechanism for achieving a reduction of the burden of rising insurance premiums on non-negligent providers is to statutorily limit or cap the amount that can be awarded to the plaintiff, similar to the Indiana law.

This extreme measure is unnecessary, would serve as a windfall to all future negligent providers and would unfairly restrict the rights of recovery of injured parties.

To put this proposal in perspective, we have relatively few high dollar cases in Kansas. Those awards directly relate to the extraordinary costs of health care and custodial services for catastrophic injuries. According to Commissioner Bell, there have been only 19 cases (2% of claims filed) which have resulted in Fund payments over $500,000 in nine years. While that number indicates that we do not have runaway juries or frequent big judgments in Kansas, it is these victims and future severely injured Kansans who will suffer if a limit is imposed.

There are alternatives to this radical proposal which will ease the burden on most Kansas doctors without creating a safe haven for the repeat offenders. A statutory solution which penalizes the victim and benefits the wrong-doer is surely not acceptable public policy for Kansas.

a. We recommend that the liability of the Fund be reduced from $3 million to $1 million. (Similar to recommendations in H.B. 2662 before the House Ways and Means Commit-

tee.) This should automatically reduce the surcharge by two-thirds. No other state in the country requires doctors to purchase insurance over $1 million in a state fund, and most Kansas doctors do not need or want this high coverage.

A small percentage of doctors in high risk surgical specialites would probably want to purchase reinsurance above the $200,000 primary coverage and $1 million Fund coverage. That market is available in other states and these skilled specialists are better paid than their colleagues and can afford the extra coverage.

b. To further reduce the financial pressure on non-negligent providers, a rating experience factor should be added to the surcharge for those providers with claims settlements or judgments against them. It seems unfair that training is regarded as a rating factor to classify doctors, but experience is ignored. If a provider has a history of malpractice, the insurance rates should be higher.

c. The premium burden in Kansas is very unevenly distributed. Providers insured with St. Paul pay almost double the premiums paid by doctors insured with Medical Protective. To further reduce the burden on doctors with the highest premiums the surcharge should be averaged, rather than remain an exact percentage of the primary coverage. Then all doctors in one class would pay the same surcharge, regardless of primary carrier.

d. The premium burden under the Fund could be further reduced by requiring risk management programs.

e. The premium burden under the Fund could be ultimately reduced by better monitoring of insurance rates and data. Illinois has a good sample statute.

III. Steps for More Effectively Dealing with Negligent Providers in Order to Prevent Future Reoccurrences by the Same Providers.

It is ironic that none of the health provider organizations made any substantive recommendations as to what could be done to prevent medical negligence, they merely said they probably could do a "better job".

There is much that can be done, however, we would suggest that you consider the following:

a. Toughen reporting requirements, as per the Arizona law.

b. Repeal the confidentiality of peer review.

c. Require by law that every settlement or judgment of malpractice against a provider be automatically referred to the Board of Healing Arts.

d. Establish by statute sanctions which the Board of Healing Arts may consider in reviewing a claim against a provider specifically to include options such as public censure, suspension, delicensure, and fines.

e. Mandate risk management.

f. Mandate peer review with reports of all positive findings being automatically submitted to the Board of Healing Arts.

g. Establish as a class E felony the provision of treatment by a provider while under the influence of alcohol or drugs.

h. Specifically incorporate all the recommendations of the general counsel of the Board of Healing Arts.

i. Specifically incorporate all the recommendations of Legislative Post-Audit.

j. Require the Western Insurance Company, which operates the state JUA, to notify the Board of Healing Arts when the likelihood of repeated negligence or questionable procedures becomes evident in claims filed.

IV. Structured Judgments.

The providers recommend that all judgments and settlements over a certain amount be mandatorily structured and subject to review periodically for the question of continued liability. This would create endless litigation and substantially increase the costs every year to the victim to protect the original judgment.

Currently the laws governing the Fund, which cover judgments and settlements over $200,000, provide for mandatory periodic payments from the Fund. Judges can order a structured settlement in any case and in fact, most large cases are structured by the lawyers. These recommendations could further the current laws.

a. The consideration of itemized jury verdicts, similar to provisions in the new Illinois law, should be considered by the Committee.

b. As long as the issue of basic liability was not reopened, consideration should be given to structurizing payments for future medical care, a major portion of any sizeable award.

V. Limitations on Attorney Fees.

The providers recommend that limitations be placed on the amount or percentage of contingent attorney fees. They do not suggest how this will remedy the problem of medical negligence.

We oppose such a recommendation as bad public policy for at least three reasons:

1. It will have no impact whatsoever on the medical malpractice problem as juries are unaware of the type of contractual relationship between the attorney and client, and of the amount or percentage of fee agreed upon. Therefore, a contingency fee is not considered by the jury in establishing its award for damages in a medical negligence case;

2. It is a deliberately punitive recommendation made by the providers and an infringement of the right to contract between attorney and client; and,

3. It is designed to prevent lower income injured victims from pursuing legal remedies.

These are some specific recommendations which meet the test of appropriate public policy for Kansas. The non-negligent health care provider is helped by lower insurance premiums, and there is a two-fold protection for the public citizens. Victims of malpractice will not be denied access to the

courts or access to attorneys of their choice and will retain the right to recover for the damages suffered due to medical negligence. In addition, provisions will be made to isolate and discipline frequently negligent providers.

A focus for the Committee in making decisions should be to establish some fundamental standards as a test for each legislative recommendation.

First, you should accept no remedy which restricts or impedes the rights of the victims to be fully compensated for their damages.

Second, you should accept no remedy which limits the liability of negligent health care providers.

Third, you should accept no remedy which is not designed to benefit the non-negligent providers.

The recommendations which we have made meet all three of these standards. The extreme recommendations made by the providers and others, here today, would totally violate these standards. They should be found unacceptable to you.

These proposals combined with the significant changes in the collateral source rules made in 1984 should result in significantly lowering malpractice premiums while ensuring the continued delivery of quality health care in Kansas.

The citizens of Kansas are mindful of the problem confronting the non-negligent providers. But as potential victims of the system, they would urge that the solution to this economic problem not be a denial of basic rights. Your charge as lawmakers of the state is to achieve the delicate balance and arrive at sound public policy for the benefit of all of the citizens of Kansas.

MEDICAL MALPRACTICE STATE-BY-STATE REVIEW

I. 33 states have some type of Review Panel or arbitration.

1. 23 of these states make the panels mandatory.

   a. 4 of the mandatory states have been declared unconstitutional.

   b. 1 of the mandatory statutes was repealed.

   c. Only 10 of the 23 mandatory states allow the admission at trial of the panel proceedings or results.

   d. 8 states have voluntary panels or arbitration.

   e. 2 states provide for the inclusion of an arbitration agreement in medical service contracts or included with the bill (statement of costs).

II. 15 states enacted some type of caps limiting a victim's recovery in medical malpractice actions.

1. 6 of these cap provisions have been declared unconstitutional.

2. 3 states provide for the termination of any damages payments at the death of the victim.

III. 5 states have provided for mandatory periodic payment of damages in medical malpractice cases.

1. 1 of those statutes was declared unconstitutional.

IV. 16 states have placed limitations on contingent fees system.

1. 2 of these statutes have been declared unconstitutional.

2. 4 states have limited contingent fees in all cases.

3. 11 states have specific restrictions on contingent fees in medical malpractice cases.

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* UNCONSTITUTIONAL

STATE	PANELS/ARBITRATION	CAPS	CONTINGENT FEE LIMITS
AL	Voluntary-nonbinding.	Court ordered periodic payments over $100,000.	
AK	Not mandatory-admissible.		
AZ	Mandatory-nonbiding-admissible.		
AR	Voluntary-binding (if both agree).	Court ordered periodic payments over $100,000. Future damages end with death.	
CA	Allows arbitration clause in medical service contracts.	$250,000 cap on non-economic damages.	Fee limitations.
CT	Voluntary-nonbinding-admissible.		
DE	Discretionary (either party may call for a panel).	Future damages end with death.	Fee limitaitons.
FL*	Mandatory-admissible.*	Various limits.*	Sliding Scale Restrictions.
HI	Mandatory-nonbinding-inadmissible.		
ID	Mandatory-nonbinding-inadmissible.	Various limits.*	40% fee limitations.
IL	Mandatory-inadmissible (cost will be counted against party contesting panel decision, if they lose at trial.)	$500,000 cap.* Periodic payments over $250,000	Sliding scale restrictions.
IN	Mandatory-admissible.	$100,000 per doctor/$500,000 total.	15% limit over $100,000.
LA	Mandatory-admissible.	$100,000 per doctor/$500,000 total.	
ME	Discretionary (either party may call for panel)-inadmissible.		
MD	Mandatory-nonbinding-admissible (burden of proof on contesting party).		
MA	Mandatory.		
MI	Arbitration agreement must be offered to by both parties.		Statutory scale limits.
MO	Mandatory-inadmissible*.		
MT	Mandatory-nonbinding-inadmissible.		
NE	Mandatory-nonbinding-admissible.	$1,000,000 cap on awards.	
NH	Mandatory.		

STATE	PANELS/ARBITRATION	CAPS	CONTINGENT FEE LIMITS
NJ	Mandatory-admissible (not subject to cross examination).		Statutory scale limits.
NM	Mandatory-inadmissible.	$500,000 cap plus actual medicals.	
NY	Mandatory-admissible (if panel unanimous).		Fee limitations.
ND	Mandatory (repealed).	$300,000 cap *	
OH	Mandatory-admissible.	$200,000 cap *	
OK			50% maximum.
OR		Physician's liability limited to insurance coverage (minimum insurance required $100,000/ $300,000).	33 1/3% minimum.
PA	Mandatory (exclusive jurisdiction)*		Fee limitation.
RI	Mandatory.		
SC		$100,000 per incident/$300,000 per year. Fund available for excess.	
SD		$500,000 general damages.	
IN	Mandatory-admissible (waivable if both parties agree).		33 1/3% limitation.
TX		$500,000 cap on non-medical damages.	
UT	Mandatory-nonbinding.		33 1/3% limitation.
VT	Voluntary.		
VA	Voluntary.	$1,000,000 overall limit.	
WI	Mandatory-binding (if agreed to by both parties-admissible).	$200,000 limit on doctor's liability. No limit on Fund.	Fee limitation.
WY		$500,000 limit on doctor's liability. $1,000,000 limit on Fund.	

ICS clearance Dept
9/11/85

Comments Regarding Closed Claims Data

1. Attached listing is for only those doctors with multiple closed claim records reported by insurance companies.

2. Closed Claim data systems were not intended to produce individual health care provider loss record summaries. The data system records the health care provider's name as it appears on the reporting form; that is, we do not varify the individual health care providers name or how it is entered into the data system.

3. The attached listing includes only closed claim records for the years 1978 through 1984. The 1984 year is not complete and the department will update 1984 in December of this year.

4. Each health care provider licensing agency is furnished with a copy of closed claims reporting for their licensees.

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CODING USED FOR PROFESSIONAL
LIABILITY CLOSED CLAIMS REPORTS

Dept. Code No.	Type of Insured	ISO Code No.
Doctors of Medicine & Surgery		
111	No Surgery (Prem. - 235) Physicians - No Surgery, Psychiatry Pulmonary Diseases, Family Practice	80230 - 80269 80321
112	No Major Surgery (Prem. - 424) General Practitioners or Specialists Performing Acupuncture, Ateriography, Catheterization, Radiation Therapy, Shock Thearapy/Geriatrics, Pediatrics, Family Practice	80270 - 80294 80322 - 80421 80533 - 80420 80117
113	No Major Surgery (Prem. - 598, 718, 838) General Practitioners or Specialists Performing Colonscopy, Laparoscopy, Needle Biopsy/Broncho-Esophagology, Emergency Medicine	80101 - 80115 80145 80158 - 80160 80323 - 80324 80534 - 80443
114	Surgery (Prem. 1,197, 1,436) Obstetrics-Gynecology, Emergency Medicine, Abdominal, Hand, Neck	80141, 80143 80153, 80155 81057 80166 - 81070 80325 - 80326
115	Surgery (Prem. 1,676,1,915)	80144, 80146 80150, 80152 80154, 80156 80171, 80327
116	Anesthesiology (Prem. 1,436) General Practitioners or Specialists Performing General Anesthesia or Acupuncture Anesthesia (Not Nurse Anesthetists). Check hcp Master to see if Dentist Anesthetist	80151
Doctors of Osteopathy		
121	No Surgery	ISO Code will be similar to MD's except end digit will be "4" instead of "0" (EXAMPLE 80230 = 110 84230 = 120
122	No Major Surgery	
123	No Major Surgery	
124	Surgery	
125	Surgery	
126	Anesthesiology	
	Intern	84268

CODING USED FOR PROF. LIAB.
CLOSED CLAIMS REPORTS (cont.)

Dept. Code No.	Type of Insured	ISO Code No.
130	Chiropractors	80410
140	Podiatrists (Chiropodists)	80993
150	Physical Therapists (Physiotherapists)	80995, 80938
160	Dentist Anesthetists	80151
170	Dentists	80210, 80211
180	Nurse	80993, 80714
300	Medical Care Facilities	80611, 80612, 84965
310	Medical Care Facilities (Non-HCP's Clinics)	80613, 80614
350	Mental Health Centers	80997
400	Pharmacists	59112
500	Optometrists	80994
600	Nurse Anesthetists	80960
700/800	Professional Corp. Partnerships	80999
900	Engineers	
910	Land Surveyors	
920	Architects	
930	Landscape Architects	
940	Attorney's	81220, 81330, 81113, 81114

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
A	115	Shawnee Mission	1983	$100,000	$56,578	0	Surgery
			1984	0	0	0	Improper Care
B	115	Halstead	1981	2,500	124	4	Improper Care
			1981	0	6,204	1,676	Surgery
C	113	Kansas City	1981	0	1,864	393	Birth Control
			1982	100,000	7,763	3,894	Incorrect Diagnos
D	111	Topeka	1984	100,000	6,378	1,865	Incorrect Diagnos
			1984	100,000	4,620	2,139	Incorrect Diagnos
			1984	100,000	1,651	6,126	Incorrect Diagnos
E	114	Overland Park	1980	16,000	7,730	2,248	Surgery
			1980	0	0	0	Improper Consent
F	111	Leavenworth	1979	2,000	2,700	446	Improper Care
			1980	144,375	6,900	2,001	Incorrect Diagnos
G	111	Wichita	1984	200,000	7,095	11,127	Incorrect Diagnos
			1980	0	0	0	Incorrect Diagnos
			1982	0	0	0	Incorrect Diagnos
H	130	Leawood	1982	0	0	0	Falls
			1983	45,963	7,631	943	Prescription Erro
I	113	Shawnee Mission	1984	0	0	0	Improper Care
		Merriam	1984	0	168	0	Miscellaneous
		Overland Park	1980	0	2,665	0	Birth Related
			1981	0	4,943	0	Post-Op Infection
			1982	0	6,520	0	Improper Care
			1983	0	17,436	0	Reaction to Drugs
J	112	Eldorado	1982	5,000	5,699	755	Incorrect Diagnos
			1982	0	500	0	Reaction to Drugs

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
K	115	Wichtia	1981	0	0	791	Surgery
			1983	14,000	3,434	0	Surgery
L	114	Kansas City	1982	0	2,595	348	Birth Related
			1983	0	1,166	162	Birth Related
M	112	Topeka	1981	0	4,908	409	Post-Op Infection
			1982	0	2,197	121	Surgery
N	114	Wichita	1978	0	0	0	Birth Related
			1979	100,000	4,500	724	Anesthesiology
O	112	Wichita	1982	15,000	3,045	184	Surgery
			1983	0	1,076	24	Psychiatric
P	114	Kansas City	1981	0	0	0	Incorrect Diagnose
			1982	2,000	444	18	Improper Care
			1983	0	7,523	1,928	Incorrect Diagnose
Q	11	Topeka	1983	60,000	0	274	Birth Related
			1983	0	3,027	0	Birth Related
			1983	0	23,300	0	Anesthesiology
			1980	100,000	25,069	0	Incorrect Diagnose
R	111	Wichita	1980	0	0	0	Incorrect Diagnose
			1982	0	0	0	Incorrect Diagnose
S	114	Leavenworth	1984	0			
			1982	5,667	12,045	0	Birth Control
			1983	4,000	50	0	Reaction to Drugs
T	112	Coldwater	1982	24,000	2,399	795	Doctor's Advice
		Salina	1982	0	5,035	1,207	Improper Care
			1983	10,000	629	129	Birth Control
U	114	Overland Park	1980	0	0	185	Reaction to Drugs
			1981	0	731	0	Birth Control
			1982	0	2,196	0	Birth Related
			1983	0	0	0	Birth Related

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
V	114	Shawnee Mission	1984	100,000	4,528	2,271	Surgery
			1983	45,000	2,139	152	Surgery
			1984	7,400	0	698	Surgery
			1984	100,000	19.987	11,447	Surgery
W	115	Kansas City	1984	16,635	6,970	479	Improper Care
			1983	100,000	4,368	3,380	Surgery
			1979	0	0	0	Vasectomy
			1978	0	3,130	203	Miscellaneous
X	112	Iola	1981	0	2,448	482	Improper Care
			1983	0	6,542	608	Improper Care
Y	114	Topeka	1981	80,000	35,592	0	Post-Op Infection
			1982	1,000	2,042	0	Incorrect Diagnos
Z	114	Overland Park	1981	1,000	265	7	Improper Care
			1981	0	1,037	18	Post-Op Infection
AA	111	Wichita	1980	10,000	628	214	Incorrect Diagnos
			1982	0	0	0	Incorrect Diagnos
			1984	83,300	4,349	1,469	Incorrect Diagnos
BB	114	Wichita	1984	0	0	846	Birth Control
	115	1982	1982	13,500	0 593	0	Improper Care
CC	112	Iola	1982	0	8,371	1,757	Doctor's Advice
			1983	50,000	3,656	789	Doctor's Advice
			1984	0	0	0	Improper Care
DD	114	Overland Park	1982	20,000	646	8,044	Improper Care
			1981	0	0	0	Personal Injury
EE	114	Salina	1984	3,500	4,681	1,049	Birth Related
			1983	0	0	0	Personal Injury
FF	115	Leawood	1983	15,000	8,747	264	Surgery
			1983	15,000	3,729	0	Surgery

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
GG	111	Hays	1980	0	0	0	Incorrect Diagnosi
			1981	35,000	3,575	1,129	Incorrect Diagnosi
HH	114	Junction City	1979	18,750	1,560	244	Surgery
			1980	20,000	7,829	2,226	Miscellaneous
II	112	Topeka	1982	0	947	363	Improper Care
			1983	0	0	114	Improper Care
JJ	114	Emporia	1978	0	0	0	Surgery
			1980	7,500	0	0	Surgery
			1980	18,000	0	0	Hysterectomy
			1983	0	2,727	1	Birth Related
KK	114	Hutchinson	1979	0	1,823	264	Hysterectomy
			1979	51,250	10,231	4,037	Birth Related
			1978	0	3,684	1,270	Birth Control
		Overland Park	1982	0	0	176	Birth Control
LL	115	Hays	1980	0	0	0	Incorrect Diagnosi
			1983	0	2,581	336	Incorrect Diagnosi
			1979	2,500	125	0	Improper Consent
MM	111	Wichita	1982	0	0	350	Reaction to Drugs
			1982	0	0	0	Reaction to Drugs
NN	122	Sabetha	1982	0	16,470	0	Reaction to Drugs
			1980	3,121	0	641	Personal Injury
OO	124	Kansas City	1980	1,250	3,112	0	Birth Control
			1981	0	0	1,000	Doctor's Advice
PP	115	Wichita	1982	5,000	0	0	Improepr Care
			1983	7,500	0	658	Surgery
QQ	115	Wichita	1983	17,500	6,482	1,713	Surgery
			1983	0	29,700	8,018	Improper Care

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
RR	115	Mission	1982	0	6,605	0	Surgery
	115	Mission	1982	6,000	1,451	1,897	Surgery
	115	Mission	1981	4,250	0	75	Doctor's Advice
	112	Mission	1981	1,667	0	2,500	Vasectomy
	114	Mission	1981	2,500	0	0	Anesthesiology
			1981	0	0	0	Surgery
SS	114	Great Bend	1984	0	0	0	Birth Related
	113		1984	0	55,595	13,861	Birth Related
TT	115	Topeka	1984	0	742	0	Improper Care
			1983	0	368	481	Surgery
			1983	18,000	6,266	2,778	Surgery
UU	113	Arkansas City	1983	12,500	6,979	0	Incorrect Diagnose
			1983	5,000	3,667	300	Incorrect Diagnose
VV	111	Overland Park	1980	0	0	93	Birth Control
			1980	250	0	111	Incorrect Diagnose
WW	115	Shawnee Mission	1984	0	1,765	0	Improper Care
			1982	0	0	0	Improper Care
XX	114	Wichita	1979	0	1,400	211	Incorrect Diagnose
			1979	6,000	0	156	Incorrect Diagnose
YY	113	Lawrence	1982	10,000	147	0	Surgery
	114		1983	0	3,800	0	Surgery
ZZ	114	Lawrence	1979	0	1,463	48	Surgery
			1980	55,000	9,707	2,974	Surgery
3A	111	Hays	1983	37,500	14,125	0	Incorrect Diagnose
			1982	0	0	0	Incorrect Diagnose
3B	114	Kansas City	1979	1,000	0	0	Improper Care
			1977	0	2,052	409	Improper Care
3C	112	Overland Park	1980	0	0	0	Surgery
	113		1981	4,505	20,560	20,000	Post-Op Infection
	113		1981	11,000	0	16,700	Dental

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
3D	112	Topeka	1979	750	778	121	Reaction to Drugs
			1980	25,500	2,710	215	Birth Related
3E	111	Wichita	1980	0	0	0	Incorrect Diagnose
			1982	0	0	0	Incorrect Diagnose
3F	112	Lawrence	1980	0	8,661	1,113	Improper Care
			1979	0	2,493	460	Doctor's Advice

Continued on next page

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
3G	122	Overland Park	1979	$ 7,000	$ 5,236	800	Birth Related
	114		1980	0	0	411	
3H	112	Lawrence	1984	0	267	5	Incorrect Diagnos
	113		1984	0	193	1,638	Incorrect Diagnos
3I	116	Topeka	1978	1,500	342	0	Improper Care
	116		1979	1,750	2,140	404	Anesthesiology
3J	113	Topeka	1979	0	6,873	917	
			1980	0	0	0	Incorrect Diagnos
3K	113	Junction City	1981	100,000	67,145	0	Birth Related
	123		1982	10,150	2,816	616	Incorrect Diagnos
3L	113	Topeka	1979	0	6,874	916	Doctor's Advise
			1979	2,500	1,455	234	Incorrect Diagnos
			1980	250	457	42	Surgery
			1980	20,000	385	47	Surgery
3M	112	Wichita	1980	1,100,000	22,719	0	Surgery
	112		1981	100,000	2,609	0	Surgery
	111		1981	34,000	2,038	0	Surgery
	112		1981	66,000	2,390	0	Surgery
	112		1981	0	4,034	0	Surgery
	115		1981	0	0	0	Surgery
	113		1981	0	0	0	Incorrect Diagnos
	113		1981	0	0	0	Incorrect Diagnos
	114		1981	0	0	0	Incorrect Diagnos
	113		1981	0	0	0	Incorrect Diagnos
	113		1981	0	0	0	Incorrect Diagnos
	115		1981	1,000,000	0	0	Incorrect Diagnos
	114		1983	25,000	18,049	0	Surgery
	114		1984	75,000	24,272	666	Surgery
	114		1984	100,000	21,395	0	Surgery
3N	112	Lenexa	1979	10,000	3,088	371	Reaction to Drugs
	121		1979	50,000	68,000	0	Prescription Erro
	112		1979	25,000	17,873	4,608	Reaction to Drugs

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
3O	114	Topeka	1982	$ 14,000	$ 3,481	0	Birth Control
	114		1982	15,000	0	972	Hysterectomy
3P	112	Prairie Village	1982	0	195	0	Miscellaneous
	115		1983	700	0	30	Surgery
	115		1984	65,000	36,581	250	Surgery
3Q	113	Topeka	1980	250	457	42	Surgery
	113		1980	15,000	485	47	Surgery
3R	112	Topeka	1978	0	2,821	443	Post-Op Infection
	111		1980	300	2,484	0	Incorrect Diagnose
3S	112	Arkansas City	1983	5,000	3,793	0	Incorrect Diagnose
	115		1983	0	728	0	Surgery
	113		1983	25,000	9,461	0	Incorrect Diagnose
3T	114	Shawnee Mission	1982	0	0	0	Improper Consent
	112		1984	0	0	0	Surgery
3U	114	Pratt	1983	0	13,934	3,041	Incorrect Diagnose
	114		1984	0	0	0	Incorrect Diagnose
	115		1984	0	0	0	Surgery
	114		1984	11,000	2,515	8,397	Surgery
3V	125	Wichita	1983	100,000	7,975	0	Miscellaneous
	125		1983	50,000	5,375	0	Improper Care
	124		1984	100,000	4,118	0	Surgery
3W	115	Topeka	1980	0	3,536.47	0	Surgery
	112		1982	0	0	0	Incorrect Diagnose
3X	115	Kansas City	1981	3,700	2,509	440	Doctor's Advice
	115		1983	0	267	247	Surgery
	115		1981	63,500	8,125	2,520	Surgery
3Y	115	Topeka	1983	500	486	0	Incorrect Diagnose
	115		1981	0	6,983	88	Miscellaneous

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
3Z	114	Wichita	1979	0	$1,076.70	105.60	Hysterectomy
	114		1979	11,700	1,602	507.11	Birth Related
	114		1979	0	1,076	105.60	Hysterectomy
4A	114	Fredonia	1980	0	12,827	0	Surgery
	114		1981	0	0	0	Birth Related
4B	111	Kansas City	1982	42,500	23,846	0	Birth Related
	115		1980	9,000	0	0	Surgery
	111		1982	30,000	7,137	0	Surgery
4C	112	Gardner	1980	0	0	0	Improper Care
	122		1979	10,000	0	0	Surgery
	114		1982	10,000	205	0	Birth Control
4D	111	Clay Center	1982	0	0	0	Improper Care
	111		1982	10,000	1,000	0	Surgery
4E	114	Topeka	1984	0	100	163	Incorrect Diagnos
	115		1981	0	1,084	81	Doctor's Advice
	115		1983	0	3,202	611	Incorrect Diagnose
	115		1983	0	1,228	511	Incorrect Diagnose
4F	115	Wichita	1981	0	0	93	Prescription Error
	115		1983	0	332	2	Surgery
4G	112	Horton	1984	0	2,096	204	Improper Care
	112		1981	0	2,716	216	Incorrect Diagnose
	112		1981	2,500	0	34	X-Ray
	112		1981	2,500	0	0	Improper Care
4H	113	Hillsboro	1984	15,000	16,579	6,930	Miscellaneous
	113		1984	0	1,569	6,000	Incorrect Diagnose
4I	114	Overland Park	1984	0	14,521	4,682	Birth Related
	114		1984	1,000	99	1,430	Birth Control
4J	113	Topeka	1981	0	323	0	Improper Care
	113		1982	2,200	2,076	0	Post-Op Infection

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
4K	112	Hoisington	1981	45,000	500	0	Improper Care
	112		1981	0	487	0	Doctor's Advice
4L	114	Topeka	1981	1,000	2,039	337	Surgery
	114		1983	7,500	1,776	273	Surgery
4M	112	Kansas City	1980	0	0	185	Surgery
	111		1982	21,667	16,972	350	Surgery
4N	113	Salina	1979	0	612.62	0	Surgery
	115		1980	0	13,894.01	0	Surgery
4O	114	Wichita	1982	25,000	4,591	1,885	Surgery
	114		1982	7,500	990	37	Improper Care
4P	111	Prairie Village	1981	40,000	13,934	9,738	Surgery
	111		1982	0	1,446	117	Incorrect Diagnos
	111		1982	100,000	7,117	1,201	Improper Care
4Q	112	Topeka	1980	12,500	2,310	524	Surgery
	113		1980	0	6,820	933	Improper Care
4R	111	Topeka	1981	0	1,512	0	Improper Care
	114		1981	0	0	0	Post-Op Infection
	000		1981	15,000	0	0	Surgery
	113		1982	343	0	0	Surgery
	113		1983	0	0	100	Anesthesiology
4S	111	Hutchinson	1979	0	641.62	68	Improper care
	111		1979	0	120	68	Incorrect Diagnos
4T	111	Ottawa	1982	0	0	75	Birth Related
	111		1984	500	1,484	68	Birth Related

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
4U	114	Kansas City	1979	0	6,576	855	Doctor's Advice
4V	180	Wichita	1984	5,000	0	735	Personal Injury
4W	114	Hays	1980	3,500	3,750	976	Improper Consent
4X	112	Topeka	1979	2,000	1,700	2	Birth Related
4Y	114	Kansas City	1979	1,000	444	39	Improper Care
4Z	114	Wichita	1978	25,000	4,132	1,541	Improper Consent
	114		1978	15,000	0	0	Surgery
	114		1978	15,000	0	0	Surgery
	114		1979	1,000	490	102	Hysterectomy
5A	111	Shawnee	1980	0	0	55	Personal Injury
	114		1980	35,625	13,369	0	Doctor's Advice
5B	122	Eureka	1984	20,000		0	Incorrect Diagnos
5C	170	Newton	1982	1,250	0	0	Improper Consent
5D	114	Eureka	1981	0	0	0	Birth Related
5E	115	Kansas City	1983	7,500	1,284	54	Surgery
5F	115	Wichita	1983	0	0	0	Surgery
5G	114	Kansas City	1979	0	800	90	Incorrect Diagnos
5H	115	Wichita	1978	0	15,231	3,345	Post-Op Infection
	115		1979	35,000	4,801	1,924	Surgery
	115		1979	0	90.75	0	Surgery

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
5I	111	Wichita	1980	200,000	11,932	4,067	Incorrect Diagnose
	111		1982	99,000	2,525	437	Incorrect Diagnose
	111		1982	100,000	1,313	213	Incorrect Diagnose
	111		1982	100,000	1,262	219	Incorrect Diagnose
5J	112	Kansas City	1979	0	0	0	Surgery
	112		1979	0	0	0	Surgery
5K	114	Wichita	1982	0	672	50	Birth Related
	114		1982	0	1,196	196	Birth Related
5L	113	Kansas City	1982	40,000	9,442	0	Surgery
	115		1984	30,000	8,012	0	Surgery
5M	170	Topeka	1979	6,215	470	79	Dental
	170		1979	5,218	505	85	Dental
5N	114	Wichita	1982	9,000	3,209	1,115	Improper care
	114		1983	100,000	1,201	40	Surgery
	114		1984	90,000	8,367	18,653	Improper Care
	114		1984	100,000	9,822	3,449	Surgery
	114		1982	8,500	293	17	Surgery

DOCTOR	SPECIALITY	CITY	YEAR CLOSED	LOSS	DEFENSE	OTHER	CAUSE
6A	114	Kansas City	1982	9,500	2,515	469	Surgery
	114		1983	200,000	12,373	3,207	Surgery
6B	111	Wichita	1981	0	1,288	0	Incorrect Diagnose
	111		1982	0	0	0	Falls
6C	114	Topeka	1982	0	0	0	Hysterectomy
	114		1981	7,500	0	536	Hysterectomy
	114		1983	145,000	18,000	0	Birth Related

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled		Amount	Primary or Excess
					Fiscal Year 1977					
(1)		M.D.	Surgery	7	7/76	9/76	2/22/77		137,500	Excess
								TOTAL	137,500	
					Fiscal Year 1978			TOTAL	0	
					Fiscal Year 1979					
(2)		M.D. 80612	Birth Control, Abortion	4	5/77	3/78	10/12/78		2,500	Primary
(3)		80612	Fall	3	7/78	9/78	3/30/79		205,143	Excess
(4)		M.D.	Surgery Related	2	10/76	4/78	6/19/79		750	Primary
								TOTAL	208,393	
					Fiscal Year 1980			TOTAL	0	
					Fiscal Year 1981					
(5)		D.P.M.	Post-Op Infection	5	12/78	11/79	7/21/80		8,500	Primary
(6)		80422 80999	Incorrect Diagnosis	6	4/78	3/79	7/28/80		255,047	Excess
(7)		M.D.	Incorrect Diagnosis	5	7/77	7/79	9/1/80		650	Primary
(8)		80612	Improper Care	9	12/80	2/81	4/3/81		200,000	Excess
(9)		M.D., P.A.	Birth Control, Abortion	5	9/76	6/80	4/24/81		59,500	Primary

Attachment XXVIII

Att. XXVIII
9/12-13/85

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(10)		80999 - Corp 80153 80154 80153 80153	Birth Related	7	12/77	3/80	5/27/81	214,485	Excess
(11)		80152 80152	Surgery Related	2	3/77	2/79	6/15/81	35,000	Excess
(12)		M.D. 80153 80612 80999 80151 M.D.	Birth Related	8	8/76	7/78	6/25/81	1,000,000	Excess
							TOTAL	1,773,182	
				Fiscal Year 1982					
(13)		M.D.	Improper Care	2	5/79	3/81	7/24/81	1,000	Excess
(14)		80612 80151 M.D.	Surgery	2	1/78	3/80	7/30/81	1,000	Excess
(15)		M.D.	Improper Care	1	6/78	11/79	8/3/81	30,000	Excesss
(16)		84534	Birth Related	8	10/77	5/79	8/14/81	600,000	Excess
(17)		M.D.	Improper Care	3	5/77	9/79	10/1/81	4,000	Primary
(18)		M.D.	Improper Care	3	6/80	2/81	10/21/81	17,500	Primary
(19)		M.D.	Incorrect Diagnosis	6	8/76	3/78	10/26/81	900,000	Excess
(20)		M.D.	Incorrect Diagnosis	5	8/76	3/78	10/26/81	14,000	Excess
(21)		M.D.	Incorrect Diagnosis	6	7/76	5/79	10/26/81	95,000	Excess
(22)		80612 80273	Birth Related	9	11/79	10/81	10/30/81	40,000	Excess

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(23)		80612 M.D.	Incorrect Diagnosis	9	9/77	9/79	11/30/81	7,000	Excess
(24)		M.D.	Anesthesiology	9	11/78	9/80	12/4/81	75,000	Excess
(25)		M.D.	Birth Control, Abortion	5	3/77	11/79	1/4/82	1,200	Primary
(26)		80261	Incorrect Diagnosis	7	7/79	7/80	2/11/82	355,000	Excess
(27)		80269 80612 80259	Improper Care	9	10/77	10/81	3/1/82	122,154.65	Excess
(28)		84151 80960	Anesthesiology	9	10/79	5/80	3/9/82	62,500	Excess
(29)		80143 80145 M.D. 80534 80177 80612	Incorrect Diagnosis	9	11/77	11/80	3/26/82	3,750	Excess
(30)		80239	Birth Related	9	8/78	9/81	4/1/82	42,500	Excess
(31)		80266	Improper Care	6	5/81	1/82	4/8/82	65,000	Excess
(32)		80267 80999 80267 80117 80612	Illness from Drugs	8	3/79	4/80	4/15/82	156,022	Excess
(33)		M.D.	Surgery	6	11/78	10/80	5/13/82	117,500	Primary
(34)		80612	Fall	5	8/81	2/82	5/13/82	65,000	Excess

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled		Amount	Primary or Excess
(35)		M.D.	Psychiatric	1	11/79	8/80	6/24/82		200,000	Excess
(36)		80117	Illness from Drugs	7	5/78	5/80	6/24/82		85,000	Excess
								TOTAL	3,060,126	
					Fiscal Year 1983					
(37)		80154	Incorrect Diagnosis	5	11/80	11/81	7/22/82		113,622	Excess
(38)		80143 D.O.	Birth Control, Abortion	3	12/79	12/81	7/23/82		1,750	Excess
(39)		80421	Incorrect Diagnosis	6	12/77	6/80	7/28/82		180,000	Excess
(40)		80154 80280 80612	Illness from Drugs	7	5/77	5/78	8/30/82		95,000	Excess
(41)		80153 80612	Birth Related	7	7/78	1/81	9/15/82		982,000	Excess
(42)		M.D.	Surgery Related	5	9/78	9/80	10/8/82		12,000	Excess
(43)		80420 80154 80612	Improper Care	5	11/80	8/81	11/3/82		175,000	Excess
(44)		80421	Incorrect Diagnosis	9	6/79	4/81	11/22/82		275,000	Excess
(45)		80153 80153 80999	Illness from Drugs	6	7/76	12/77	1/6/83		25,000	Excess
(46)		80143 80999	Surgery Related	5	1/81	3/82	1/7/83		216,730	Excess
(47)		M.D. 80117	Vasectomy	4	5/77	7/79	1/18/83		20,000	Primary

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(48)		M.D.	Surgery	5	5/79	4/81	2/7/83	243,300	Excess
(49)		M.D.	Birth Related	7	2/79	10/81	2/28/82	443,426	Excess
(50)		M.D.	Incorrect Diagnosis	9	11/78	9/80	3/11/83	150,000	Excess
(51)		M.D.	Surgery	5	7/80	7/81	3/17/83	75,000	Excess
(52)		M.D.	Improper Care	9	3/82	10/82	3/30/83	150,000	Excess
(53)		M.D.	Birth Related	9	12/78	3/80	3/30/83	150,000	Excess
(54)		CRNA	Anesthesiology	9	6/81	10/81	5/4/83	170,000	Excess
(55)		M.D.	Incorrect Diagnosis	8	12/80	5/82	5/9/83	122,452	Excess
(56)		M.D.	Surgery	5	6/81	8/81	5/23/83	800,000	Excess
(57)		M.D.	Surgery	7	10/80	9/82	6/7/83	1,500,000	Excess
(58)		M.D.	Incorrect Diagnosis	9	1/79	2/80	6/1/83	275,255.47	Excess
(59)		M.D.	Incorrect Diagnosis	3	1/80	12/81	6/2/83	85,456.54	Primary & Excess
(60)		M.D.	Surgery	5	5/78	3/82	5/27/83	248,500	Excess
(61)		M.D.	Incorrect Diagnosis	9	7/80	7/81	6/15/83	5,758	Primary
							TOTAL	6,515,250	
					Fiscal Year 1984				
(62)		M.D.	Improper Care	6	5/79	7/81	7/5/83	28,400	Excess
(63)		M.D.	Improper Care	6	3/81	12/81	7/11/83	126,559	Excess

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(64)		M.D.	Incorrect Diagnosis	9	9/80	8/82	7/27/83	12,500	Primary
(65)		M.D.	Improper Care	7	10/79	7/82	8/4/83	25,000	Excess
(66)		M.D.	Birth Related	6	12/79	8/81	8/11/83	200,000	Primary & Excess
(67)		M.D.	Birth Related	8	7/77	10/79	8/12/83	1,200,000	Excess
(68)		M.D.	Surgery	6	11/80	9/82	9/29/83	750,000	Excess
(69)		M.D.	Surgery	4	3/80	10/81	10/19/83	75,000	Excess
(70)		M.D.	Incorrect Diagnosis	7	7/80	8/82	10/19/83	268,952	Primary
(71)		M.D.	Improper Care	5	7/80	7/82	10/25/83	40,000	Excess
(72)		M.D.	Surgery	5	1/80	10/82	10/31/83	1,900,000	Excess
(73)		M.D.	Improper Care	3	2/79	10/81	11/7/83	32,500	Excess
(74)		Hospital	Incorrect Diagnosis	7	8/80	8/82	12/2/83	17,205	Excess
(75)		CRNA	Anethesia	9	5/80	11/81	12/7/83	65,000	Excess
(76)		M.D.	Surgery	5	9/78	8/80	12/13/83	115,000	Excess
(77)		Hospital	Improper Care	9	11/78	11/80	12/19/83	320,000	Excess
(78)		Hospital	Anethesia	7	7/80	8/82	1/19/84	150,000	Excess
(79)		Hospital/ Doctor	Improper Care	9	1/82	10/82	2/23/84	390,000	Excess
(80)		M.D.	Incorrect Diagnosis	9	6/81	10/81	1/9/84	500,000	Excess
(81)		M.D.	Surgery	5	5/80	11/81	1/26/84	550,000	Primary

	File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(82)		M.D./ Hospital	Surgery/ Incorrect Diagnosis	5	12/76	4/82	2/16/84	101,700	Primary & Excess
(83)		M.D.	Surgery/ Incorrect Diagnosis	5	12/81	7/82	2/1/84	7,000	Primary
(84)		M.D.	Birth Related	7	3/80	3/82	2/14/84	567,182	Excess
(85)		M.D.	Surgery	5	8/80	8/82	2/28/84	100,000	Excess
(86)		M.D.	Incorrect Diagnosis	9	6/82	4/83	3/16/84	50,000	Excess
(87)		CRNA	Anesthesiology	9	11/79	4/81	4/3/84	686,166	Excess
(88)		M.D.	Surgery	9	8/78		4/13/84	1,150,000	Excess
(89)		M.D.	Surgery	9	3/80	4/82	4/15/84	300,000	Excess
(90)		M.D.	Incorrect Diagnosis		1/78	9/80	4/27/84	30,800	Excess
(91)		M.D.	Incorrect Diagnosis	6	2/81	2/83	5/15/84	331,786	Excess
(92)		M.D.	Surgery	9	6/80	3/82	6/1/84	50,000	Excess
(93)		M.D.	Incorrect Diagnosis	3	6/80	6/82	6/ /84	99,040	Excess
(94)		M.D.	Incorrect Diagnosis	3	4/79	12/81	6/18/84	30,000	Primary
(95)		M.D.	Incorrect Diagnosis	9	2/81	11/82	6/20/84	186,664	Excess
							TOTAL	10,456,454	
					Fiscal Year 1985				
(96)		M.D./ Hospital	Anesthetic	9	10/82	2/83	7/24/84	339,081	Excess
(97)		M.D.	Birth Related	8	5/81	2/84	7/23/84	447,479	Excess
(98)		M.D.	Surgery	5	7/81	7/83	8/ /84	35,000	Primary

File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(99)	M.D.	Improper Care	3	1/82	1/84	8/ /84	1,500	Primary
(100)	M.D.	Improper Care	3	3/81	3/83	7/9/84	22,500	Primary
(101)	M.D.	Surgery	5	4/82	2/83	8/4/84	175,000	Excess
(102)	M.D.	Improper Care	9	10/82	12/83	8/ /84	239,375	Excess
(103)	M.D./ Hospital	Birth Related	8	1/83	1/84	8/17/84	760,358	Excess
(104)	Hospital	Miscellaneous	1	12/81	11/82	9/20/84	100,000	Excess
(105)	M.D./ Hospital	Birth Related	6	7/78	5/82	9/25/85	175,000	Excess
(106)	M.D.	Surgery	1	3/81	3/83	9/25/84	195,000	Excess
(107)	Hospital	Improper Care	4	9/82	10/83	10/4/84	143,348	Excess
(108)	M.D./ Hospital	Birth Related	6	4/80	4/82	10/10/84	1,550,000	Excess
(109)	M.D./P.A.	Surgery	9	3/82	12/82	11/13/84	96,483	Excess
(110)	M.D.	Improper Care	3	5/81	5/83	11/21/84	20,000	Primary
(111)	D.C.	Improper Care	5	2/81	10/82	11/21/84	4,900,000	Excess
(112)	M.D./ Hospital/ CRNA	Anesthesiology	5	8/80	10/81	11/27/84	841,937	Excess
(113)	M.D./P.A.	Surgery	5	9/80	10/83	12/3/84	289,300	Excess
(114)	M.D.	Birth Related	7	11/79	11/81	12/6/84	1,140,000	Excess
(115)	M.D./P.A.	Surgery	5	2/81	9/82	12/7/84	187.500	Excess

File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(116)	M.D.	Birth Related	8	5/79	5/83	12/13/84	395,000	Excess
(117)	D.C.	Improper Care	5	2/81	10/82	2/4/85	1,600,000	Excess
(118)	M.D., D.O.	Surgery	4	11/81	1/83	2/6/85	110,903	Primary
(119)	M.D., P.A.	Surgery	5	1/81	2/83	2/7/85	292,865	Excess
(120)	M.D.	Birth Related	7	4/79	4/83	2/28/85	521,426	Excess
(121)	M.D.	Surgery (resulting in lost kidney)	6	9/81	9/83	3/5/85	10,000	Excess
(122)	D.O.	Birth Related	9	11/81	10/83	3/11/85	15,622	Primary
(123)	P.A., Hosp. D.O., D.O.	Birth Related	8	12/83	11/84	3/15/85	835,516	Excess
(124)	M.D.	Surgery	6	4/82	4/84	3/15/85	170,000	Primary
(125)	M.D.	Improper Care Emergency Room	9	9/79	8/81	3/19/85	168,433	Excess
(126)	M.D.	Improper Care	3	2/82	2/84	3/27/85	1,500	Primary
(127)	M.D.	Back Surgery	5	7/81	7/83	4/2/85	250,278	Excess
(128)	M.D., Hosp.	Birth Related	7	3/77	1/82	4/4/85	68,500	Excess & Primary
(129)	D.O., Hosp.	Improper Care Emergency Room	9	12/80	1/83	4/5/85	27,887	Excess
(130)	P.A., M.D.	Surgery	5	2/80	3/84	4/8/85	390,000	Excess
(131)	M.D.	Improper Care of Diabetic Patient Following Surgery	5	11/82	3/84	4/10/85	408,725	Primary

File #	Provider by ISO Class Code	Type of Injury	Severity	Date of Occurrence	Date HCSF Notified	Date Settled	Amount	Primary or Excess
(132)	Hospital	Improper Care-Administration of Test	5	7/82	4/83	5/3/85	39,125	Excess
(133)	Hospital M.D., P.A.	Failure to Notify Patient of Lab Results	8	7/84	2/85	5/15/85	250,000	Excess
(134)	M.D.	Surgery Tubal Ligation	4	2/83	5/84	5/17/85	15,622	Primary
(135)	M.D.	Emergency Room Treatment Following Car Accident	9	2/83	1/85	6/5/85	5,000	Primary
(136)	M.D.	Incorrect Diagnosis	8	2/83	7/84	6/19/85	788,997	Excess
						TOTAL	13,124,261	
						GRAND TOTAL	35,275,164	

Insurance Committee
9/11/85

AVERAGE MEDICAL DOCTOR PROFESSIONAL LIABILITY
INSURANCE PREMIUM COST - KANSAS
($200,000/$600,000 Limits, As of July 1, 1985)
PROJECTIONS - NOT ACTUAL DATA

Average Premium Cost by Insurer

A. St. Paul Fire and Marine Insurance Company 1,430* insured doctors	$ 6,656
B. The Medical Protective Company 839* insured doctors	$ 4,064
C. Other insurance companies and the Health Care Provider Insurance Availability Plan 676 insured doctors	$ 6,510
Statewide Average Medical Doctor Premium Cost	$ 5,743
Add Health Care Stabilization Fund Surcharge (110%)	$ 6,317
Total Statewide Average Medical Doctor Premium and HCSF Surcharge Cost	$12,060

* Number of Medical Doctors based on HCSF Compliance data as of June 6, 1985

9/12-13/85
Attachment XXIX

ST. PAUL FIRE AND MARINE INSURANCE COMPANY

Class	Premium	No. of M.D.'s	Total Premium
I	$ 2,676	548	$1,466,448
II	3,956	194	767,464
III	5,236	146	764,456
IV	7,028	48	337,344
V	10,750	304	3,268,000
VI	12,079	95	1,147,505
VII VIII	16,065))18,059 20,052)	88	1,589,192
IX	25,368	7	177,576
		1,430	$9,517,985
		Average Premium	$6,656

THE MEDICAL PROTECTIVE INSURANCE COMPANY

Class	Premium	No. of M.D.'s	Total Premium
I	$ 1,363	297	$ 404,811
II	2,522	201	506,922
III	3,408	90	306,720
IV	4,771	40	190,840
V	8,451	114	963,414
VI	9,814	50	490,700
VII	11,586	44	509,784
VIII	12,267	3	36,801
		839	$3,409,992
		Average Premium	4,064

OTHER INSURANCE COMPANIES AND HCPIA PLAN

Class	Premium	No. of M.D.'s	Total Premium
I	$ 1,924	241	$ 463,684
II	3,608	66	238,128
III	4,785	61	291,885
IV	6,450	44	283,800
V	10,851	126	1,367,226
VI	11,461	85	974,185
VII	13,899	41	569,854
VIII	17,666	12	211,992
		676	$4,400,759
		Average Premium	$6,510

MEMORANDUM

August 29, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: Physician Income

The American Medical Association (AMA) does an annual survey and summary of physician income which is reported in an AMA publication entitled Socio-Economic Characteristics of Medical Practice. The latest data available from the annual survey is for calendar year 1983. The data for 1984 is currently at the printers and is expected to be available in about six weeks. However, the AMA cannot release the 1984 data until the publication is available and released.

The AMA survey is summarized by census divisions, i.e., Kansas is included in the data for the West North Central States Division. This division includes Kansas, Iowa, Minnesota, Missouri, North Dakota, South Dakota, and Nebraska.

The summary physician income data is given as average physician income after expenses are deducted, but before taxes are deducted. On this basis, the average physician income for the West North Central states in 1983 was $110,500 annually, compared to all physician income (nationwide) of $106,300 annually in 1983. The average professional liability premium for physicians in the West North Central states was $4,900 in 1983.

Although data is not compiled by census divisions by medical specialty, national average income data is compiled by practice specialty. The data below under the heading of income represents income after the deduction of expenses, but before taxes.

1983 Physician Income

Specialty	Income
General and Family Practice	$68,500
Internal Medicine*	93,300
Surgery (except OB-GYN)	145,500
Pediatrics	70,700
Obstetrics and Gynecology	119,900
Radiology	148,000
Psychiatry	80,000
Anesthesiology	144,700
Pathology	117,700
All Physicians	106,300

* Includes all subspecialties

Source: American Medical Association

7/12-15/25
Attachment XXX

S85-251/EC

MEMORANDUM

September 11, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: Malpractice Insurance Rate Setting — Commonwealth of Virginia

In response to a request that staff provide information concerning malpractice insurance rate setting in the Commonwealth of Virginia, the following information has been obtained from Mr. Paul Synnott, Deputy Commissioner of Insurance, Commonwealth of Virginia.

Rate standards are governed by VA. CODE § 38.1-279.33. "Rates shall not be excessive or inadequate. . . nor shall they be unfairly discriminatory." (§ 38.1-279.33(a)). Subsection (b) of this statute specifies that in determining whether rates meet this standard, "due consideration shall be given to past and prospective loss experience within and outside this State . . . ." When an insurer submits a rate filing for approval, if the statistical evidence indicates that the statewide figures are credible, these figures will be used. "Credible" in this context means "actuarially sound," that is, the number of insureds and the number of claims are sufficient as a base for the statistical probability analysis performed by actuaries.

For rate filings submitted for medical malpractice insurance, companies are required to use only the statewide data in their ratemaking base. One rationale given is that countywide data could reflect jury awards of a magnitude not generally awarded in Virginia. In cases when Virginia data are filed, the Commissioner may or may not request countrywide data for comparative purposes. In any case, the insurer may request a hearing concerning the appropriateness of the state-only based filings.

The following table lists the major malpractice insurance writers in Virginia and their respective market penetration.

Insurance Company	% of Premium Volume		% of Market by No.	
	Doctors	Hospitals	Doctors (10,000)	Hospitals (85)
Pennsylvania Casualty	16.2%	39.6%	28.8%	3.5%
St. Paul Fire and Marine	60.6	3.1	40.0	15.3
Virginia Insurance Reciprocal	21.8	57.2	17.2	80.0

In all cases, statewide data are required in rate filings. For the Virginia Insurance Reciprocal, these would be the only data available, since that company does business only in Virginia. For the two other companies, the statewide data are credible. If the Pennsylvania Casualty statewide statistics were not credible, the Insurance Commissioner would require that the company use St. Paul's figures as a base.

9/12-13/85

Attachment XXXI

It should be noted that, although state data are used for the major portion of the malpractice policy ratemaking base, countrywide data are used for the "increased limits" portion of the rates, because Virginia does not experience many losses in amounts over $100,000.

85-271/MH

HOW DOCTORS' ECONOMIC PROFILES VARY IN 13 MAJOR STATES

There are big differences in earnings, expenses, patient-visit rates, and fees, our Continuing Survey reveals.

By Arthur Owens SENIOR EDITOR

More than three-fifths of the nation's population—and an even larger proportion of its patient-care physicians—are jammed into about one-fourth of the states: California, New York, Texas, Pennsylvania, Illinois, Ohio, Florida, Michigan, New Jersey, North Carolina, Massachusetts, Georgia, and Virginia. That's not to say, however, that all of those 13 states have high ratios of physicians to population; only five of them exceed the national average of 173 per 100,000.

Partly because of variations in those ratios, the economics of private practice differs greatly from state to state. To pinpoint some of those distinctions, MEDICAL ECONOMICS' latest Continuing Survey included breakdowns of practice earnings, expenses, patient-visit rates, fees, and other data for office-based M.D.s in each of the 13 most populous states.

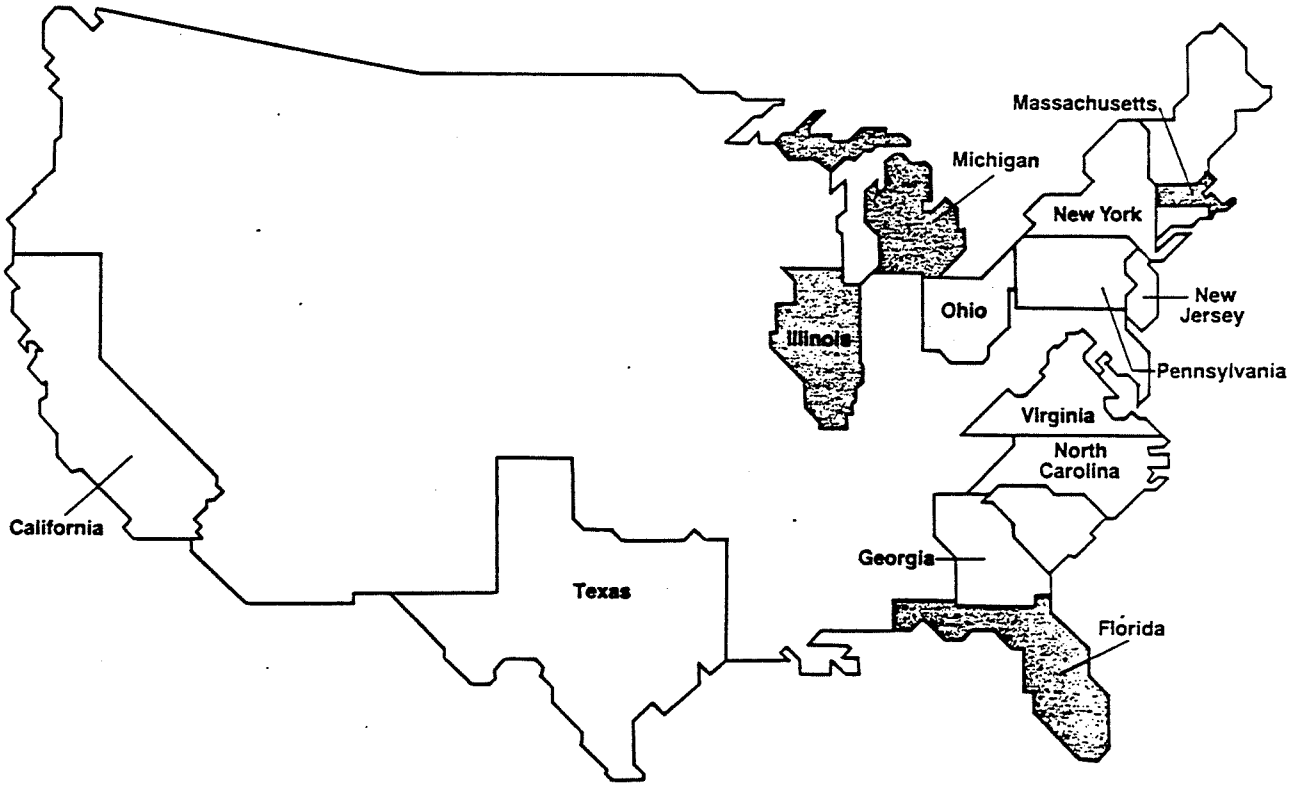
Detailed survey findings are reported in the accompanying charts, tables, and commentaries. Here are some highlights:

Professional expenses. This is the area of greatest variation from one state to another. Median per-doctor costs in 1982 were highest in Florida—$29,710 higher than in Virginia, at the bottom of the list, and $15,550 above the national median. Virginians also enjoyed the lowest expenses as percentages of gross receipts; the highest expense ratios were in California.

Fees. A comparison of early 1983 fees in California, at the top, with those in last-place North Carolina and Virginia shows that charges in the Golden State were $16 higher for first office visits and $7 higher for office revisits. Five years earlier, a MEDICAL ECONOMICS analysis of fees for the same services in 10 major states also showed them to be highest in California—47 percent higher for first office visits and 58 percent higher for revisits than in low-fee Virginia.

Patient-visit rates. Doctors are busiest in Pennsylvania these days, handling half again as many weekly visits as those in California, even though Pennsyl-

9/12-13/85
Attachment XXXII



COMPETITION IS GREATEST IN TWO NORTHEASTERN STATES

	Physicians per 100,000 population*
New York	239
Massachusetts	230
California	203
Pennsylvania	193
New Jersey	191
Illinois	173
Michigan	173

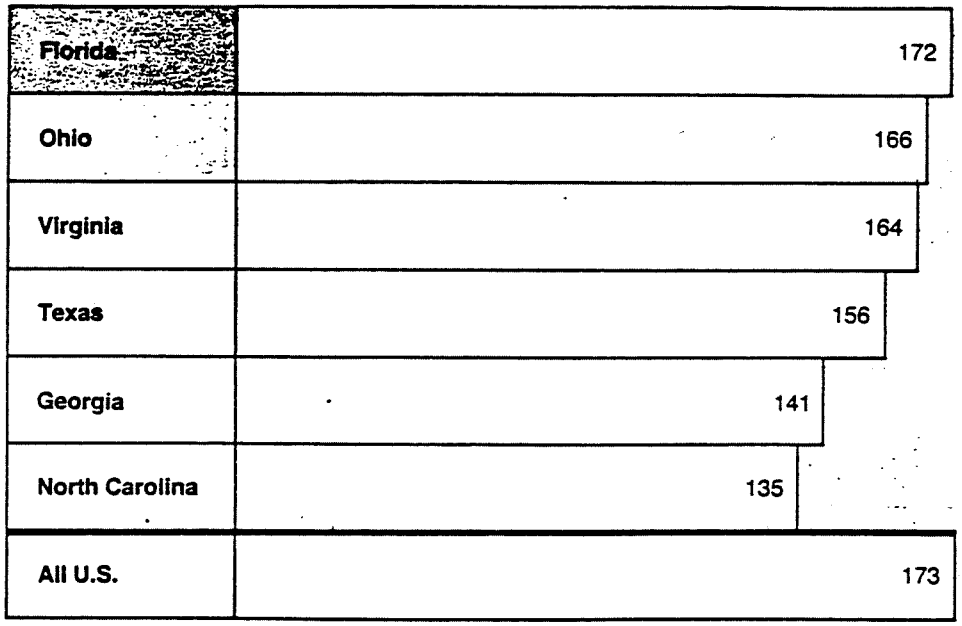
*Non-military M.D.s and D.O.s in patient care, including residents and hospital staff.
Sources: Clark-O'Neill Inc. and the U.S. Bureau of the Census.

vania has only about 5 percent fewer physicians per unit of population. It's the only state among those studied to have increased its median patient-visit rate since 1978 (by two visits weekly). The biggest five-year drops have been in Texas (a median loss of 36 visits per week), Michigan (32 visits), and Ohio (26 visits), as compared with a drop nationally of 14 visits.

Gross receipts. Earnings per doctor before expenses have been increasing everywhere, but at varying rates. Over the five years ended with 1982, annual gross grew as much as 62 percent in Florida and as little as 12 percent in New Jersey. Thus, in those five years, Florida climbed from second place (after Texas) among 10 states studied to first place among 13 (just ahead of Texas). New Jersey, which had been third, dropped to 11th place.

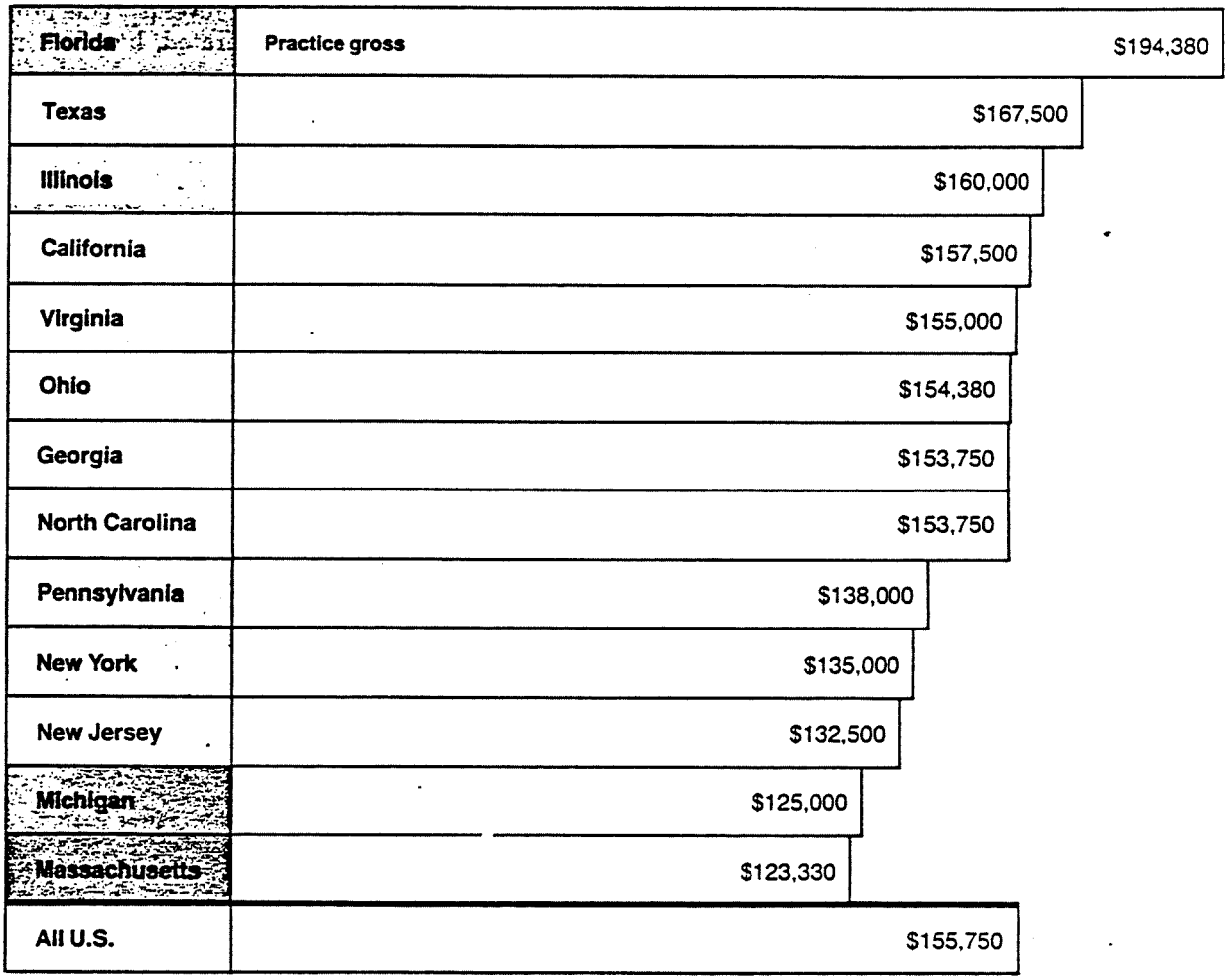
Net earnings. Doctors in Florida were the top earners, netting a median of $27,860 more in 1982 than their colleagues in Pennsylvania. The Floridians were 18 percent above the national norm, the Pennsylvanians 12 percent below it. The latter were also in last place in 1977, when earnings were highest in Virginia.

Incorporation. Corporate practice, whether solo or group, is now the choice of two-thirds of the nation's office-based M.D.s, the survey reveals. The proportion incorporated, however, rises to three-fourths in North Carolina, Florida, and Michigan, and drops to well below half in New York state.



FLORIDA M.D.s GROSS ONE-FOURTH MORE THAN THE U.S. AVERAGE

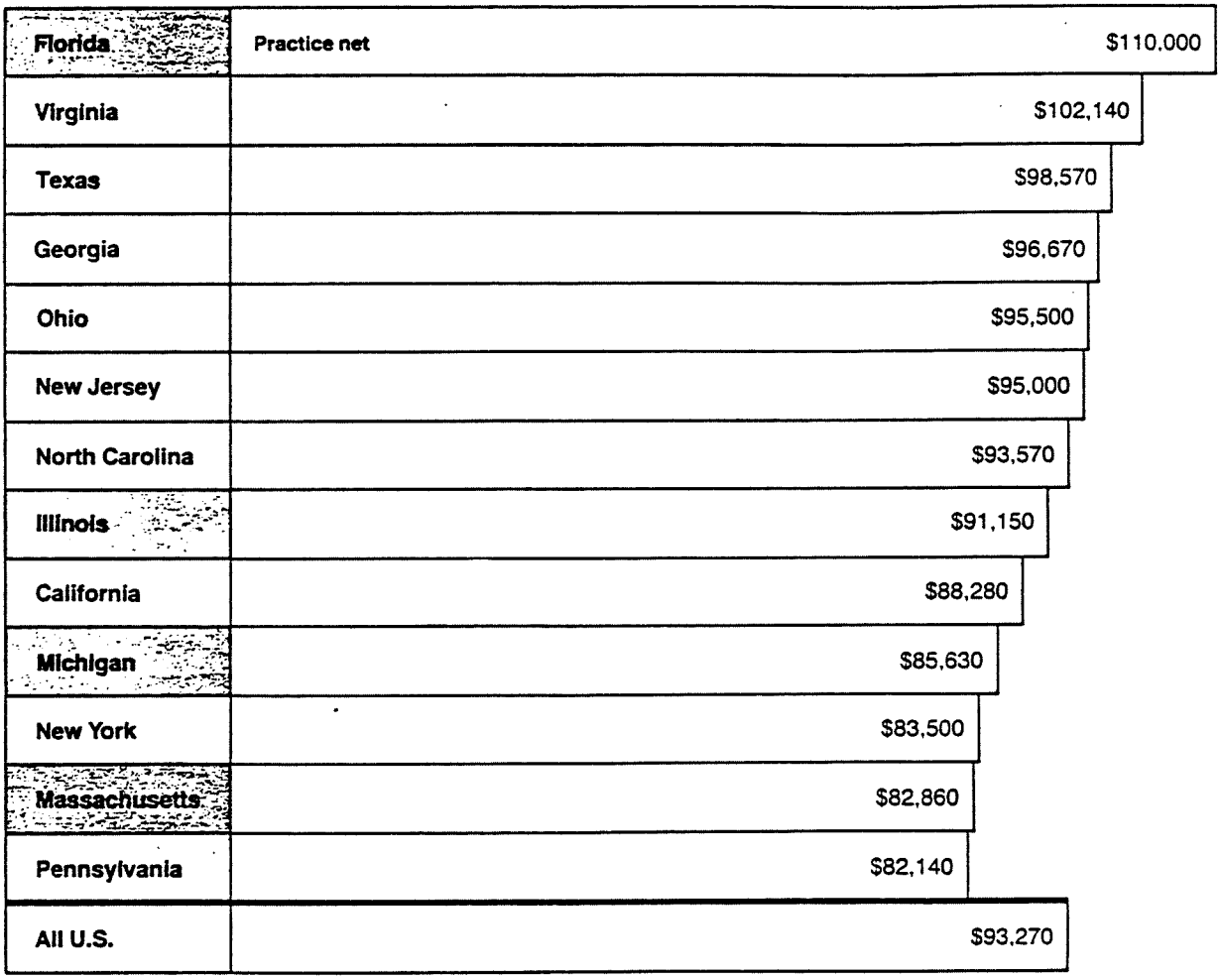
Gross receipts per Florida M.D. topped the countrywide median by 25 percent and the median for second-ranking Texas by 16 percent in 1982. Five years earlier, Texas was first in practice gross among 10 states studied—10 percent above Florida. Floridians also enjoyed the biggest five-year gain in annual gross—a median of 62 percent, as compared with 46 percent for all 50 states. The gains since 1977 in other states: Illinois, 61 percent; Pennsylvania, New York, and California, 51 to 48 percent; Virginia and Ohio, both 39 percent; Texas, 27 percent; Michigan, 26 percent; and New Jersey, only 12 percent.



Gross represents individual 1982 receipts from practice before expenses. Figures are medians. Except where otherwise indicated, data in this and the charts that follow apply to office-based M.D.s and are drawn from the MEDICAL ECONOMICS Continuing Survey.

FOUR SOUTHERN STATES ARE TOPS IN NET EARNINGS

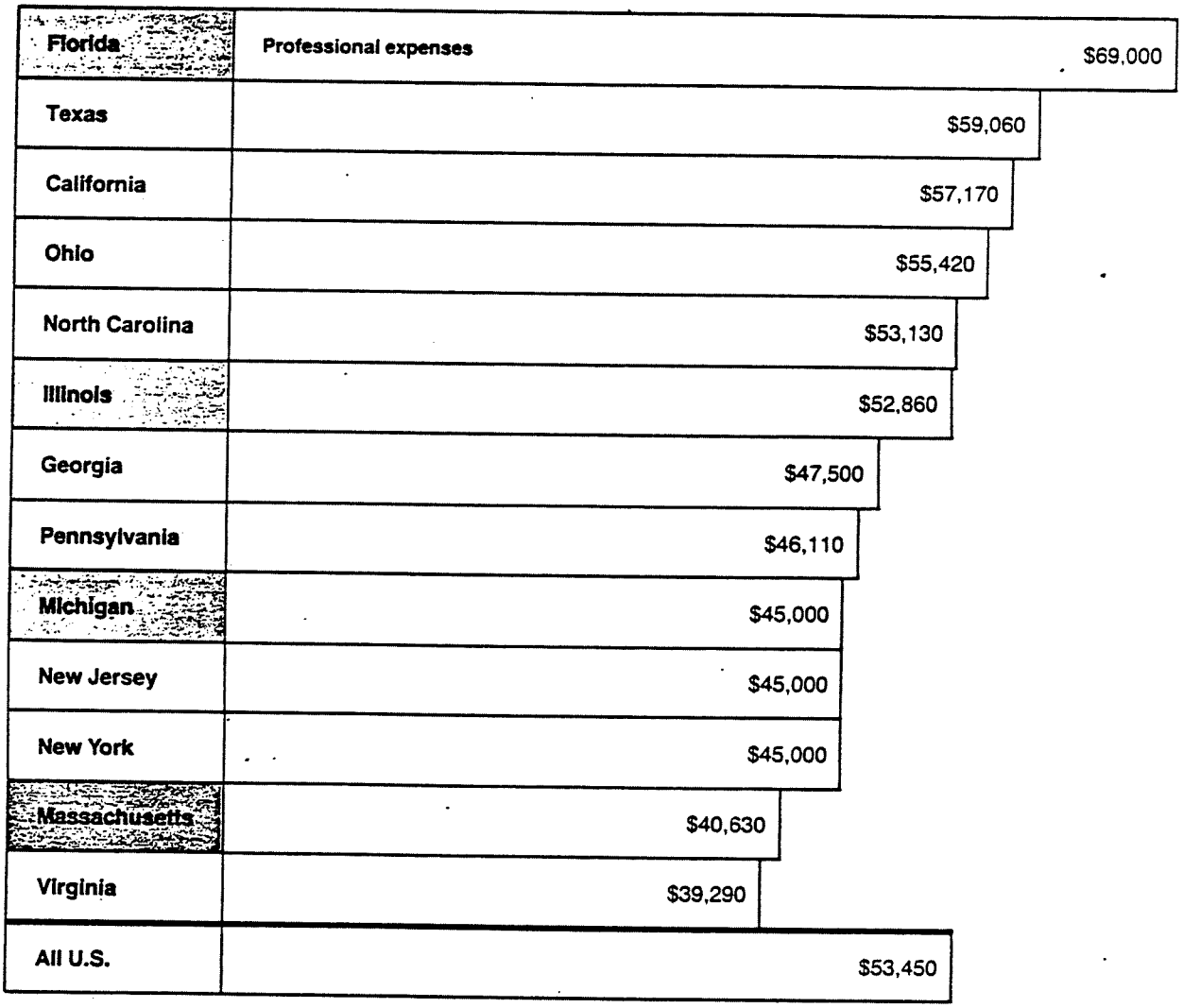
In both 1977 and 1982, the net-earnings leaders were M.D.s in Florida, Virginia, and Texas. However, Florida jumped from third to first place during the five-year interval. The five-year gain in annual net for all states was 43 percent. Florida beat that with a medi-an increase of 52 percent, while Illinois gained 48 percent and New York 43 percent. Below the all-U.S. medians in both years were Pennsylvania, New York, Michigan, California, and Illinois. Earnings in Massachusetts fell below the national norm in 1982.



For unincorporated M.D.s, net represents income from practice minus tax-deductible professional expenses, but before income taxes; for incorporated M.D.s, total compensation from practice (salary, bonuses, and retirement set-asides). Figures are medians for 1982.

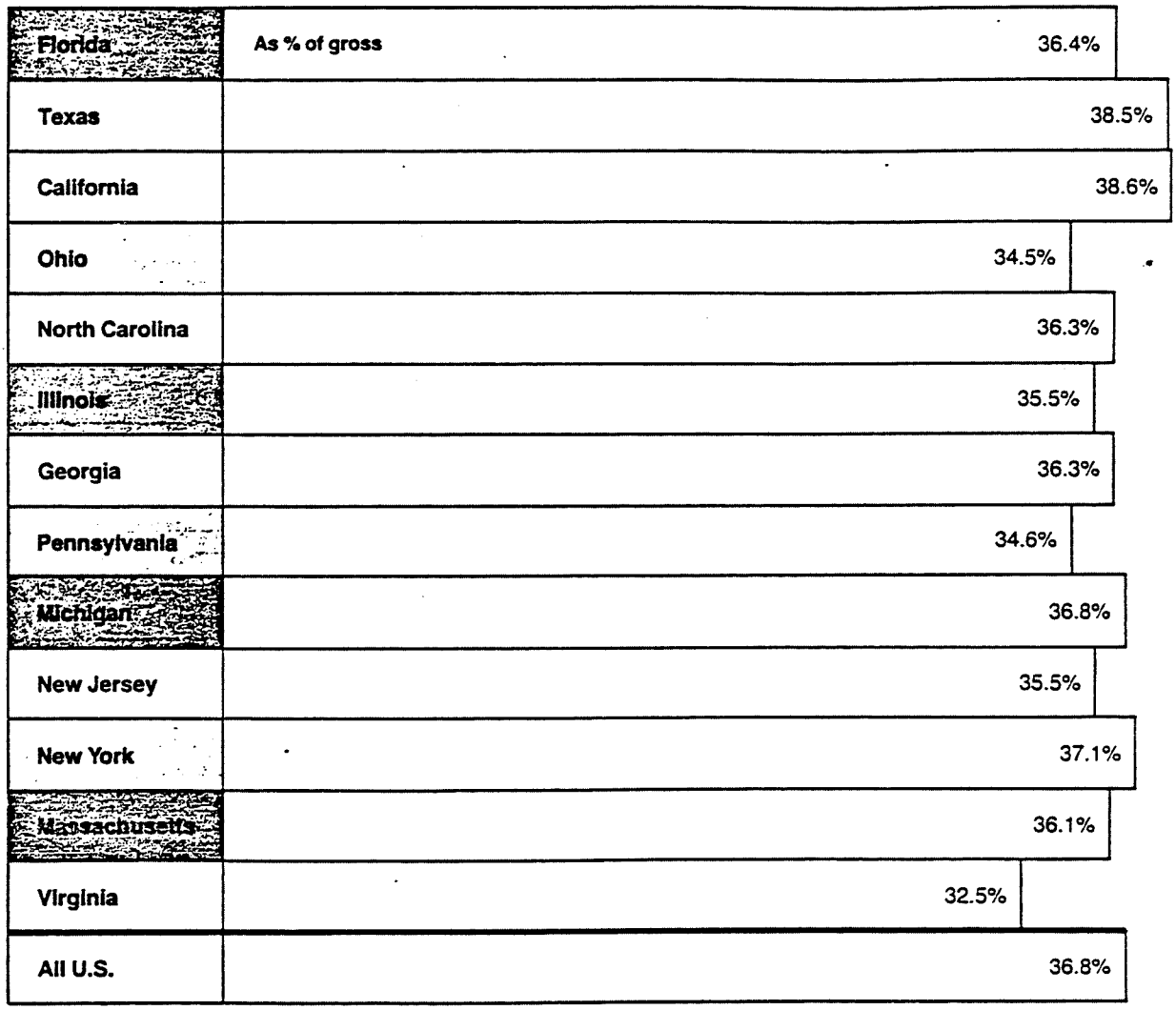
PRACTICE COSTS: 76% HIGHER IN FLORIDA THAN IN VIRGINIA

Although 1982 professional expenses were higher in Florida than in any of the other 12 states singled out in the survey, physicians there also wound up with the highest earnings both before and after expenses. And the Floridians spent a lower median percentage of gross receipts than most colleagues in other states. The most favorable ex-



Professional expenses are per M.D. and refer to tax-deductible items only. Figures are medians for 1982.

pense ratios among the states studied were in Virginia and Ohio, the least favorable in California and Texas. Over five years, the biggest advances in dollar costs were in Florida (73 percent), Pennsylvania (60 percent), New York (50 percent), Ohio (47 percent), and California (44 percent), compared with a 41 percent rise nationwide.



MEDIAN EXPENDITURES FOR MAJOR ITEMS IN 13 STATES

Florida doctors, who have the highest total expenses, also lay out the most dollars for office space, malpractice insurance, and depreciation on medical equipment, but not for the other items listed here. Texans spend the most on office payroll, New Yorkers the least. Expenditures for office rent or mortgage payments are lowest in North Carolina. Drugs and medical supplies cost Georgia doctors the

	Office payroll[1]		Office space[2]		Drugs and medical supplies[3]	
	In $	As % of gross	In $	As % of gross	In $	As % of gross
Florida	$30,420	11.8%	$11,700	4.8%	$5,080	3.4%
Texas	32,000	11.3	10,830	4.6	4,130	3.1
California	24,330	12.5	10,590	5.8	4,250	3.5
Ohio	24,290	12.1	7,880	4.5	3,800	3.5
North Carolina	31,360	16.7	7,000	4.8	4,630	3.8
Illinois	23,930	12.3	10,000	5.3	4,100	3.4
Georgia	26,250	10.8	10,000	6.1	6,750	3.8
Pennsylvania	25,360	12.1	7,170	4.1	3,400	3.6
Michigan	26,070	12.7	9,630	5.7	4,500	3.2
New Jersey	21,670	12.5	9,250	5.0	3,500	3.6
New York	20,750	13.5	9,570	5.8	3,570	3.3
Massachusetts	23,060	13.9	7,500	5.7	2,500	3.2
Virginia	27,220	13.5	8,380	4.8	5,170	3.3
All U.S.	26,410	12.8	9,520	5.0	4,260	3.5

[1]Includes salaries, bonuses, and retirement-plan contributions, if any, for non-physician employees only. [2]Rent or mortgage payments. [3]Includes non-depreciable small instruments. [4]Includes depreciation. [5]Includes registration fees, cost of materials and travel, meals and lodging for doctor only. All figures are medians per physician, based on only those M.D.s who reported some 1982 expense of the type indicated.

most and those in Massachusetts the least. New Jerseyites' car costs are the highest—largely because auto insurance is extremely expensive in their state—and North Carolinians' are the lowest. Expenditures for malpractice insurance, too, are lowest in North Carolina, and the figures on medical-equipment depreciation are lowest in Illinois.

Malpractice-insurance premiums		Professional-car upkeep[4]		Depreciation on medical equipment		Continuing education[5]	
In $	As % of gross	In $	As % of gross	In $	As % of gross	In $	As % of gross
$6,000	3.7%	$4,000	3.3%	$3,670	3.1%	$2,000	3.1%
2,800	3.1	3,950	3.3	3,000	3.3	1,750	3.0
5,660	3.8	4,090	3.4	2,550	3.2	1,670	3.1
4,300	3.4	3,000	3.1	2,300	3.2	1,500	3.1
1,400	3.2	2,250	3.2	2,880	3.2	1,500	3.1
3,430	3.4	3,460	3.2	1,500	3.0	2,000	3.0
3,500	3.4	3,250	3.4	3,000	3.3	1,500	3.0
3,830	3.5	3,390	3.3	2,300	3.0	1,630	3.1
2,630	3.5	3,000	3.2	2,060	3.0	2,060	3.2
4,000	4.1	4,500	3.7	2,500	3.4	2,000	3.1
5,250	4.2	3,600	3.3	2,090	3.1	1,670	3.1
1,440	3.1	3,190	3.3	2,170	3.1	2,000	3.1
2,850	3.2	3,130	3.2	2,250	3.1	1,500	3.0
3,840	3.5	3,350	3.2	2,550	3.2	1,930	3.1

HIGH PATIENT VOLUME DOESN'T ALWAYS MEAN HIGH EARNINGS

Low patient-visit rates tend to produce unimpressive earnings, even when fees are relatively high. In California and New York, median visits per week are well below the national norm, no doubt due to unusually high ratios of doctors to population. Office-visit fees in both states are high. Yet in California, median gross is only slightly above the national norm, and in New York, it's well below that mark. Pennsylvania, with the highest median patient-visit rate, ranks only ninth among the 13 states in gross, and that's at least partly due to relatively low fees. Florida, with above-average visit rates *and* high fees tops all others in earnings.

Patient visits are per M.D. per week. Figures are medians representing the total of visits in office, hospital, home, and other locations during which the physician personally saw the patient during a representative full workweek in the spring of 1983. Pathologists have been omitted from the tabulations.

	Patient visits per M.D. per week
Pennsylvania	131
North Carolina	130
Illinois	127
Texas	121
Virginia	121
Georgia	119
Florida	117
Ohio	114
New Jersey	112
Massachusetts	110
Michigan	110
New York	101
California	88
All U.S.	112

OFFICE-VISIT FEES ARE HIGHEST IN CALIFORNIA

Fees shown are medians representing M.D.s' usual charges early in 1983. Anesthesiologists, pathologists, psychiatrists, and radiologists have been excluded from the tabulations.

	Initial office visit	Office revisit
California	$41	$26
New Jersey	41	25
Florida	40	25
New York	36	25
Massachusetts	35	25
Georgia	31	21
Texas	30	21
Pennsylvania	30	20
Ohio	28	20
Illinois	26	20
Michigan	26	20
North Carolina	25	19
Virginia	25	19
All U.S.	31	21

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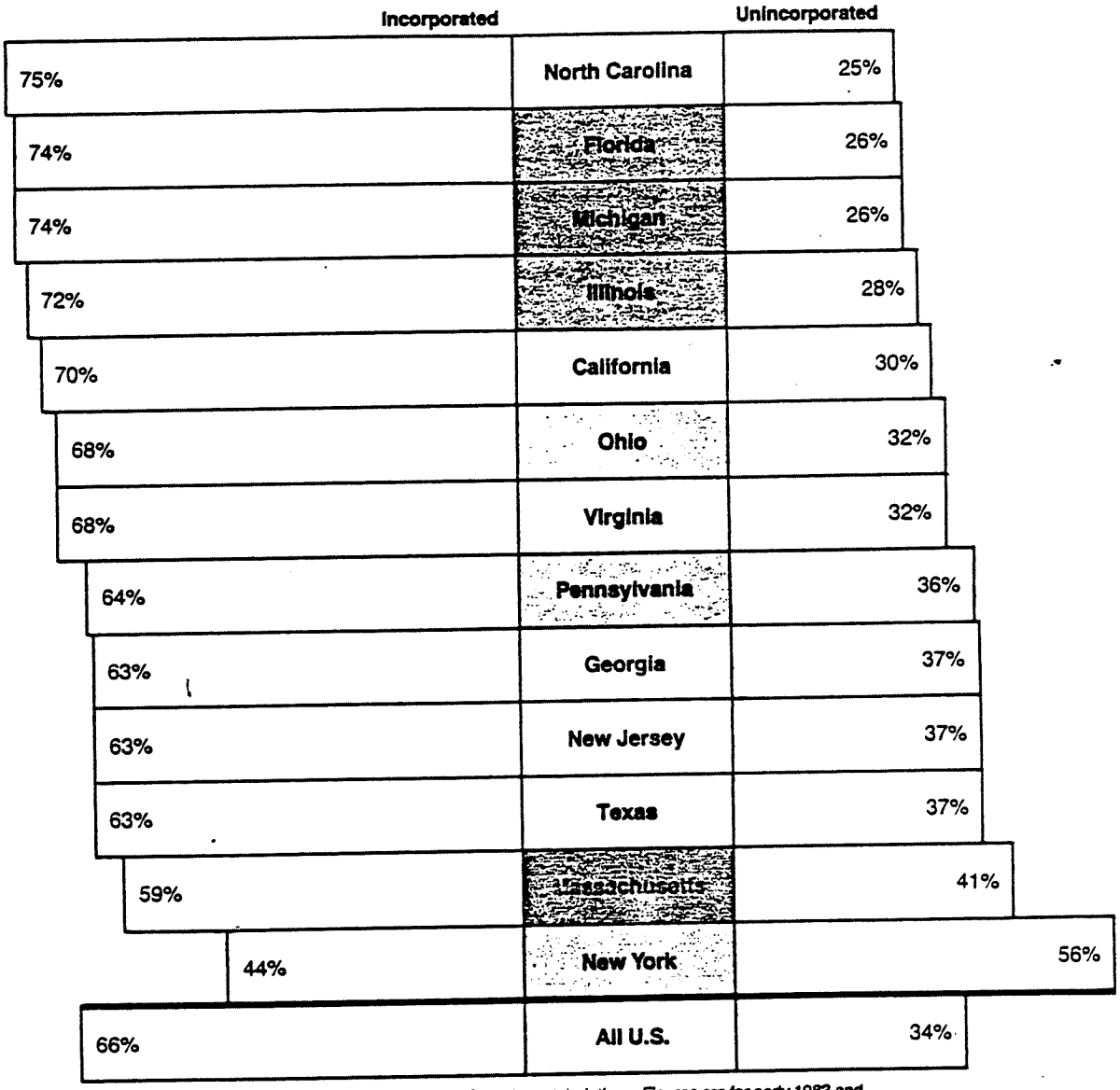
INCORPORATION: STRONGEST IN NORTH CAROLINA, WEAKEST IN NEW YORK



Non-shareholding physician employees have been excluded from these tabulations. Figures are for early 1983 and apply to office-based M.D.s only. ■

CITY VS. COUNTRY PRACTICE: WHICH PAYS OFF BEST TODAY?

With a few exceptions, the money's not in rural practice, but the cost of living is attractive—and so is the lack of competition.

By Jane See White SENIOR EDITOR

More and more office-based physicians are finding themselves economically up against the wall as this new era of doctor glut and heightened competition gathers momentum. What to do?

For some the answer is throwing in the towel and taking a salaried job with an HMO or convenience clinic. Others are making the costly, time-consuming leap into less crowded and more lucrative specialties. And still others are moving out to rural locales where fewer physicians are competing for patients and traditional practice still dominates the field.

Is moving to the country a good way to keep your head above water? The latest MEDICAL ECONOMICS Continuing Survey highlights the economic pros and cons. The survey shows that office-based M.D.s still tend to congregate in urban areas—52 percent practice in cities, compared with 32 percent in the suburbs and 16 percent in rural areas. But growing numbers are putting the metropolitan field behind them: The number of rural physicians increased 23 percent between 1974 and 1978, and it's still going up.

It remains true that urban practitioners generally earn more than their suburban or rural counterparts. However, there are some interesting exceptions. General surgeons, family physicians, and general practitioners who practice in the country actually net more than their colleagues in the cities and suburbs, the survey reveals. Rural physicians in other fields don't do as well, but in many cases the rural median net income of $88,910 goes further than the $97,390 median of urban doctors.

Beyond their cost-of-living benefits, what accounts for the rural practitioners' relatively attractive practice situation? It's not that they charge more for their services. Historically, their fees have lagged behind those of urban and suburban physicians, and the survey data confirm that they still do. Nor is it cheaper to run a practice in the country. In fact, the practice expenses reported by ru-

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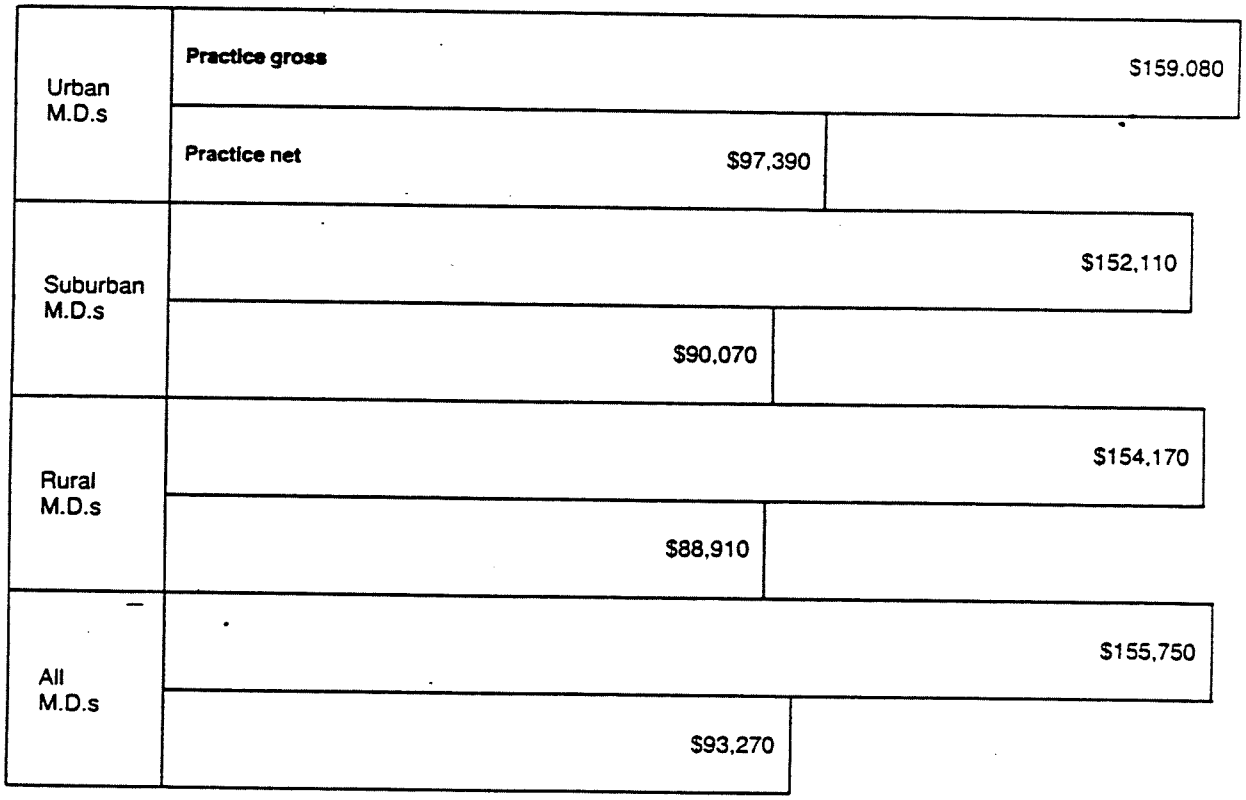
ral doctors are significantly higher than those of the typical office-based M.D.

"These doctors can't just send a patient down the street to an independent lab," notes management consultant Glenn C. Kreamer of Professional Management Midwest in Kansas City, Mo. "They often run their own lab in the office, and many of them have X-ray machines, too. That means they have to spend a lot more on staff and supplies."

If it weren't for these higher costs, many more rural practitioners would be top earners in their fields. In 1982, the typical rural physician grossed $154,170, compared with a median gross of $152,110 reported by suburban

HOW INCOME VARIES BY TYPE OF COMMUNITY

Physicians practicing in cities come out ahead of their suburban and rural colleagues in both median gross practice income and median net. Rural M.D.s register a higher median gross than suburban doctors, but in the end they're able to keep less because their expenses are higher.



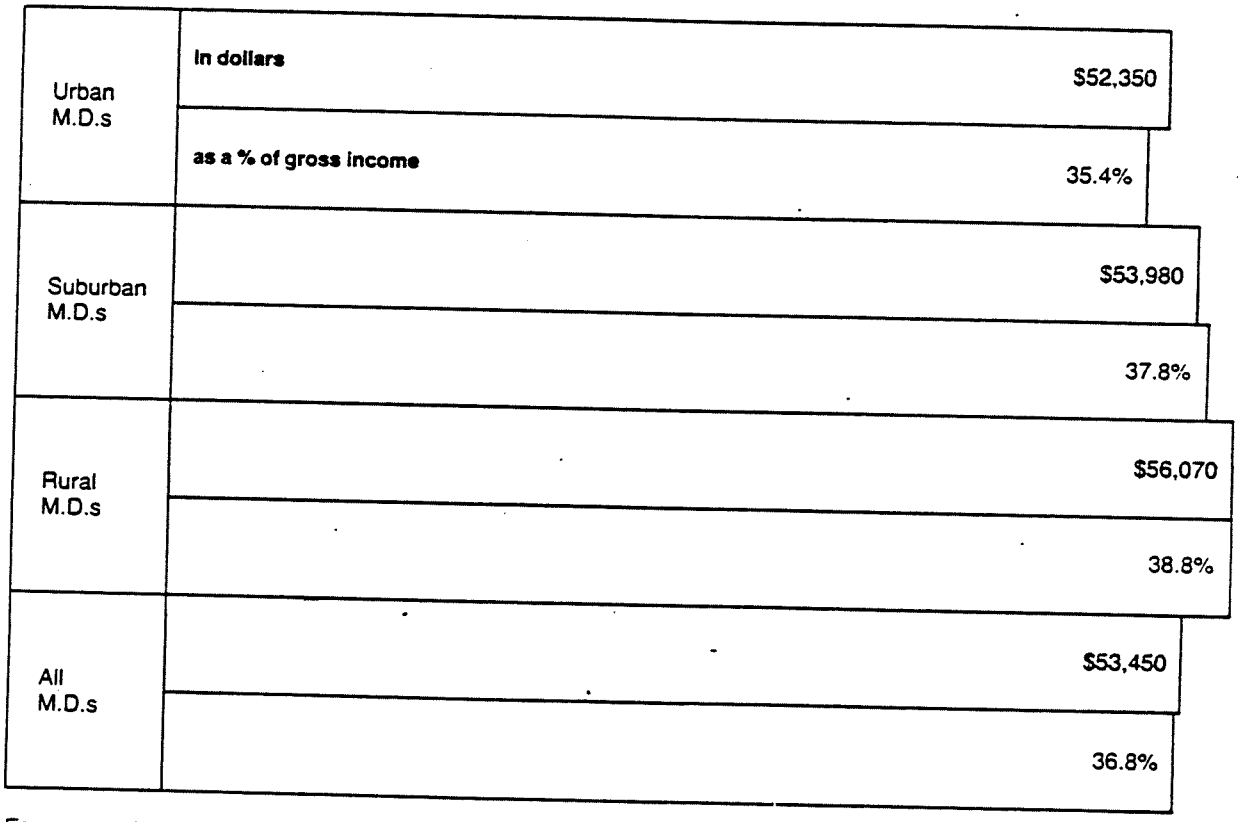
Gross represents physicians' individual shares of 1982 receipts from practice before professional expenses and income taxes. For unincorporated physicians, net is individual income from practice minus tax-deductible professional expenses, before income taxes; for incorporated physicians, it's total compensation from practice (salary, bonuses, and retirement set-asides) before income taxes. Data in this and the charts and tables that follow apply to office-based M.D.s and are drawn from MEDICAL ECONOMICS' Continuing Survey. Where no year is specified, data are for 1982.

doctors. The reason clearly is that the country doctors have less competition. What contributes to their economic well-being is that they see 22 percent more patients per week than office-based M.D.s as a whole and significantly more than their urban and suburban colleagues.

Of course, that means working longer hours. The urban and suburban practitioners more than compensate for fewer patients with higher fees and lower practice costs. The question is whether they'll all be able to maintain this level as competition gets tougher.

For more particulars on the present situation, see the accompanying survey-based charts and tables.

HOW PROFESSIONAL EXPENSES VARY



Figures are medians for total tax-deductible professional expenses per physician.

HOW SPENDING ON SEVEN MAJOR ITEMS VARIES

Rural practitioners' professional expenses outstrip those of their urban and suburban counterparts for office payroll, drugs, and medical supplies. They're able to spend much less, however, on office space, and their premiums for malpractice insurance are generally lower.

Office payroll[1]

Urban M.D.s	$26,950
Suburban M.D.s	$25.050
Rural M.D.s	$28,850
All M.D.s	$26,410

Office space[2]

Urban M.D.s	$9,880
Suburban M.D.s	$9,650
Rural M.D.s	$7,870
All M.D.s	$9,523

Drugs and medical supplies[3]

Urban M.D.s	$3,770
Suburban M.D.s	$4,510
Rural M.D.s	$5,310
All M.D.s	$4,260

Malpractice insurance premiums

Urban M.D.s	$4,290
Suburban M.D.s	$3,620
Rural M.D.s	$3,000
All M.D.s	$3,840

Professional-car upkeep[4]

Urban M.D.s	$3,410
Suburban M.D.s	$3,290
Rural M.D.s	$3,220
All M.D.s	$3,350

Depreciation on medical equipment

Urban M.D.s	$2,470
Suburban M.D.s	$2,600
Rural M.D.s	$2,830
All M.D.s	$2,550

Continuing education[5]

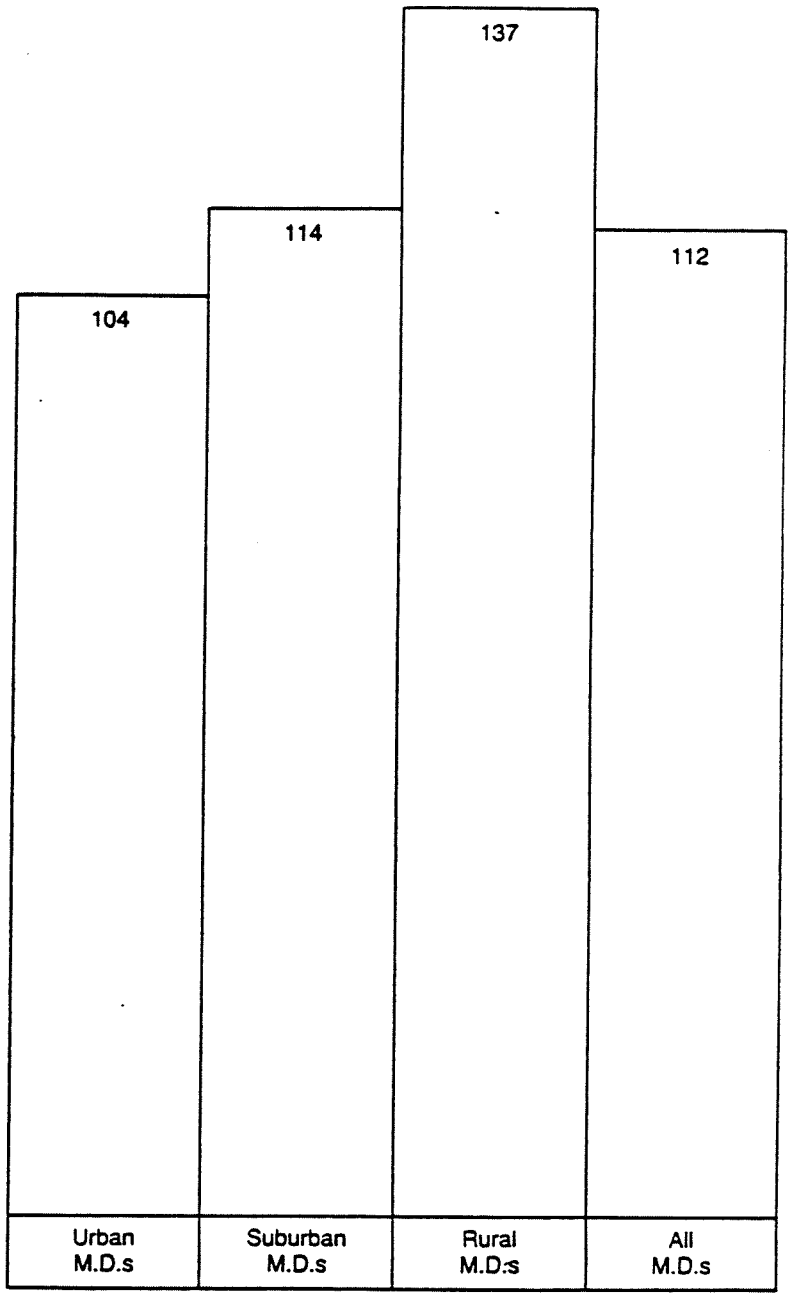
Urban M.D.s	$2,000
Suburban M.D.s	$1,640
Rural M.D.s	$1,500
All M.D.s	$1,930

[1]Includes salaries, bonuses, and retirement-plan contributions, if any, for non-physician employees only. [2]Rent or mortgage payments. [3]Includes non-depreciable small instruments. [4]Includes depreciation. [5]Includes registration fees, cost of materials and travel, meals, and lodging for the doctor only. Dollar figures are medians per physician and are based only on returns from physicians who reported having that type of expense.

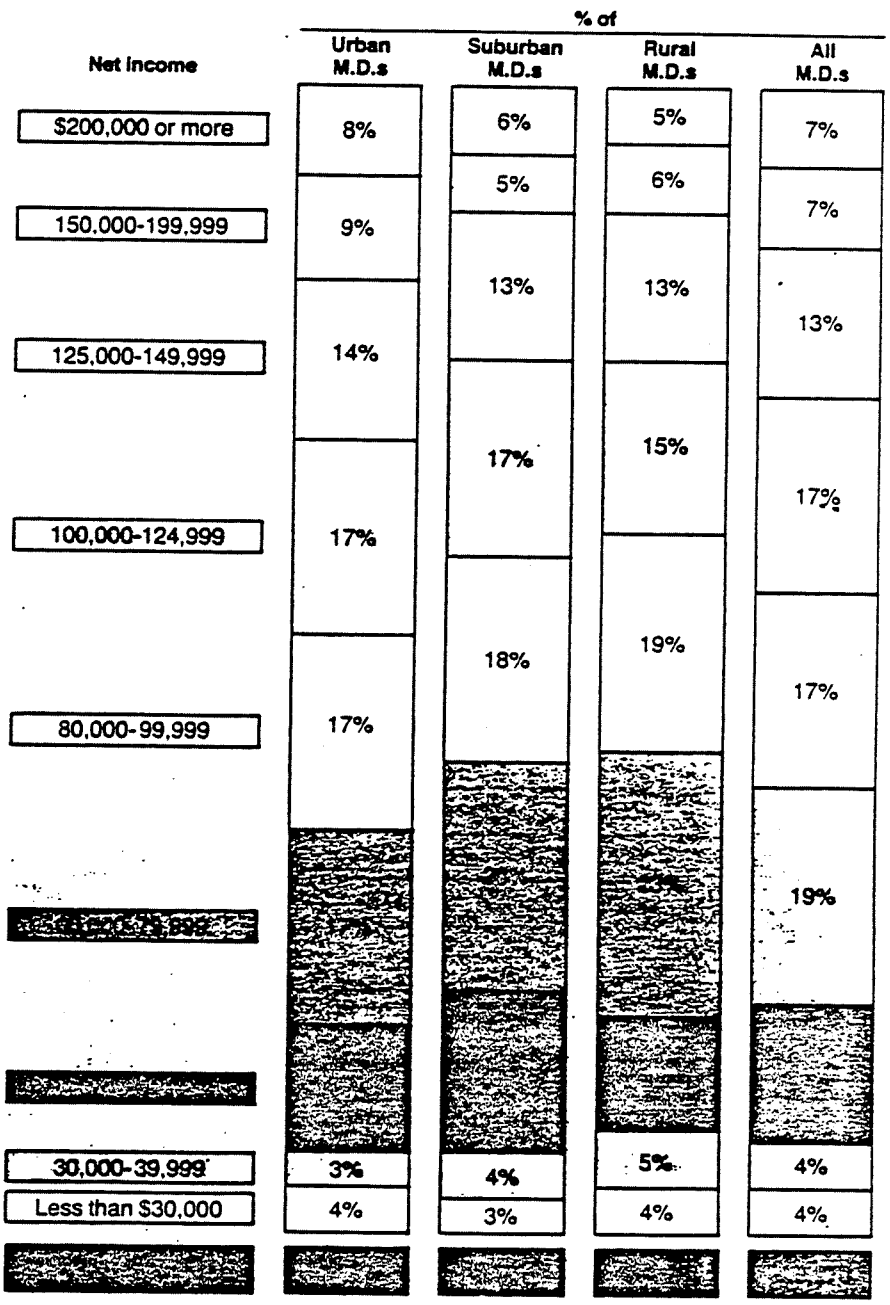
RURAL DOCTORS HAVE MORE PATIENT VISITS PER WEEK

Rural physicians are seeing an impressive 22 percent more patients each week than the typical office-based M.D. In fact, they presently see more patients than the typical physician did in 1974, when the median was 134 patient visits a week.

Patient visits are the total of visits in office, hospital, home, and other locations during which the doctor personally saw the patient in a representative week early in 1983.



NET-INCOME RANGES BY TYPE OF COMMUNITY



GPs AND FPs DO BEST IN THE COUNTRY

Though rural physicians as a whole are low earners compared with the average office-based physician, rural general practitioners and family physicians take home more than their urban and suburban counterparts. One reason is their dramatically higher patient-visit rates. Other factors include less competition from internists and other specialists and less interest among rural patients in seeking specialized care.

	% of GPs					% of FPs			
Net income	Urban	Suburban	Rural	All GPs		Urban	Suburban	Rural	All FPs
$200,000 or more	1%	2%	1%	1%		3%	—*	1%	1%
150,000-199,999	3	—*	3	2		4	3	1	2
125,000-149,999	6	6	6	6		4	5	4	4
100,000-124,999	10	9	19	13		14	14	15	15
80,000-99,999	16	16	15	16		16	22	23	21
60,000-79,999	24	30	25	26		20	27	33	28
40,000-59,999	22	21	12	19		24	20	15	19
30,000-39,999	8	9	10	9		7	2	6	5
Less than $30,000	10	7	9	8		8	7	2	5
Median practice net	**$66,900**	**$68,000**	**$73,930**	**$69,029**		**$75,010**	**$74,670**	**$75,830**	**$74,580**
Median patient visits per M.D. per week	**134**	**146**	**161**	**145**		**150**	**142**	**163**	**150**

*Less than 1 percent.

HOW FEES COMPARE

As the tables that follow show, the median charges of rural doctors are invariably lower than those of urban and suburban doctors. The fees shown represent the most frequent charges of individual M.D.s in the spring of 1983.

Initial office visits

Urban M.D.s	$35
Suburban M.D.s	$31
Rural M.D.s	$23
All M.D.s	$31

Office revisits

Urban M.D.s	$21
Suburban M.D.s	$22
Rural M.D.s	$18
All M.D.s	$21

History and physical exam*

	GPs	FPs	Internists
Urban M.D.s	$50	$50	$80
Suburban M.D.s	42	51	74
Rural M.D.s	36	36	62
All M.D.s	41	47	75

*Comprehensive diagnostic, in office, new patient, excluding lab fees.

Hospital care

Initial[1]	GPs	FPs	Internists
Urban M.D.s	$66	$73	$85
Suburban M.D.s	51	70	80
Rural M.D.s	50	61	73
All M.D.s	51	66	80

Follow-up[2]	GPs	FPs	Internists	Pediatricians
Urban M.D.s	$25	$25	$26	$25
Suburban M.D.s	25	25	29	25
Rural M.D.s	20	20	24	21
All M.D.s	21	23	26	25

[1]With comprehensive diagnostic history and physical exam. [2]Examination and evaluation, usual or routine, per day.

Continued on page 268

GENERAL SURGEONS: ON TOP OF THE HEAP IN RURAL AREAS

Among rural practitioners for whom specialty breakdowns are available, the biggest earners are general surgeons, who even out-earn their urban and suburban counterparts. The probable explanation: Less competition from surgical specialists and subspecialists gives them higher patient-visit rates.

Higher incomes . . .

	% of general surgeons			
Net income	Urban	Suburban	Rural	All locales
$200,000 or more	5%	4%	7%	5%
150,000-199,999	8	8	5	7
125,000-149,999	13	15	24	16
100,000-124,999	24	17	17	20
80,000-99,999	16	21	19	18
60,000-79,999	19	14	14	17
40,000-59,999	10	13	10	11
30,000-39,999	3	1	4	3
Less than $30,000	2	7	—*	3
Median practice net	**$99,500**	**$94,440**	**$106,670**	**$98,850**
Median patient visits per surgeon, per week	**83**	**97**	**113**	**91**

*Less than 1 percent.

despite lower median fees

	General surgeons' fees			
	Urban	Suburban	Rural	All locales
Appendectomy	$ 551	$ 601	$ 501	$ 551
Cholecystectomy	901	1,000	826	901
Inguinal hernia, unilateral	551	601	505	551
Subtotal gastrectomy	1,200	1,280	1,126	1,200

By Line of Business
By Insurer
By State

Insurance Premium Distribution—1984

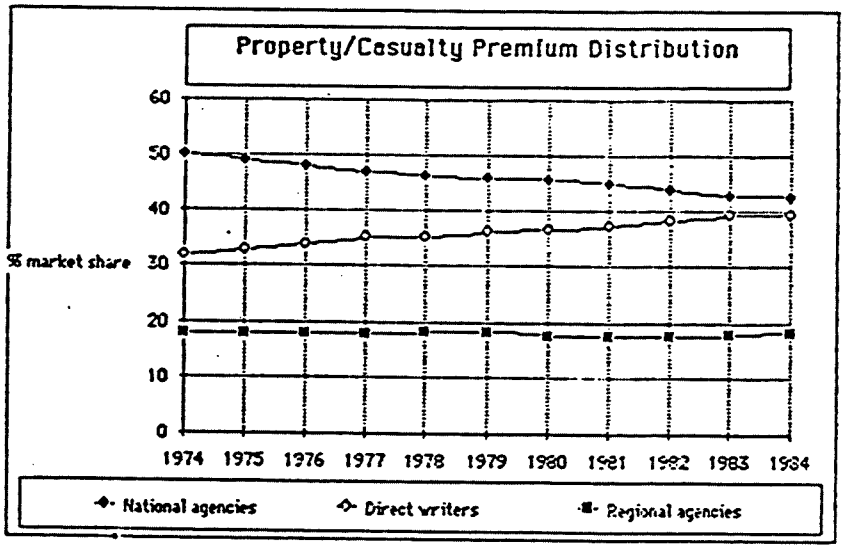
BY VIRGINIA VOGT

In 1984, the national agency companies experienced a two-tenths of a point drop in property/casualty premium market share, the smallest loss of the last 11 years. Since 1974, the national companies steadily have been losing market share to direct writers, their percentage of total business going from almost 50% to less than 43%.

National insurers received 42.6% of the $121.9 billion direct premiums written in 1984, and the regional agency companies claimed 18.2%, their largest share since at least 1974. The market share of direct insurers, which has grown more than seven percentage points since 1974, declined slightly, to 39.3%.

The direct writers' inability to add to market share in 1984 should come as no surprise in view of the firming of rates in the predominantly agency-written commercial lines that began to accelerate in the latter part of 1984. Premiums from personal lines, the majority of which are written by direct insurers, remained relatively static.

Another developing trend is the renewed interest among independent agents in pursuing personal lines business aggressively, particularly by offering comprehensive insurance packages in conjunction with commercial writings. Some groups have formulated programs to provide advice on products, marketing and public relations to achieve this goal.



While overall market share shifts among the three main distribution systems were small, there were some lines of business where national, state and direct writers made larger inroads into each other's market shares. The national agency writers made a small gain in Commercial Inland Marine and recorded an increase of two percentage points in Medical Malpractice. State agency writers gained more than one percentage point of the Allied Lines, Commercial Multiperil and Inland Marine business while showing some decline in Workers' Compensation and Commercial Auto Liability. Direct writers lost ground in Inland Marine and Medical Malpractice market share, but replaced these market losses with advances of about one point in Fire, Workers' Compensation and Commercial Auto Liability; and more than two points in Commercial Auto Physical Damage. Substantial increases also occurred in some of the smaller volume

VIRGINIA VOGT is a contributing editor to Best's Review.

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ges such as Glass, Boiler and Machinery, and Credit.

Direct premiums written by U.S. property/casualty insurers rose 10% in 1984, compared with 6% in the previous year. However, much of this increase occurred in the fourth quarter of 1984, when net premiums written gained more than 13%, the largest quarterly growth rate since the second quarter of 1978. In addition, this accelerated growth continued into the first quarter of 1985 as premiums went up another 16%, with further growth throughout the year expected. Among 24 major property/casualty lines displayed here, the majority of the 16 lines showing double-digit premium gains were in commercial lines, a reversal of the pattern of premium growth in 1983.

Of these 24 major lines of property/casualty insurance, six lines showed improvement in loss ratios in 1984. Half of these, most notably Allied Lines and Inland Marine, also had significant percentage increases in premium growth for the year, indicating a firming of prices. Other major lines demonstrating double-digit premium gains but where loss ratios showed excessive increases were Commercial Multiperil, Total Miscellaneous Liability, Commercial Auto Liability and Commercial Auto Physical Damage. The Surety business, although it had a significant rise in loss ratio, had a premium increase of 28%, the highest of any line.

All of the 20 largest property/casualty insurers of 1984 had premium gains, compared with 1983 when six experienced declines. Of these companies, the five insurers with increases of 15% or more (higher than any gain made by 1983's largest writers) were all national agency companies. The u, swing demonstrated by these large national insurers again reflects price firming in the commercial lines and is in direct contrast to 1983, when all six companies with premium declines were national agency writers.

Some changes in the leading writers among the major lines of business include the movement of

Percent of Property/Casualty Market

	National Agency Companies	Regional Agency Companies	Direct Writers
1984	42.6	18.2	39.3
1983	42.8	17.8	39.4
1982	44.0	17.6	38.5
1981	45.0	17.6	37.4
1980	45.6	17.6	36.8
1979	45.9	18.0	36.2
1978	46.5	18.1	35.4
1977	46.9	17.9	35.2
1976	48.1	17.9	34.1
1975	49.1	17.8	33.0

Leading Insurers and Their Market Share

Company/Group	Premiums ($ 000)	% Prem. Gain	Market Share % 1984	1983
State Farm	11,687,557	10.5	9.6	9.6
Allstate	6,736,068	5.8	5.5	5.8
Aetna	4,237,957	10.2	3.5	3.5
CIGNA	4,053,674	4.1	3.3	3.5
Travelers	3,540,230	13.0	2.9	2.8
Farmers	3,472,296	10.4	2.8	2.8
Hartford	3,149,126	6.9	2.6	2.7
Fireman's Fund	3,143,460	7.2	2.6	2.7
Liberty Mutual	2,856,969	7.9	2.4	2.4
Continental	2,763,347	4.1	2.3	2.4
AIG	2,740,769	15.0	2.2	2.2
Crum and Forster	2,594,312	23.7	2.1	1.9
Nationwide	2,447,200	10.9	2.0	2.0
USF&G	2,278,987	16.8	1.9	1.8
St. Paul	2,029,982	10.1	1.7	1.7
CNA	1,890,775	19.8	1.6	1.4
Chubb	1,677,127	18.9	1.4	1.3
Home	1,671,665	12.7	1.4	1.3
Royal	1,416,591	3.9	1.2	1.2
Wausau	1,410,051	11.7	1.2	1.1

1984 Premium Distribution by Line

Line	*Total Direct Premiums	% of Total	% Change	Loss Ratio 1984	1983	Leading Writers	% of Total	% of Writings		% of Total		% of Total
Fire	2,643,798	2.2	-1	62.1	56.8	Travelers	4.9	3.7	St. Paul	4.3	Hartford	4.2
Allied	2,009,454	1.6	12	69.1	73.5	CIGNA	5.6	2.8	Old Republic	5.0	St. Paul	4.3
Homeowners	13,436,559	11.0	5	68.1	66.3	State Farm	17.2	19.8	Allstate	9.3	Farmers	4.6
Commercial MP	9,458,846	7.8	14	86.9	75.0	CIGNA	8.1	18.9	Fireman's Fund	6.2	State Farm	4.9
Inland Marine	3,594,131	2.9	17	65.9	68.7	Amer. Intern.	8.0	10.5	CIGNA	5.0	Fireman's Fund	4.9
Workers Comp.	16,632,146	13.6	8	92.0	77.9	LibertyMutual	7.6	43.6	Travelers	5.8	Aetna L&C	5.1
Total Misc. Liability	11,060,147	9.1	17	101.7	87.6	Amer. Intern	6.9	27.8	St. Paul	5.9	Crum & Forster	4.6
Medical Malpractice	2,257,760	1.9	12	110.9	106.0	St. Paul	17.9	19.9	Med. Liab. Mut. NY	6.2	Med. Protect.	5.2
Other Liability	8,802,386	7.2	19	99.4	82.9	Amer. Intern.	7.9	25.3	Crum & Forster	6.0	CIGNA	5.2
Private Pass. Auto Liab.	24,995,679	20.5	6	79.0	75.6	State Farm	17.2	36.8	Allstate	11.0	Farmers	5.7
No-Fault	2,797,991	2.3	-2	89.6	93.1	State Farm	16.2	3.9	Allstate	11.7	Nationwide	4.9
Other Liab.	22,197,687	18.2	8	77.5	73.2	State Farm	17.3	32.9	Allstate	10.9	Farmers	6.0
Commercial Auto Liab.	5,812,555	4.8	15	101.9	91.7	Aetna L&C	4.6	6.4	CIGNA	4.5	Travelers	4.2
No-Fault	161,131	0.1	6	98.0	95.1	Aetna L&C	6.1	0.2	CIGNA	5.4	State Farm	4.6
Other Liability	5,651,424	4.6	15	102.0	91.6	Aetna L&C	4.6	6.1	CIGNA	4.5	Travelers	4.2
Priv. Pass. Auto Phys. Dam.	18,534,702	15.2	9	68.9	64.7	State Farm	18.5	29.3	Allstate	9.9	Farmers	5.1
Comm. Auto Phys. Dam.	3,298,204	2.7	18	73.2	65.9	State Farm	4.3	1.2	Aetna L&C	4.2	USF&G	3.9
Farmowners	768,497	0.6	4	80.6	70.1	Continental	4.7	1.3	Country	4.2	CIGNA	4.2
Earthquake	116,513	0.1	15	5.1	3.5	Mission	13.8	2.3	Aetna L&C	13.5	Allstate	12.2
Ocean Marine	1,189,828	1.0	6	76.2	83.3	Continental	12.6	5.4	CIGNA	10.7	Fireman's Fund	5.8
Aircraft	657,463	0.5	14	59.0	62.3	Crum and Forster	11.8	3.0	Chubb	11.1	CIGNA	6.7
Fidelity	505,963	0.4	15	78.3	73.9	Chubb	12.9	3.9	Aetna L&C	11.8	CUNA Mut.	11.3
Surety	1,911,118	1.6	28	46.8	33.5	Fireman's Fund	8.4	5.1	Aetna L&C	7.4	Crum and Forster	6.5
Glass	26,986	0.0	0	24.8	31.6	Farmer's	15.1	0.1	Mass.Plate Glass	11.6	Zurich Group	7.4
Burglary & Theft	112,803	0.1	1	24.8	29.5	Chubb	25.2	1.7	Aetna L&C	9.2	CIGNA	5.9
Boiler & Machinery	402,409	0.3	20	70.6	45.3	Hartford Steam Boiler	23.3	84.4	Ark. Boston	13.2	Protect. Mut.	9.1
Credit	129,796	0.1	21	205.2	88.4	Comm. Credit	30.4	16.0	Continental	10.3	Old Republic	9.5
Miscellaneous	1,697,379	1.4	56	85.5	79.8	Baldwin United	19.1	55.7	Ark. Boston	14.4	Protect. Mut.	9.3
Group A&H	1,838,343	1.5	3	78.7	84.0	Allstate	12.5	3.4	Hartford	9.5	Wausau	7.5
All Other A&H	1045,798	.9	17	62.1	66.2	State Farm	34.7	3.1	Amer. Family	10.3	CNA	6.3
Totals	121,879,118	100.0	10	79.9	73.3	State Farm	9.6	100.0	Allstate	5.5	Aetna L&C	3.5

* In dollars, 000 omitted

Loss ratio is losses incurred to premiums earned, not including loss adjustment expense, but adjusted for dividends to policyholders, if any.

Travelers to first place position as a writer of fire insurance, Travelers not having been among the three largest writers in 1983. Travelers moved into second place in Workers' Compensation, moving ahead of CIGNA as one of the three largest writers in this line, and Aetna became the leading writer of Commercial Auto Liability. State Farm, due to the changeover in classification of recreational vehicles to commercial from personal insurance, became the largest writer of Commercial Auto Physical Damage. This change has moved State Farm from 21st to 10th place in Commercial Auto Liability in terms of premiums written.

State Farm was the leading overall property/casualty insurer in 1984 in terms of market share, while Allstate stood second. Aetna Life & Casualty replaced CIGNA as third in market share.

The average loss ratio for the total U.S. property/casualty industry in 1984 was 79.9%, up 6.6 percentage points from 1983. All but three of the states had increases in loss ratios in 1984, ranging from Connecticut's 1.4 point increase to Wyoming's 26.7 jump. Only Hawaii, North Dakot. Texas showed improvement, the last-mentioned by bouncing back from the highest loss ratio of 1983, the result of a visit by Hurricane Alicia.

Of 16 states that achieved a less-than-average increase (6.6 percentage points) in loss ratio, 13 also had premium growth equal to or more than the average 10% increase.

State Farm is now among the three leading writers in 41 states and the largest insurer in 35 states, gaining first place status in Nevada, Washington and Ohio and losing it in Delaware.□

Insurance Premium Distribution and Leading Writers by State

Rank	State	Total Direct Premiums	% Incr. DPW	% of U.S. Total	Loss Ratio % 1984	Leading Writer	Premiums	% of State Market	Second and Third Leaders and Their Market Shares			
26	Alabama	1,496,034	13	1.2	75.3	State Farm	251,163	16.8	Alabama FB	9.5	Allstate,	6.3
43	Alaska	466,251	7	0.4	70.1	State Farm	57,042	12.2	CIGNA	8.5	Crum and Forster	7.9
25	Arizona	1,508,650	12	1.2	86.7	State Farm	174,871	11.6	Farmers	10.8	Allstate	7.7
33	Arkansas	950,338	10	0.8	86.9	State Farm	120,643	12.7	Southern FB	8.4	Shelter	5.8
1	California	16,602,008	15	13.6	80.7	State Farm	1,562,568	9.4	Farmers	7.9	Allstate	5.7
24	Colorado	1,716,275	13	1.4	98.3	State Farm	252,994	14.7	Farmers	9.6	Allstate	4.2
17	Connecticut	2,250,617	11	1.9	69.8	Aetna L&C	234,263	10.4	Hartford	7.5	Allstate	5.6
47	Delaware	354,686	19	0.3	80.8	Nationwide	40,997	11.6	State Farm	11.5	Travelers	4.6
44	District of Columbia	420,823	17	0.4	75.2	Hartford	47,675	11.3	Travelers	6.9	GEICO	6.9
6	Florida	5,843,471	15	4.8	80.4	State Farm	717,497	12.3	Allstate	8.0	Travelers	3.8
11	Georgia	2,641,452	16	2.2	84.8	State Farm	352,197	13.3	Allstate	8.7	Fireman's Fund	3.2
37	Hawaii	622,097	10	0.5	65.9	Continental	68,305	11.0	Hawaiian	8.9	Hartford	8.0
45	Idaho	414,430	8	0.3	80.9	State Farm	41,708	10.1	Farmers	9.4	SAFECO	5.0
5	Illinois	5,861,440	9	4.8	85.2	State Farm	774,658	13.2	Allstate	7.4	Country	4.5
19	Indiana	2,157,158	9	1.8	74.0	State Farm	270,611	12.5	United Farm Bureau	7.4	Indiana Ins.	5.2
29	Iowa	1,353,914	5	1.1	68.9	State Farm	120,156	8.9	AID Ins.	5.4	Farm Bur., Iowa	4.8
30	Kansas	1,277,933	8	1.1	74.1	State Farm	158,372	12.4	Kansas Farm Bureau	8.3	Farmers	6.3
27	Kentucky	1,423,674	14	1.2	80.8	State Farm	136,931	9.6	Kentucky Farm Bureau	7.1	Allstate	3.8
12	Louisiana	2,499,150	5	2.1	88.3	State Farm	394,242	15.8	Allstate	6.0	USF&G	4.3
39	Maine	586,440	11	0.5	83.1	Liberty Mutual	56,387	9.6	Comm. Union	7.4	Amer. General	7.1
15	Maryland	2,342,271	11	1.9	73.7	State Farm	266,793	11.4	Allstate	6.9	Nationwide	6.6
9	Massachusetts	4,011,271	13	3.3	72.6	Liberty Mutual	400,199	10.0	Travelers	6.6	Aetna	6.3
7	Michigan	4,649,975	12	3.8	88.6	Auto Club, Mich.	491,155	10.6	State Farm	10.0	Motors Ins.	7.1
13	Minnesota	2,400,952	10	2.0	84.5	State Farm	260,070	10.8	Amer. Family	5.2	St. Paul	5.2
32	Mississippi	1,009,566	13	0.8	79.4	State Farm	144,259	14.3	USF&G	13.6	So. Farm Bureau	8.7
16	Missouri	2,335,593	12	1.9	89.3	State Farm	324,190	13.9	Amer. Family	6.0	Shelter	5.1
46	Montana	399,745	8	0.3	81.2	State Farm	48,382	12.1	Farmers	7.7	CIGNA	4.1
34	Nebraska	812,046	9	0.7	67.2	State Farm	85,055	10.5	Farmers Mut. Neb.	4.5	St. Paul	4.1
42	Nevada	477,686	8	0.4	78.5	State Farm	68,345	14.3	Farmers	13.7	Allstate	8.3
38	New Hampshire	593,696	12	0.5	68.2	Amer. Intern.	54,357	9.2	Liberty Mutual	5.3	Am. General	5.2
8	New Jersey	4,423,489*	13	3.6	75.6	Allstate	325,856	7.4	N.J. Manufacturers	6.9	CIGNA	5.2
35	New Mexico	708,981	19	0.6	73.7	State Farm	95,391	13.5	Farmers	6.1	Allstate	5.9
2	New York	10,191,570	10	8.4	76.6	Allstate	749,785	7.4	Aetna	6.3	CIGNA	5.0
18	North Carolina	2,207,577	9	1.8	78.2	Nationwide	182,734	8.3	State Farm	7.7	Aetna	6.6
48	North Dakota	346,577	11	0.3	62.3	Baldwin-United	27,672	8.0	State Farm	6.5	Amer Family	6.4
10	Ohio	3,971,700	11	3.3	69.4	State Farm	413,027	10.4	Nationwide	7.6	Continental	5.2
23	Oklahoma	1,748,355	7	1.4	88.1	Farmers	188,995	10.8	State Farm	10.8	Allstate	4.1
31	Oregon	1,263,546	11	1.0	81.0	State Farm	143,687	11.4	Farmers	8.9	Allstate	5.0
4	Pennsylvania	6,124,219	11	5.0	83.6	State Farm	476,297	7.8	Nationwide	6.6	Allstate	5.5
40	Rhode Island	539,642	9	0.4	74.7	Aetna	61,925	11.5	Allstate	5.8	Amica	5.7
28	South Carolina	1,361,351	13	1.1	85.6	State Farm	195,382	14.4	Allstate	6.8	Nationwide	5.1
49	South Dakota	302,765	9	0.3	75.2	State Farm	27,196	9.0	Amer. Family	7.2	Western	5.5
21	Tennessee	1,879,735	11	1.5	77.7	State Farm	240,387	12.8	Tenn. Farmers	7.0	Allstate	5.2
3	Texas	9,442,242	11	7.7	83.4	State Farm	1,073,056	11.4	Allstate	6.0	Farmers	4.4
41	Utah	536,728	11	0.4	87.8	State Farm	74,689	13.9	Farmers	12.8	Allstate	5.7
50	Vermont	268,556	11	0.2	68.8	Amer. Intern.	28,220	10.5	Aetna	8.0	Travelers	5.2
14	Virginia	2,365,860	11	1.9	71.5	State Farm	266,244	11.3	Nationwide	6.6	Travelers	6.5
22	Washington	1,656,430	12	1.5	78.4	State Farm	167,913	9.0	Farmers	5.9	SAFECO	7.1
36	West Virginia	637,657	7	0.5	78.2	State Farm	124,793	19.6	Nationwide	12.4	Allstate	5.3
20	Wisconsin	1,995,102	8	1.6	77.6	Am Family	244,884	12.3	Wausau	7.0	State Farm	6.4
51	Wyoming	225,197	7	0.2	86.1	State Farm	35,659	15.9	Farmers	7.9	CIGNA	4.9
	Totals US	121,879,118	10	100.0	79.9	State Farm	11,687,557	9.6	Allstate	5.5	Aetna L&C	3.5

*Does not include premiums recorded by the New Jersey Auto Full Insurance Underwriting Association (figure unavailable at press time)
In dollars, 000 omitted.
Loss ratio is losses incurred to premiums earned, not including loss adjustment expense, but adjusted for dividends to policyholders, if any

BEST'S REVIEW
JULY 1985
PROPERTY/CASUALTY
INSURANCE EDITION

Property/Casualty Executives Speak Out

In the wake of the first year on record in which investment income failed to offset the industry's staggering underwriting loss, property/casualty insurers are immersed in the difficult task of effecting a recovery—a task complicated by the specter of financial services deregulation and concern about the possibility of a prolonged capacity shortage, and other problems.

A great deal of commentary has appeared in the trade press about how property/casualty insurers can extricate themselves from their current difficulties and how long this process is likely to take, given the price increases already instituted in the ailing commercial lines sector. To find out how property/casualty executives themselves feel about the issues confronting the industry, *Best's Review* sent a list of questions compiled by our editorial staff to a cross section of insurers, large and small, stock and mutual, in various sections of the country. Thirty-four executives were invited to participate, and 15 responded. All of the replies are included here; in the few instances where a reply is missing, it means that the executive chose not to respond to that particular question.

Last year, the property/casualty industry posted the worst underwriting loss in its history. How long will it take for insurers to achieve underwriting stability?

William O. Bailey
President
Aetna Life and Casualty Co.
Hartford

Cyclicality reflects the course of the economy and the competitive nature of the property/casualty insurance industry. We don't believe it will ever be possible to achieve complete underwriting stability. Underwriting results will improve in 1986 and further improve in 1987 and 1988, but the cyclicality that is ingrained in the business will not disappear.

Edward K. Trowbridge
President
The Atlantic Companies
New York

The consensus in the industry seems to be that 1985 will be the "turnaround" year—with an operating result roughly equivalent to that of 1984. The significant difference is that 1985 will show an improving trend.

If underwriting stability can be equated with a satisfactory return on capital, we believe it will be 1987 at the earliest before we have achieved such "stability." This projection is based on expected average rate increases of 20% over the next two years, with increases at a much greater rate in commercial than in personal lines. The projection also assumes no significant changes in interest rates or in the value of equity investments.

One additional note of uncertainty is the level of adequacy of loss reserves. Estimates are that industry reserves are as much as 10% to 15% inadequate. If this is correct, it may well delay the return to underwriting stability by as much as another year.

9/12-13/85 Attachment XXXV

Robert B. Morgan
President
Cincinnati Insurance Co.
Cincinnati

If underwriting stability is defined as underwriting profitability, 1986 has a shot, but it probably still will not occur until 1987. There is not a chance that underwriting stability—over a period of years—is feasible. Supply and demand in the insurance business always seem to be "too much" or "in short supply."

Edward J. Noha
Chairman and Chief Executive Officer
CNA Insurance Companies
Chicago

The property/casualty industry traditionally has experienced significant underwriting or business cycles, the duration and severity of which have varied, but whose inevitability appears to remain constant. The current cycle has been particularly severe, but many companies appear finally to be reacting in the traditional ways, that is, by raising rates, instituting more selective underwriting criteria, restricting new business, getting out of certain lines of business, and attempting to beef up surplus in any way possible. Companies with a strong financial base will not have to take severe actions, but there are others which will have to use all possible steps to improve their situation.

GARY L. COUNTRYMAN

Just as it was very difficult to predict how long it would take for property/casualty companies to begin to react to increasing underwriting losses due to the complex set of factors at work, it is also difficult to determine now how long it will take until companies again begin the competitive push for more production.

John Bretherick Jr.
President
Continental Corp.
New York

Certainly, some insurers will achieve underwriting stability sooner than others. Those able to recover most quickly will be insurers that have streamlined operations, strengthened underwriting standards, refined their producer network, increased prices and have the capital to take advantage of the tightening market. However, six years of damage cannot be rectified in a matter of months. We don't expect the changing market to work its way to the bottom line until 1986.

Donald R. Frahm
President and Chief Executive Officer
Hartford Insurance Group
Hartford

Underwriting stability is a function of "adequate profitability." For most primary companies heavily dependent on commercial lines, this return to a profitability "threshold" should occur on the completion of the current and the next one or two renewal cycles. Additionally, this is dependent on reinsurers having recovered from their extraordinary losses of the last several years as they continue to provide instability in the marketplace through withdrawal of capacity and accelerated pricing.

Gary L. Countryman
President
Liberty Mutual Insurance Companies
Boston

In the past, the insurance industry's response to financial difficulties has been rapid and surprisingly successful in a short period of time. While one could speculate that a similar response will be seen in 1985, the current underwriting cycle has been very different from previous ones in that (1) the need for price correction has been precipitated by underwriting alone rather than a stock market slump; (2) the need for price correction is predominantly in commercial insurance rather than in personal lines; and (3) reinsurers have suffered particularly severe losses.

The impact of the reinsurance market on the timing of earnings correction is the hardest factor to assess. Another unknown is the degree to which the industry may be underreserved. Overall, it is likely that a full recovery may take several years, while a substantial reversal of the trend will take less than two years.

Robert F. Ballus Jr.
Senior Vice President
Lumbermens Mutual Casualty Co.
Long Grove, Ill.

The industry did not take real action until the second half of 1984. Stability (acceptable but not profitable results) will not be achieved for 18 months or until early in 1986.

Don D. Hutson
President
Maryland Casualty Co.
Baltimore

Most companies and trade associations are surprised at the depth of rate adjustments that are being exacted in the commercial lines, suggesting that for those insurers that are not too far gone already, a period of stability could be realized in three to five years.

Paul A. Donald
President
Nationwide Insurance Companies
Columbus, Ohio

It took the industry some time to get into the current situation, so the recovery will be slow—perhaps from three to five years before we're fully healed.

George W. Ansbro
Chairman and
Chief Executive Officer
Royal Insurance
New York

If we look at the history of our very large and heterogeneous industry, since the 1950s we have had five underwriting cycles ranging from five to eight years in duration. Two pronounced trends have occurred during this period: these cycles have gotten shorter on the upside and longer on the downside and much more unprofitable. The first three cycles bottomed out at about a 103 combined ratio, the fourth at about 108 and the most recent one at nearly 118, suggesting that results are more volatile than ever before and that underwriting stability in the traditional sense no longer exists.

This can be attributed to many causes, including the destructive com-

mercial lines price competition resulting from the industry's cash flow underwriting techniques that in recent years were facilitated by high interest rates. Because of the inadequate rates that this philosophy helped bring about, and the consequent need for still further price increases in the commercial lines, we expect only a gradual underwriting recovery over perhaps the next three years.

By perhaps late 1988, we would expect a reintensification of competitive pressures followed by a rise once again in combined ratios. While proper underwriting is thus more important than ever, the industry no longer treats underwriting on a stand-alone basis, but rather focuses on the rates of total

WILLIAM O. BAILEY

return that are available in different insurance markets.

James W. Cannon
President
SAFECO Insurance Companies
Seattle

The first step in returning to underwriting stability is to get today's high combined ratio down to a much lower number, at least below 110. That level of combined ratio will still produce an underwriting loss but, at that level, it should also produce a small operating profit which will be the only sound basis for underwriting stability.

In SAFECO's view, true underwriting stability can be achieved only when the combined ratio is under 100 or, in selected commercial coverages, when it is only slightly above 100. Our current efforts are aimed at getting us under 100 just as soon as possible; I estimate this will be 1986 at the earliest and possibly not until sometime in 1987. My guess is that it will take the industry as a whole longer than that and, in terms of "stability," the real question in my mind is once the industry gets to that point, how long will it stay there? Experience would suggest that it will not be too long.

Robert J. Haugh
Chairman, President and
Chief Executive Officer
St. Paul Companies
St. Paul, Minn.

If by "underwriting stability" you mean the achievement of pricing commensurate with the risk being insured, most companies seem to be well on their way to that target.

However, contrary to the past when cartel pricing permitted a major swing in pricing within a very short time frame, deregulation means that each company is on its own. Each company reaches its own conclusions about pricing objectives, each has its own pace at which it can implement pricing changes throughout its operations and each has its own method and time for knowing how well its pricing changes are being implemented by its field forces. Achievement of underwriting stability will vary from line to line, region to region and company to company.

Of course, getting adequate pricing in place is not the only factor for stability today. Some insurers have not been able to obtain adequate reinsurance to support additional business, or even to maintain what they have, and

PAUL J. SCHEEL

some primary insurers have capacity problems.

Paul J. Scheel
President and Chief Operating Officer
United States Fidelity
and Guaranty Co.
Baltimore

While the companies are underwriting the business for the first time in six years, it will take at least two more years before stability is achieved. At least two more rounds of sizable price increases are needed, and we need to see the level of investment income significantly greater than the level of underwriting losses before any semblance of stability can be restored. The key will be when contributions are being made to surplus from operations. □

What lessons did property/casualty insurers learn from their recent flirtation with cash flow underwriting? Has the role of the underwriter undergone permanent change?

Bailey: The role of the underwriter is as important now as it has ever been. From their adventures with cash flow underwriting, insurers may have learned that it is important to understand total return in managing the business.

Trowbridge: The entire industry has been reminded of the importance of sound underwriting practices. Financial schemes of various shapes came into vogue during the recent cash flow cycle, and the result was an almost total disregard for pricing adequacy and risk selection. In the long run, underwriting principles cannot be replaced by short-term financial schemes.

The role of the underwriter is

changing dramatically in that the industry environment within which he or she works has changed. An underwriting entity's success will depend on the business acumen of its underwriters in dealing with individual risk and business proposals. No longer will underwriting activity be propped up and protected by a tariff environment.

Morgan: Property/casualty insurers didn't learn much except that you can lose a lot of money really fast. The role of the underwriter hasn't changed, but we sure are reevaluating and, more important, re-educating them.

Noha: The property/casualty industry as a whole continues to overreact to the competitive pressures of the marketplace, in turn causing periods of solid profitability, severe financial strain such as we are still experiencing and many transition periods. We have found that few companies or agents have been able to remain immune to these pressures. The existence of these cycles forces the quality players involved to emphasize the importance of financial soundness and stability, sound marketing skills, and stable and long-term relationships between companies and agents and agents and customers. Companies and agents continue to look for quality partners and loyal long-term relationships.

As we gradually move from the bottom of this underwriting cycle, the fundamentals of our business again will be stressed by those companies which, like CNA, are in a sound enough financial position to take advantage of the current market. These fundamentals include adequate and proper pricing, a reasonable selection and evaluation of risks and mix of business and the choice of trustworthy business partners. These factors, which are the key ingredients of sound underwriting, will remain important in the future.

Bretherick: Underwriting is always in the process of change, but the fundamentals remain the same. The underwriter's role has evolved over the years as the needs of society have changed—underwriting more complex risks like offshore drilling platforms, for example—and will continue to evolve specifically as the computer is put to use more and more. But the basic role of the underwriter remains unchanged—properly evaluating risk and avoiding the temptations of the marketplace that divert the underwriter's attention from the bottom line.

Frahm: The term "cash flow underwriting" has been the broad generality used to sweep under the mat a variety of industry ills and critical errors. It is true that in the late 1970s and early 1980s, we seemed to have an extraordinary amount of capital chasing a limited volume. The period intensified the consumers' awareness of insurance costs and alternative methods of risk

STEVEN H. NEWMAN

transfer, as well as having the financial world scrutinize such factors as return on premium and return on equity in measuring an insurance company's success.

Each of these factors contributed to the underwriters' awareness that the standard benchmark of not exceeding a 100% combined ratio was clearly being challenged. Perhaps the major difficulty in responding to this challenge was the combination of vagueness as to where the new benchmark was, coupled with the lack of inherent ability of the underwriter to "underwrite to a fixed loss."

The basic greed of new-found capital also led to some unusual new underwriting and processing arrangements in the industry, which effectively eliminated any semblance of underwriting while processing premium at very thin rates. The myriad of insurance and reinsurance schemes which fostered this market have at least temporarily collapsed, and this business now is seeking more traditional (and secure) companies.

A myriad of factors have and will continue to impact the underwriting process, among them a better understanding of the implications of investment income on the rate-making process. In response to all of these factors, the underwriter must adjust his thinking. However, the basic role of pricing and selection of risks has not changed; it merely needs to be reaffirmed.

Steven H. Newman
President
Home Insurance Co.
New York

Indiscriminate downward pressure on pricing for the purpose of securing market share or positive cash flow directly contributes to an environment in which underwriting discipline is sacrificed. Depressed price levels also cut deeply into funds thought to be available for investment purposes, further aggravating results.

Hopefully, all now understand that insurance is a long-term business in which initial cash flow from risks accepted, and the early incremental investment income it generates, can be overwhelmed in short order as insured liabilities emerge and are settled.

Countryman: Major property/casualty insurers have not "flirted" with cash flow underwriting. The competitive insurance marketplace merely adjusted to changing financial markets. The role of the underwriter has not changed, but the insurance industry must learn to better manage the new elements of risk introduced by the volatility of financial markets.

Ballus: It is unlikely that the industry learned anything from its "flirtation with cash flow underwriting." It's more likely that a significant segment of the industry has become entranced with overall financial income and has forsaken a combined ratio of less than 100% as an achievable goal.

Hutson: If insurers learned any lesson, it was the folly of permitting loss ratio levels to chase interest rate levels. Investment income had recognizable limits, while insurer loss levels were considerably greater. It was inevitable that the latter would exceed the former.

Hopefully, underwriters will revert back to much, if not most, of their previous responsibilities, i.e. the selection and pricing of commercial risks on the basis of exposure and expected loss costs. Our company is spending a great deal of resources on training of field

underwriters in basic underwriting techniques.

Donald: The underwriting role has changed, and for many it will require learning the job from scratch. I certainly hope the need to maintain adequate price for the risk assumed will be long remembered. However, the realist in me suggests that if interest rates escalate to the mid and upper teens, and we haven't been sacked by significant tax changes, we could repeat our history again.

Ansbro: It is really too early to be certain whether property/casualty insurers as a group have learned a lasting lesson from their latest foray into cash flow underwriting. However, the main lesson that they should have learned is that carriers cannot reduce their prices below profitable levels for a sustained period of time without creating enormous operating losses. As we have seen, these losses in turn can seriously undermine the financial strength of insurers and therefore their all-important claims-paying ability.

While cash flow underwriting in its broadest sense (writing business at almost any price in order to obtain investable funds) can be a ruinous approach, we do have to recognize that the definition of underwriting profitability generally has been broadened to recognize investment income. This could more appropriately be called "rate of return" underwriting and accordingly the underwriter's role is being redefined to encompass a broader consideration of the financial consequences of underwriting decisions.

As our industry has become much more highly competitive and rates of return have become thin or nonexistent, the fundamentals of careful selection and judicious pricing of risks are more important than ever, and the underwriter must be much more aware of the bottom-line impact of his or her underwriting decisions.

Cannon: I'm not sure that property/casualty insurers in general have learned any lessons from their recent flirtation with cash flow underwriting. They should have learned, again, that it doesn't work. It never has. I don't feel that the role of the underwriter has undergone a permanent change; to the contrary, I would suggest that what we have experienced over the last several years has strongly reaffirmed that the role of the underwriter should be what it has been defined to be.

Haugh: We have learned this still is a business of measuring risks and exposures. The traditional role of the underwriter has not changed; it has been rediscovered. Individual risk selection for the majority of our business, at least the majority of commercial accounts, is more important than ever.

Scheel: While the property/casualty industry always will be cyc I believe that companies will be more cautious next time. The lesson learned is that if you allow your products to be severely underpriced for a long enough period of time and abandon all underwriting principles in the process, the price you have to pay is a hefty one. I believe that if present managements are still around when the cycle turns again, we will see more moderation. If not, who knows? The underwriter remains a key employee in our organization and that will continue. □

Many observers have pointed to the likelihood of additional insolvencies in the property/casualty industry before companies return to underwriting profitability. Do you agree? Will state guaranty funds have the capacity to cope with such a situation, given the fact that assessments for the state funds cannot exceed a stated percentage of the capital base of assessed insurers?

Bailey: We do not believe that any well-run insurer is in imminent danger of insolvency.

Trowbridge: We agree with the suggestion that many companies in the property/casualty industry are headed for, if not already in, financial difficulties. It is hard to say how many insolvencies there actually will be since many will no doubt be averted through the merger and acquisition route. To the extent that companies will reach the state of insolvency, there will be a growing strain on state guaranty funds and this, in itself, could contribute to a snowballing problem of companies' solvency problems on a wider scale.

Morgan: There will be more insolvencies, but little ones. The industry will not let a big one go under. State funds can't handle big ones. They were designed for little busts.

Nolan: As in all such periods, there certainly will be a number of property/casualty insurers that will fail. These failures will occur for a variety of reasons. It is difficult, if not impossible, to predict how many and what size they will be, as the dynamics of the marketplace and management actions will work toward the improvement of many insurers currently in trouble.

The primary challenge in this area is a better system of preventing these failures before they occur. State regulators must give this area of their responsibility a high level of priority. Their identification and oversight of

PAUL A. DONALD

weak companies must improve. If identified early enough, the number of potential failures should be minimized. This should be handled by more timely and appropriate analysis of a more focused set of insurers, by more highly qualified personnel and by more timely action to correct the particular problems being addressed.

Bretherick: The fact that in 1984 investment income in the property/casualty industry did not cover the underwriting loss has sent home a clear message, and that includes the prospect of additional insolvencies. Those insurers that continue to resist taking corrective steps beyond a critical point for their companies will have to adjust their operations in some other way—possibly through capacity withdrawals.

There indeed may be some insolvencies. Should they occur, we believe some state guaranty funds will be unable to respond in full and that will necessitate delaying payment for some claims. Changes in the funds are needed to ensure that their resources are used appropriately. We also believe a properly structured pre-funded guaranty fund would be a better alternative to the current method of assessment.

Frahm: Additional insolvencies will occur. We believe more and more individual state guaranty funds will become inadequate (Florida has already "maxed" out and some claimants could wait as long as three years for sufficient funds to flow to them.) An industry move towards developing a prefunding mechanism through mandatory surcharges on policyholders is supported by the Hartford. This could provide a more adequate alternative to the current percentage of capital base assessment method.

Countryman: Whether or not the property/casualty industry ever will return to underwriting profitability is open to serious question. However, it is likely to achieve underwriting stability and overall profitability. There is some likelihood of insolvencies before returning to more stable conditions, although this could be prevented by mergers, consolidations or higher interest rates. On the other hand, destabilizing macroeconomic conditions or worsening trends in tort liability cases could push the industry into multiple insolvencies, in which case the guaranty funds probably would not have the capacity to respond adequately.

Ballus: We expect not only additional insolvencies but also that the internal financial constraints in many companies will impact the industry. We do feel state guaranty funds have the capacity to cope with the expected level of insolvencies.

Hutson: Yes, additional companies will become insolvent, actual or technical, because (a) many companies show surplus positions only because of deep underreserving in loss reserves, and (b) gimmicks designed to inflate the value of the balance sheet no longer are available.

> "If identified early enough, the number of potential failures should be minimized."

We do not anticipate any major insolvencies. Rather, we expect to see more changes in the form of mergers and additional growth in the form of acquisitions. Therefore, state guaranty funds should be able to cope with the insolvencies that do occur. Depending on the amount of new money flowing into the industry, the pressure on state guaranty funds may not be as great as some project. In the end, the big losers will be the stockholders of the carriers forced to the wall.

Donald: Yes, there will be insolvencies. I think the state guaranty funds should have sufficient capacity unless a very large carrier becomes insolvent. Much more likely, in my view, are more acquisitions and mergers within the industry.

Ansbro: We believe that the very magnitude of operating losses being experienced by the industry quite possibly could generate additional insolvencies, although the encouraging turn in commercial lines pricing gradually should alleviate some of the financial pressures on companies writing this business. However, the industry still faces the longer-term possibility of insolvencies from the industry's more persistent problems, including social inflation, asbestos, pollution coverages and a growing number of environmental issues.

While guaranty funds have significant resources to meet policyholder obligations even should demands on these funds increase far beyond historical levels, their capacity really has not been challenged to date. When a major insolvency has materialized in the past, the inadequacies of the guaranty fund mechanism have become apparent. The solution usually has rested in infusions of fresh capital, takeovers by outsiders, or voluntary, insurer-supported rehabilitation efforts at great cost to the industry. In light of this experience and continuing concerns about prospective insolvencies, the industry is seeking to develop alternatives that will expand the guaranty fund system's financial capacity and improve its flexibility to deal with varying situations involving such insolvencies.

Cannon: It seems possible at this point that there may be additional insolvencies in the industry before most of the companies have returned to underwriting profitability. However, I expect that the state guaranty funds will have the capacity to cope with the situation as it develops and that to the extent that the state guaranty funds do not have the capacity, the private sector will step in as it has on other occasions and do

JAMES W. CANNON

what is necessary to keep insolvencies from becoming a major problem for the industry.

Haugh: There are companies operating today whose financial security is severely impaired. I would not be at all surprised to see additional insolvencies. Of course, whether impaired companies are placed into rehabilitation or declared insolvent depends on a number of things, including the degree of scrutiny by regulators, the confidence of a regulator in a management's ability to manage the company through the difficulty without further impairing capital and the ability of the companies to raise additional capital. A severe weather catastrophe might put some companies over the edge.

Many insurance departments do not have the resources to monitor companies' solvency adequately. The National Association of Insurance Commissioners needs to develop a comprehensive computerization plan.

As to the capacity of the state guaranty funds, obviously their capacity is no better than the capacity of the insurers that have to pick up the tab for insolvencies. The insolvency of a large multiple-line company could bankrupt some small companies and certainly would further reduce the underwriting capacity of most insurers.

Scheel: There will be more insolvencies, but the dramatic price increases we are seeing will tend to prevent some companies from getting into serious trouble. The many steps taken by the larger companies to bolster surplus makes me believe that we will not see a major insolvency. I'm referring to the raising of new capital, termination of overfunded pension plans and various innovative investment accounting transactions. □

Has the situation in the property/casualty industry reached the point where insurers must seriously consider the use of supplementary distribution channels in order to cut down on expenses? Is your company contemplating the use of supplementary channels, or has it already done so? What form will they take?

Bailey: Yes, insurers must consider using supplementary distribution channels. We have experimented with agencies in piloting the distribution of insurance products through bank outlets and employer-sponsored arrangements. We are also working on ways to make agents more effective in responding to the needs of the marketplace.

Trowbridge: There seems to be an expanding search for alternative distribution methods in the property/casualty industry, with the growing realization that our costs of doing business are just too high.

Any different approach to distribution on the part of the Atlantic would be centered on the independent producer since we remain committed to that system. We do feel, however, that there must be a fundamental change in the way companies and producers interact in the independent system if that system is to survive and flourish.

Operating functions must be intelligently allocated between the company and producer; compensation must be related to actual costs and intelligent incentive programs; and a long-term plan for stability must exist. The relationship between the two entities should be structured so that the carrier and the distribution force can regularly exchange ideas and work on agreed-upon business plans.

We are in the age of the entrepreneur and the independent agent is, or should be, an entrepreneur. We believe a well-managed insurance company, combined with professional independent agents and brokers operating under a streamlined system, can meet the future very sucessfully.

Morgan: Insurers don't have to seriously consider using supplementary distribution channels, and we're not contemplating them at Cincinnati.

Noha: The cost of doing business is a significant profitability and competitive concern, both on the part of insurers and agencies. We are both attacking this concern on the expense side by moving rapidly on the automation front, as well as seriously examining the question of where administrative functions can be performed most efficiently. Partially as a result of the recent rise in premium rates, some companies are moving to reduce the rate of commissions in an effort to reduce their overall expense levels.

Many insurers that are financially sound are reanalyzing their marketing strategies to determine what markets will be profitable in the future and how these markets can be more effectively penetrated, in terms of both the cost involved and potential market share. For example, some direct writers and life companies have begun utilizing brokerage sources of business while some independent agency companies have begun to experiment with alternative distribution methods such as direct mail and selling through banks and exclusive agency arrangements. These are all attempts to increase profitable business while reducing overall

EDWARD J. NOHA

unit costs. This trend toward target marketing of both agents and customers and the use of multiple methods of reaching different segments of consumers will continue.

We feel that there is significant potential to be gained by working with our independent agents in making

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them more effective sales organizations to achieve a higher level of penetration of their markets. We are encouraging this trend and assisting agents through benefits and tools that we offer as a part of our High Performance Agency Program. These more effective sales operations should improve agents' volume and unit costs, and also our volume and unit cost level, as a result of both our agents' increased volume and our higher penetration of that volume.

In sum, we feel that we and our agents have the potential for significant unit cost savings with more efficient operations, increased volume of profitable business and higher penetration of our marketplace.

Bretherick: Early in 1982 Continental developed a new strategic plan to redirect its resources toward development of multiple distribution channels, instead of relying exclusively on a single channel. This is not supplementary nor specifically intended to reduce expenses. Each distribution system stands on its own with respect to costs as well as the markets it intends to serve. Although our independent agency network has decreased in the number of agents, it has improved in performance and it will remain our primary source of revenue for the foreseeable future.

At the same time, we are finding new and expanded ways to work with large national and international insurance brokers through our recently formed brokerage and special operations group, as well as with the new nontraditional distributors of insurance products that are entering the marketplace as the financial services industry continues to develop. Two experimental distribution programs within our financial services group are Cenguard and The Insurancenter.

> "We must recognize that some customers are seeking alternatives that eliminate an intermediary."

Frahm: There is no doubt that marketplace forces are mandating that insurance companies look at other distribution techniques to reduce total corporate expenses to compete successfully for business commonly referred to as commodity products.

The Hartford Insurance Group entered into a large merchandising program in association with Alexander & Alexander to provide personal lines coverage to the members of the American Association of Retired Persons. This program is being marketed and serviced both through the mail and by telephone. While there are no current plans to expand the use of this or other distribution techniques, to insure our mutual long-term survival, companies and agents will continue to give serious consideration to enhancing existing distribution techniques, and some companies will develop supplemental channels.

Countryman: Increasing productivity and expense control will continue to be major competitive weapons in the insurance industry. Acquisition expense clearly is a major expense component that must be monitored and controlled. Liberty Mutual does not anticipate any substantive change in its distribution system.

Ballus: Some companies probably will use supplementary distribution channels in quest of expense reduction. This may cost more than it will save. There is no contemplation of this on our part at this time.

Hutson: We do not believe that the current industry situation warrants major use of supplementary distribution channels. At this time, we are committed to the viability of the independent agency system, and we will continue to operate accordingly. There will be changes within that system which will be innovative.

Donald: We are using as many as eight different channels of distribution at specific locations right now. Some of these overlap and we're continuing to evaluate new approaches. Our motives are partly for expense reduction, but also to facilitate our expansion efforts, as well as recognizing the marketing

value of multiple distribution systems.

Ansbro: The industry must consider supplementary channels of distribution for reasons beyond the unquestionably important need to reduce product delivery expenses. In today's marketplace, an increasing proportion of buyers feel comfortable handling their own financial services transactions. Witness the evolution of discount brokers, the popularity of catalog buying, the enormous number of transactions through bank ATMs and the success of telemarketing programs.

While there always will be a market for insurance services provided by agents and brokers, we must recognize that some customers are seeking alternatives that eliminate or minimize the need for an intermediary. Therefore, while our primary marketing thrust will continue to be through independent agents and brokers, we also must keep abreast of changing buying habits and the marketing opportunities they may present.

Cannon: We feel that we should consider the use of additional, supplementary distribution channels not only to cut down on expenses, but also simply to better sell our products. We are presently experimenting with one or two such supplementary distribution methods (one of them involving a bank in California) and although it is still far too early to make any final judgment on how successful they will be, we believe the need is great enough that we should continue looking for such additional methods.

Haugh: While both insurers and agents should be open minded about testing new approaches, we have no programs in the works to bypass the independent agency system. To the contrary, we're working hard to strengthen the system. Several years ago, we commenced a program which is helping the independent agents representing us to become more effective in marketing strategy, enhancing their sales management capabilities, assisting them in automating office operations and supporting their business expansion.

Scheel: Many insurers already have concluded that they must have alternative distribution channels available to them. We have concluded otherwise. We believe that the American Agency System is the best distribution system available, and we intend to market our insurance products exclusively through independent agents. □

A recent study by the Insurance Services Office projected that the capacity of the property/casualty business could fall short of demand by as much as $62 billion over the next three years, with 90% of the expected shortage falling in the commercial lines. Do you agree with ISO President Daniel J. McNamara's assertion that the coming crunch warrants a reevaluation of the barriers to entry into the insurance business by other financial institutions?

Bailey: We do not shrink from responsible competition on a "level playing field," but we know from past experience that there is no place in the property/casualty insurance business for amateurs that do not have significant financial strength and staying power.

Trowbridge: We believe the barriers to entry into the insurance business by other financial institutions eventually will be reduced or removed. We do not view this in a negative light, as long as they are not given special advantages as compared with the rest of the industry.

In other words, if supply and demand attract additional capital into the business, we have no objection to its being allowed to enter as long as it plays by the same rules, with the interests of the consumer appropriately considered.

Morgan: I don't agree that the coming crunch warrants a reevaluation of the barriers to entry into the insurance business by other financial institutions. The insurance industry needs to reemphasize its commitment to underwriting profit, and the investors will respond. The banks don't handle their business well; they will create problems because of their lack of understanding of the insurance business.

Noha: We feel that the insurance marketplace is more resilient than Mr. McNamara indicates. Although the underwriting cycle is now at its lowest point, there are signs of improvement on the horizon. Although some insurers are still short in their reserves, movement is being made in the right direction. We recently have seen successful stock offerings made by several insurers to increase their capacity to write business. This shows that the market is willing to put its money into the property/casualty insurance business and that the industry is able to raise additional capital. Financially sound companies like CNA are ready and willing to expand their writings. The growth in the last decade in the variety and volume of self-insured plans also will help to meet a capacity shortfall.

However, there are property/casualty companies which have cut back significantly. Other market forces are at work in our dynamic industry to make up for significant chunks of this reduced capacity. The most significant capacity problems will involve risks with substantial extra hazards, such as EIL and malpractice. The fundamental problems involved with such high-risk areas, with interpretations arising from our current tort system of justice, the cost of administering this system and the role and cost of lawyers in this civil justice system, will result in significant challenges in the years to come.

Allowing other financial institutions to enter the insurance underwriting business will not significantly help to solve these problems. They now have no particular expertise in insurance. Outside money is more likely to be raised by organizations with this expertise. In order to gain expertise, other financial institutions would most likely have to buy their way in by pur-

chasing existing insurance companies. Such acquisitions would not by themselves add any capacity.

These financial institutions are highly unlikely, if they purchase companies, to want to expand in the areas where the significant capacity problems may arise, i.e., high-risk industries, risks and coverages. They have not yet recognized the damage to their existing customer relations that will be caused by the selective nature of the underwriting process and the adversarial nature of the claims process.

In addition, there are other, often quoted problems with having other financial institutions enter insurance. These include (1) probable tie-in sales

JOHN BRETHERICK Jr.

or at least the perception of the existence of tie-in sales; (2) the current financial difficulties of the banking industry; and (3) the combination of the importance of the banking industry to the economy and the extreme public sensitivity to financial cycles or shocks that could impact banks, e.g., the recent Ohio banking crisis.

Bretherick: The capital needs of our business should not be a reason to change the rules governing the marketplace. But I don't believe that Mr. McNamara was suggesting this. The reevaluation of the barriers, frankly, has been going on for some time. The current changing insurance environment should not, however, be viewed as a threat requiring preventive legislation, nor need it have a negative impact on insurance companies or agents. We believe that innovative, aggressive marketing is the key to success in the evolving financial services marketplace for both insurers and independent agents. Banks may successfully distribute insurance to some markets, and that presents opportunities to insurance companies as well as some agents.

Frahm: We do not agree with Dan McNamara's position on the coming crunch because (1) those large companies that had real or potential capacity problems already have addressed the issue through equity and debt market financing and through surplus contributions from conglomerate parents; (2) the benchmark against which ISO measures its capacity shortage has been widely challenged; and (3) most financial analysts are forecasting a growth in capital in excess of premium from 1986 onwards.

We feel that any form of capacity crunch therefore will be very short-lived because the property/casualty industry has plenty of opportunities for increased capacity. However, the disarray in the reinsurance business will put a severe short-range strain on the property/casualty business.

Countryman: Although there is general support for the notion that there will be a severe capacity shortage, primarily in commercial insurance, this capacity crunch does not bear on whether other financial institutions should be allowed entry into the insurance business. There are many potential sources of capital for the insurance industry other than banks.

The merging of two critical elements of the economic infrastructure—banking and risk spreading—should be considered in light of much deeper issues. The argument should center on the capability of various government regulatory entities to safeguard the capital of the two industries if merged. This capability is dependent on the development of reporting and control mechanisms that would give regulators the ability to determine the capital adequacy of a combined financial institution. In any case, all players in the game should conform to the same rules.

Ballus: We do not support or oppose the entry of financial institutions into the insurance business as long as their activity is carried on through independent affiliates and is subject to equal functional regulation. Competitors must adhere to the same rules and regulations.

Hutson: I agree with Mr. McN a that there will be a capacity shortfall over the next three years. Many companies already are pushing certain NAIC warning categories, especially the ratio of surplus to written premium.

The question is, "How much?"—$62 billion probably overstates the amount. In the last 60 days (as of this writing), at least six major insurers have gone into the money market, issuing either stocks or bonds without any problem. Also take note that London is not having any great problems bringing in new money and new names. Therefore, it is premature to assert that other financial institutions will be needed to forestall a serious crunch in insurer capacity.

Donald: Whether or not we reevaluate the barriers to entry into the insurance business, they will change since the market will demand it. However, the insurance industry will recover and will develop new ways to accommodate the capacity shortfall. I believe the other financial institutions have significantly underestimated the difficulties of the property/casualty business.

Ansbro: Although the markets for reinsurance and certain classes of commercial business are very tight, and we

ROBERT F. BALLUS Jr.

believe that the industry's premium to surplus ratio will continue to rise, we do not foresee a capacity crunch of the magnitude suggested by Mr. McNamara. Some companies are leveraging their underwriting capacity by writing at premium-to-surplus levels that are significantly higher than the industry

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average, while others recently have been raising new capital to partially replenish their eroded surplus positions.

Banks and other domestic providers of financial services already have made clear their interest in entering our business, and we also expect that further foreign capital will be attracted to our industry in the belief that commercial lines profitability is being restored and the industry earnings outlook is improving. Since we do not expect a severe capacity crunch, we do not agree with Mr. McNamara's contention that this creates a need to reevaluate the barriers to entry into the insurance business by other financial institutions.

Cannon: Dan McNamara has a good record for predicting what's going to happen in our business, and I agree with him that there is going to be a capacity shortage—especially in commercial lines—over the next several years. Whether it's going to be $62 billion or not is not particularly important in my mind because it will be measured in the billions of dollars and, as such, will create quite a bit of pressure, especially on the independent agency side of the system.

Conceivably, that could result in the lowering of the barriers to entry into the business by other financial institutions. It's quite possible that could happen, but it will not be a particularly significant development in the business overall.

Haugh: We believe the critical question is whether our industry has the right to oppose new competition as long as everyone operates under the same rules, and the rights and interests of the general public are protected. But there certainly are issues to be addressed.

One of the most serious potential problems is that of insolvencies. Policyholders and claimants of an insurer affiliated with a bank must be insulated from the financial effects of a bank failure and vice versa. We do not believe a bank should be allowed to engage in the business of insurance directly. Only a bank holding company, under provisions which separate both assets and management of the banking and insurance operations, should be permitted to own and operate an insurance operation. And, of course, tie-in sales, explicit or implied, must be prevented.

Scheel: The entire financial structure warrants a reevaluation. The barriers between various financial institutions have been created and are based upon good and substantial reasons, and they should not be significantly altered.

This is not the method to increase capacity. With the chairman of the Federal Deposit Insurance Corp. predicting an all-time high in post-depression bank failures, it is hardly an auspicious time for lowering barriers allowing banks to do other than banking. To do so would strengthen neither banks nor the insurance industry, but rather permit commingling of funds.□

If financial services deregulation does gain congressional endorsement, what changes in the insurance regulatory structure would be warranted?

Bailey: If financial services are deregulated by Congress, we would seek a level playing field through which insurers could enter businesses which are now restricted to them, on equal terms with current players, and in which new players entering the insurance field would be subject to the same capitalization and reserving requirements as traditional insurers. Moreover, we would seek either state or federal regulation, but not both. (We'd prefer the flexibility of state regulation.)

Trowbridge: If financial institutions enter the insurance business, it seems almost certain that change will have to take place in the insurance regulatory system. Since most other financial institutions are regulated at the federal level, it is likely we would see a push for more federal regulation of the insurance business. The financial institutions themselves, already used to federal regulation, would feel more comfortable with expansion of regulation at that level rather than the uncertainty of state insurance departments. We doubt that federal regulation will ever replace state regulations completely, but it does seem likely that dual regulation would occur.

Morgan: No changes in the insurance regulatory structure would be warranted.

Noha: A specific answer to this question really depends upon the type and degree of deregulation which is enacted. In general, two changes would naturally be in order. First, all regulations relating directly or indirectly to rates should be eliminated. Freedom of action in the area of pricing products should be allowed for all financial institutions, not just some.

Second, if other financial institutions are allowed to own or operate insurance underwriting facilities, then insurance companies should be able to enter into other financial service arenas. This implies that all such institutions or appropriate subsidiaries should be able to operate in any or all segments of the financial services industry. One side should not be restricted if the other is not.

Bretherick: If financial services deregulation comes about, we believe that bank-owned insurance companies should be regulated as self-contained entities in the same way that any other insurance company is regulated. There should not be a blurring of the lines between the bank's and the insurance company's finances and underwriting functions.

Frahm: If banks are authorized to underwrite and sell all forms of insurance, it is likely that their insurance operations will have to be "walled off" from their banking operations with separation of assets and liabilities and separate regulatory systems. Regulatory concern over coercive tie-in sales, predicating loan-making on the purchase of insurance, is likely to generate enactment of new, more effective "anti-coercion" laws designed to protect the public against such unfair trade practices. In large part because of concern over tie-in arrangements, Congress is seriously considering a flat prohibition

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SPEAK OUT—FROM PAGE 36

on banks getting into the insurance business.

Countryman: All players in the financial services game should conform to the same rules. Federal deregulation of banking would not imply that state insurance regulations could be ignored.

Ballus: We believe that there is very little likelihood that any action will be taken by Congress this year with regard to financial services deregulation. It is most important that any Congressional action that may ultimately be taken assure the continued regulation of all insurance operations at the state level and the present right of insurers to continue activities now permitted under state insurance laws.

Hutson: Introduction of now excluded financial institutions into the property/casualty insurance business would doubtless place greater weight on state regulation to oversee their financial capacity. State statutes would have to be greatly revised, setting forth additional legal and financial requirements and prohibitions. A considerable rewriting of state insurance laws would be required.

Donald: I would expect to see a closer coordination between state banking and insurance regulation. The focus would be largely on maintaining the arms-length relationship between the banking and insurance transaction, while perhaps allowing a single enterprise to engage in both endeavors.

Ansbro: We understand that the current session of Congress probably will not address financial services deregulation beyond the specific issues of nonbank banks and the South Dakota loophole. If this is the case, the pressures possibly leading to change in the insurance regulatory structure are likely to be eased. Moreover, we currently do not expect the individual states to be promoting financial services deregulation in the near future.

While there is much room for improvement in the insurance regulatory structure, we see no need for wholesale change. In particular, we are concerned that combinations of banking and insurance within single operating entities have great potential for regulatory conflict. The uniquely different nature of banking and insurance, reflected in totally different kinds of risk assumption and means of providing for those risks, requires separate regulation. Any consolidation of funds or failure to separate them for regulatory accounting purposes could confuse or conceal activities that would otherwise warn of trouble in either or both of the merged enterprises.

Cannon: If financial services deregulation does indeed gain Congressional approval, I don't have any firm convictions on exactly what changes in the regulatory structure should be made, but I do feel that the focus of the regulation should be at the state level, with as little as truly necessary at the federal level.

Haugh: The ability of either bank regulators or insurance regulators to monitor for solvency obviously is already a problem now. Bank deregulation would increase the problem, and, as noted, this is our main concern with bank deregulation.

Insurance operations, regardless of ownership, should be capable of being regulated by the states' insurance regulatory authorities. Keeping the insurance function separate from the banking function would enhance the ability of insurance regulators to regulate the insurance function without interfering with bank regulators' oversight of the banking function.

Scheel: Banks have the central role in the commerce of the United States, particularly due to their role with credit. Given the volatility of the insurance industry, an insurance company owned by a bank could prove, in bad times, to be very costly to banks' financial status. Financial reporting, commingling of funds, insolvencies and guaranty funds are all problems to be worked out.

Given the variety of bills considered in Congress and the prognosis that the more conservative ones—those which will strengthen the barriers—have an excellent chance of passing, it is difficult to predict what changes in the insurance regulatory structure would be warranted.

State regulation has a vital part to play in any insurance climate, both from a consumer and company standpoint. It provides the consumer with the ability to deal with problems through a local entity, one more effective than an omnibus department in Washington. □

Some observers have pointed to hazardous waste litigation—the possibility of mass liability suits resulting from exposure to toxic substances and pollution—as an area that could dwarf the problems relating to asbestos. Is environmental pollution the pending "catastrophe" that could break the back of the property/casualty industry? Is it likely that private insurance in this area will be replaced by federal "superfunds" in the future, given the fact that few markets for EIL coverage remain?

Bailey: Pollution-related costs remain a great unknown, but they are a national problem, not the problem of the property/casualty industry alone. By one recent estimate, it may take 50 years and cost $100 billion just to clean up known toxic waste sites in the United States, and this figure does not begin to anticipate potential costs related to health and property damage.

Despite some recent court decisions to the contrary, comprehensive general liability policies written since the early 1970s specifically exclude liabilities related to gradual pollution, and it is in this area that the American Insurance Association has petitioned the Congress for relief from claims made by the Environmental Protection Agency under the Superfund's enforcement of strict, joint and several, retroactive liability. Perhaps a small but broad-

based tax on all major industries may fund a more effective clean-up effort in the future.

Trowbridge: There are two principal segments to this question—the first having to do with the treatment of pollution by the courts and the second having to do with the position in which insurers have been placed. On the first point, it would seem that for the longer run, more extensive legislation will have to be developed, probably at the federal level, to deal intelligently with actual damages and with punitive actions.

If some level of realism is not introduced into the system, the potential catastrophes are of such magnitude that the impact on American society will be devastating. Until something is done in the way of specific legislation, it is likely that federal "superfunds" will grow since industry cannot bear the brunt of these environmental pollution catastrophes. The weight will be shifted to the shoulders of the taxpayer.

As far as the insurance industry's role is concerned, we think it is fair to say that the industry never intended to cover conscious, deliberate pollution of the environment with hazardous wastes. What was intended was coverage for accidental events, but the courts have tended to refuse to distinguish between deliberate and accidental pollution, thus rendering the gradual pollution exclusion useless.

The legal system has managed to corrupt the clear intent of insurers by deciding the existence of coverage for many pollution and toxic substance exposures as part of what seems to be an effort to rearrange the wealth of the nation to satisfy social and political ends. If the merits of any specific case call for punitive action, the consequences should not be passed along to the insurance industry, and appropriate alternative remedies must be found.

Noha: The potential problems associated with pollution are tremendous and complex. The insurance industry cannot solve these problems by itself. First, proper attention must be placed on prevention of future problems that might be caused by new manufacturing facilities, new treatments of hazardous waste, etc. New standards need to be developed, most likely by researchers, industry and government working together, to help assure that the future does not hold as many surprises as we are now experiencing. Extra dollars spent by the business or governmental units responsible now for prevention will be well spent.

Second, substantial effort must be undertaken to clean up existing facilities. Part of this is now beginning to be undertaken by the federal Superfund. Some combination of business and government must develop the massive amounts of money needed to properly clean up currently existing hazardous sites. Exactly how this effort should be funded is a matter for public debate and will likely differ by type and source of hazard.

> "The legal system has managed to corrupt the clear intent of insurers."

Third, the question which directly relates to the insurance industry is who should pay for the liabilities and damages that will occur as a result of the large current problem. Accidents and injuries involving hazardous substances involve significant and complex legal and funding questions. The application of the current tort system has muddied these issues and exacerbated the severity of future problems in this area. Some of these problems have arisen from extremely broad and vague federal regulations.

The courts have added to these problems by modifying the common law liability for injuries with overexpansive interpretations. Costs have been magnified by rising social expectations and the high cost of attorneys and the legal system. One of the issues that must be resolved is to achieve a clearer and narrower definition of the risks involved to make them more manageable and determinable. If a resolution of these legal issues can be reached and the ultimate cost lowered, the insurance industry will be more able and willing to participate in appropriate solutions.

Bretherick: It is difficult to speculate whether hazardous waste litigation will reach or surpass the level of the asbestos situation. The major problem in the environmental field is future exposure, which is incalculable. The present attitude of the EPA and the status of the law are such that insurance companies are unlikely to write any kind of environmental liability exposure. The doctrine of joint and several liability, coupled with the strict liability doctrine, makes it an impossible risk to assume. We believe that the Superfund should in fact develop a nontort method of responding to cleanup, damage and injuries resulting from the sins of the past.

Frahm: Insurers long have been skittish about writing pollution liability coverage. Unless they intended to write gradual pollution coverage (as they did under the very few specifically worded endorsements which provided it), they limited coverage to sudden and accidental occurrences. A recent court decision has reinterpreted this limitation to find coverage where none was intended by the insurer. This has resulted in more and more insurers turning to "absolute" pollution exclusion endorsements.

It is too early to tell how other courts will treat old policies with "sudden and accidental" language in them, but insurers will strongly defend any new challenges to that language. Federal legislation probably will be necessary to resolve these problems before they reach a crisis stage. That legislation could retain a private insurance function, while recognizing that it is inappropriate for insurers to be expected to absorb the risk of gradual pollution losses without federal help.

Countryman: We believe the problems of environmental pollution are extremely important, and a solution is crucial to the industry. Certain limited pollution coverage was intended, and that could be managed. But the sweeping expansion beyond what was intended cannot be managed without adequate revenue to support the expansion. Further, private industry and its insurers should not be expected to be accountable for actions that were considered acceptable at the time they were taken. A Monday-morning rewrite of the rules should not be accommodated. It is very likely that little, if any, private insurance will be available, that there will be few markets if any, and that federal support will be necessary.

Ballus: The requirement for immediate

anup and payment of liability claims for exposure to toxic substances and pollution would dwarf the asbestos problem and far exceed the industry's capacity to respond and survive in its present form. Major reform of the civil justice system and, over time, cleanup would moderate the situation, but help from all industries responsible for the problem along with responsible governmental assistance still would be necessary.

Hutson: Environmental pollution may not be the pending "catastrophe" that could break the property/casualty industry, but its specter looms large, posing a potential catastrophe to the industry. The likelihood that private insurers will be unable to cope with the exposure now or in the future is directly related to what demands the courts and the Congress place on us. The issue is before Congress now, and the courts are sitting poised to do their worst if some changes are not forthcoming.

Donald: I suspect that our limitations in knowledge on a wide-scale basis will keep the EIL market very restricted. The industry does not have the capacity for the potential loss and litigation some seem to expect from environmental pollution, yet I do not see the solution coming from any federal superfunds.

Ansbro: The bottom line of hazardous waste litigation is that no one really knows exactly what will happen. Although we are not predicting that environmental pollution claims will break our industry's back, this could happen unless legislative action is taken at both the state and federal levels to correct growing abuses of the tort system, including reinterpretations of insurance industry liabilities and contracts by the courts.

The private market for pollution liability coverage continues to dry up at an alarming rate, but Congress currently does not seem interested in replacing the private insurance mechanism with a new federal superfund. This is despite the fact that prevailing law essentially has forestalled the effective use of private insurance by applying a nearly absolute joint and several liability approach to pollution liability.

This approach creates retroactive liability and eliminates or reduces defenses, preventing today's insurers from prospectively assessing the individual risk and providing coverage bearing a rational and predictable relationship to an enterprise's conduct and potential for creating harm caused by hazardous waste.

Cannon: I've been in the insurance business some 36 years, and in that period of time have heard of several impending catastrophes that were going to break the back of the property/casualty industry. Yet, in each case, the industry has proven surprisingly resilient, and I feel that will be the case once again when we look to the issue of hazardous waste litigation and the potential liability that could result from exposure to toxic substances and pollution.

However, it seems to me that in this area of hazardous waste litigation (as in the case of earthquake), there is a legitimate role for the federal government. The challenge is to define a combination role involving both the government and the private insurance industry that will fit the needs of the population at large and yet keep the involvement of the government to no more than necessary to reach a workable solution. This is one of those few situations where it seems apparent that the financial capacity of the private insurance industry may simply not be capable of responding to the need.

Haugh: Environmental pollution is a very serious concern. Adoption of the ISO total pollution exclusion is essential because recent judicial decisions have expanded the interpretation of the more limited exclusion. Nothing short of total exclusion seems safe from judicial broadening of the coverage. Of course, that doesn't eliminate potential exposure from policies written prior to adoption of the new exclusion.

Congress is more aware today than in the past of the legitimacy of the industry's concerns and why the EIL market is almost nonexistent. However, it's very difficult to predict what Congress will do.

Scheel: Hazardous waste legislation is subject to constant change. The present climate in Washington is encouraging from an insurance standpoint in that many in Congress recognize that it was never intended that the insurance industry pay for on-site cleanup costs of hazardous waste.

While it may be an oversimplification, I believe that the insurance industry will be in a much better position regarding the retroactive coverage of hazardous waste disposal than anticipated, even a short time ago. Congress has recognized the gravity of this problem and the unfairness of imposing this burden on the insurance industry. I do not believe that toxic waste will break the back of the property/casualty industry. Availability is an area that, given present case law, is uninsurable. □

The financial security of reinsurers and the quality of a primary company's reinsurance program have attracted increased attention in recent months. Are primary companies likely to become more selective about choosing their reinsurers, or is reinsurance in certain lines becoming difficult to obtain at any price?

Bailey: The answer to both questions is yes.

Trowbridge: There has been a definite contraction in reinsurance capacity in recent months as a number of companies have withdrawn from all or part of the marketplace. Cash flow underwriting has caught up with the reinsurance industry, and it is expected that a number of companies no longer will meet the standards established by the ceding companies. Because of strains on their financial assets from other sources, primary companies will no doubt grow more concerned about the quality of their reinsurers, and well-managed companies will become even more selective in this regard.

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Morgan: Yes, primary companies are more likely to become more selective about choosing reinsurers. In malpractice and tough casualty lines, reinsurance is becoming more difficult to obtain at any price.

Noha: The reinsurance market appears to be getting tighter by the day,

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both in terms of capacity and price. Reinsurers are becoming more selective about whom they will do business with and are increasing their rates to better reflect the quality of the insurers they are insuring and the coverages they are reinsuring. On the other side, primary insurers, when they have a choice, now are more carefully considering the financial stability of potential reinsurers than they have in the past in putting together their reinsurance programs.

Both of these trends point to a need for developing and nurturing long-term partnerships between the primary insurer and its reinsurer. Both will be concerned with the financial stability of their partner and quality working relationships.

However, I believe that long-term relationships have been impaired due to the willingness of many reinsurers to provide cheap reinsurance during the past five years. In some cases, the availability of such reinsurance allowed irresponsible rate actions to be taken by certain primary companies that are no longer in business that have severely damaged the credibility and the profitability of the insurance industry. In addition, these same reinsurers now want sufficient rate increases to be made whole in a single year, an action which primary carriers cannot responsibly pass on to their policyholders in such a short period of time.

Bretherick: The financial condition of reinsurers always has been of paramount concern in the process of selecting markets for our placements. However, in light of industry developments, specifically poor results and numerous withdrawals, this has been intensified in the last two years, and professional commitment to the industry as well as long-term financial viability have become critically important to the primary insurer. We continue to find our reinsurance markets responsive to classical casualty covers. However, significant rate increases have become commonplace.

Although the response is there, capacity and some specialty exposures are another story. Many risks with large limits have found that the total amount of insurance available has been cut back. In some cases, programs with more than $200 million in limits have been reduced to less than $50 million on renewal. Are additional limits available to these concerns? We believe so—at the right price and terms.

Frahm: The financial security of reinsurers is a paramount consideration in the purchase of any reinsurance coverage. While this factor has not been uniformly considered by all companies, its importance is a sad lesson learned for many. The availability of market for most reinsurances is (like the primary market which it serves) in most instances a product of affordability. However, there will be severe shortages of cheap reinsurance supporting loose underwriting and extraordinary exposures. There also will be coverage shakeouts and relationship changes (follow the fortunes?). However, soundly priced and well-underwritten exposures will not lack reinsurance partners.

Newman: Prudent managements always have monitored the financial ability of their reinsurers. This is necessary whether a company's reliance on reinsurance relates to routine risk capacity or to catastrophe protection, and whether its exposures are long tail or short. Now, in light of recent guidelines issued by the American Institute of Certified Public Accountants and directives like New York State's Regulation 98, those who haven't implemented such procedures in the past are suffering from the need to do so quickly in order to meet compliance requirements.

As respects the availability of reinsurance in certain lines, the demand for insurance protection, especially in the higher risk casualty classes, is outstripping supply. In the last several months many reinsurers, stunned by massive 1984 underwriting and operating losses brought on by inadequate rates compounded by historically underrecognized liabilities, have become increasingly selective or simply have ceased accepting business.

Many now are emphasizing the simpler classes and better quality risks, and are limiting their acceptances to smaller participations. This situation will no doubt continue until terms harden to a point at which new entrants or new capital are attracted to the business, a process which appears already to have begun.

Countryman: Reinsurance capacity, like primary insurance capacity, will be inadequate, particularly in the reinsurance area as financial security becomes

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a greater issue. There has been much fringe activity in reinsurance and this is no longer acceptable. Regulators are more interested in reinsurance and security is more carefully measured. As suggested, companies are becoming more selective, and reinsurance is more difficult to obtain.

Ballus: Primary carriers must become more responsible in selecting reinsurance. There is no free lunch. Beware of cheap reinsurance.

Hutson: Reinsurance in certain lines,

for some carriers, is becoming difficult to obtain at any price. Primary carriers have little to choose from today. The best security lies in decreasing participation and requiring significantly higher premiums. The primary carriers, therefore, are required to sometimes lower, not raise, their security requirements. This, of course, does not refer to offshore shams, Johnny-come-latelies, etc. This class of reinsurer has

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always been outside the limits of proper business decisions.

Donald: I would think the reinsurers themselves will keep the heat up pretty high. The primary book has to be brought more under control through selective underwriting and adequate pricing. To a large extent this will be driven by the reinsurers.

Ansbro: Well-managed primary insurers are more aware than ever of the need to select only financially sound companies as their reinsurers. As a major buyer of reinsurance, we seek to deal only with reinsurers with strong balance sheets and the financial ability to provide a lasting market that will be able to respond when needed. At the same time, all primary carriers can expect to pay more for given amounts of reinsurance coverage, assuming the reinsurers are still willing to write them at existing or higher limits.

Reinsurance premiums are rising across the board, and the more troubled classes (environmental pollution, municipal liability, directors and officers, medical malpractice, to name a few) are experiencing a dramatic contraction in the reinsurance market. Also, retrocessions and reinsurance for managing general agents have become much more difficult to place, and availability is far less than a year or two ago.

Cannon: Given some of the shenanigans that we've seen over the last several years in reinsurance, it seems very likely to me that the primary companies are going to have to pay much more attention to their reinsurance programs. It's my impression that they already are well into doing this, and I think it emphasizes once again that the best long-term reinsurance program is one that involves picking out stable, well-managed reinsurance partners, treating them fairly and sticking with them through good times and bad. It's one more example of the need for a true partnership that will prove mutually beneficial over the long term.

Haugh: The answer to both questions is yes.

Scheel: We always have been selective about choosing our reinsurers and we will continue to be so. Reinsurers have lost confidence in certain lines due to legislation and court decisions, and this makes it hard to find a market in those lines. We hope that, through legislation and regulation, we will be able to bring stability to those lines and make them insurable. We believe that it is important, in good times or bad, to stick to basic fundamentals, and intrinsic in that is the importance of the selective use of reinsurers. □

What trends in the property/casualty industry and marketplace do you view as most encouraging?

Bailey: Encouraging trends include the firming of prices, the escalating (more realistic) cost of reinsurance and the serious attention being paid to the plight of insurers in the area of liability for toxic waste clean-up.

Trowbridge: The most encouraging trend currently is the obvious effort to return the industry to sensible underwriting activity and the achievement of profitability. The other encouraging trend is the effort to increase productivity and reduce our costs of doing business. This is centered primarily on significant advances in computer technology.

Not only is the computer being more and more utilized to drive the processing functions in both companies and producers, but the trend is also for using the computer in more timely and meaningful decisions on the part of insurance professionals. As a result, rote redundant tasks are disappearing as source processing by professionals increases. We are experiencing an improvement in the quality of jobs in the industry at all levels as a result of these technology advances.

Morgan: The trend I see as most encouraging is the return to sound underwriting practices through price increases.

Noha: A few of the more encouraging emerging trends are the following:

- Rate levels are beginning to move in the right direction. This movement is still not as widespread as it should be and will require significant additional rate increases in the next few years. We are happy that companies are now acting more rationally.
- Some companies are beginning to step up to capital and reserve shortages. Some recently have started to beef up their surplus position by going to the capital markets, indicating their willingness to continue to write business as well as to shore up deficient reserve positions. For the long term, this is a sign that there will be property/casualty capacity and more financially sound players in the marketplace.
- Both companies and agencies are taking advantage of automation to hold down costs and be more effective.
- Serious debate is beginning on some of the fundamental problems of our industry, such as the limitations of our current tort system. We are far away from solutions, but continued

dialogue will help us focus on the issues and reach eventual resolution.

Bretherick: The industry is living in an exciting time—a turning point in many ways. If the return to adequate pricing continues, and we sincerely hope it does, it marks the beginning of the long-awaited upturn in the cycle. At the same time, the evolution of the financial services marketplace that we are witnessing will create new opportunities to be tapped through innovative, aggressive marketing techniques and approaches.

Forced to deal with the intensely competitive pressures of the current market, companies and agents alike have become leaner, more efficient and healthier organizations, and the consumer will benefit from not only varied distribution sources but the kinds of products and levels of expertise desired at competitive prices.

Frahm: From the Hartford's point of view, it is encouraging to see:

- The return to more sensible pricing in commercial lines.
- The trend towards the industry having the financial stability to be more predictable to consumers and producers. This will eventually result from the financial "shakeout" that has occurred in the marketplace with some of the weaker players not a factor for the future.
- The return to professionalism from an underwriting viewpoint.
- Primary and reinsurance companies that show financial stability and professionalism being sought out by people who want to do business with them.
- The broad-scale concern for the need to review the general liability policy.

From an industry viewpoint, it is encouraging to see the industry recognize that it provides financial services. This has resulted in an increasing awareness of the need to focus on the consumer and how to package and deliver financial services products to the consumer. Also encouraging is the industry's recognition of the necessity to be cost-competitive with other segments of the financial services business.

Newman: It is encouraging that rates are moving up. There have been significant price increases in virtually all classes of commercial business, and we're seeing higher deductibles more readily obtained. We're also noting greater differentiation in pricing and coverage between average and poor risks.

The tightened reinsurance market has dried up the capacity of transient and at times unprofessional competitors, reducing the incidence of indiscriminate price competition. The security of reinsurers now is being more

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closely scrutinized by most primary carriers, reducing the risk that weak reinsurers still writing for cash flow could disrupt the primary marketplace.

Countryman: The change in industry attitude, the end of the cycle and the beginning of recovery are the most encouraging trends. The costs of the past few years have been heavy and are not yet fully determined. If adversity builds strength and if one learns from experience, the industry will be much stronger and wiser in the future.

Ballus: Encouraging trends include the return of sanity to commercial lines; the growing sentiment not to let personal lines reach the same position; and the upgrading of independent agents as professional representatives of their companies.

Hutson: The most encouraging trends in the property/casualty industry marketplace are (a) unanimity in the marketplace that commercial rates must be increased and quickly; (b) acceptance by agents that writing the risk, not substantially increasing the rates, is the most important consideration; and (c) gradual acceptance of market-driven products and delivery procedures.

Donald: The most encouraging sign is the reawakening of a price adequacy consciousness throughout the industry. Companies are returning to sound underwriting standards, and this means a faster return to stability and risk capacity.

Ansbro: I consider the following trends to be the most encouraging:

- The prospective widespread use of "claims made" liability coverage, in the presence of continued uncertainties related to such potentially costly coverage questions as cumulative trauma and environmental hazards.
- The apparently accelerating movement towards price adequacy in the commercial lines.
- A more flexible attitude on the part of some independent agents towards restructuring and strengthening their relationships with insurers to meet the growing competitive challenges to this system of product distribution.
- The trend towards greater automation and standardization to provide our industry's products in the most efficient and reliable manner possible.
- Recent efforts to limit the excesses of litigation such as California's cap on medical malpractice awards that was recently upheld by that state's supreme court.

Cannon: The trends that I view as most encouraging today are certainly the firming up of pricing in the com-

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me lines market and the rather obvious evidence that the majority of companies are beginning to do the things necessary to get back to a satisfactory level of profitability.

Haugh: The hardening of prices is very encouraging for the short term—1985 to 1987. Of course, hard pricing and restricted capacity won't last forever. New competitors will enter the marketplace, existing competitors will rebuild their capital positions and price competition will return. This won't happen at once, and we believe company managements will avoid the destructive price levels of the recent past, if for no other reason than that their boards and shareholders will have long memories about the consequences of deep price discounting.

I'm also encouraged that more and

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more customers are concerned with how well they are protecting their assets when they buy insurance. They are recognizing that the promise to pay is no better than the financial ability, or willingness, to pay. They understand the differences in coverage, service and financial security that exist from company to company.

Scheel: The most encouraging trend I see is the return to sound pricing policies and sound underwriting principles. Only when the industry is financially sound in its principal business are we truly healthy. We are seeing that return to basic underwriting which is, without a doubt, the most important and most encouraging factor in the industry today. □

BEST'S REVIEW
JULY 1985
PROPERTY/CASUALTY
INSURANCE EDITION

No More Free Lunches

BY THOMAS M. KELLY

It literally will take years for the property/casualty industry to gain back the ground that was lost during the last soft market. Rates will have to be increased dramatically in some areas. Order will have to be introduced to chaos. A 180-degree turnabout in underwriting practices must take place.

The task that faces us is the task of coping with liabilities from losses and claims already on the books, and those incurred but not reported, to say nothing of new losses and claims that will be generated on renewal or by new business underwritten. This is an undertaking that many companies will find extremely difficult to accept, much less accomplish. However, our industry simply must become loss and claim oriented again.

Somewhere squirreled away in the basement, away from the main traffic pattern, most insurance companies have a loss and claim department. There, men and women toil limitless hours, dealing with losses and claims generated by the sales and underwriting functions of the company for which they are employed. They usually carry staggering work loads which require them to examine, investigate, adjust, settle or deny ever-increasing numbers of losses and claims involving a wide variety of coverages and degrees

of severity and complexity. These people rarely are consulted about the operation of the company and seldom participate actively in the decision-making process.

Unfortunately, too, the claim operations did not escape the cost-cutting procedures employed in our industry's struggle to reverse the drain on resources, leaving fewer employees to cope with increased volumes of work. In many instances, in order to pare operating costs, claim offices were closed, early retirement of experienced adjusters was encouraged, and restricted budgets caused many adjusters at all levels of expertise and experience to give up their careers in adjusting and move into other areas to make a living. Some of the more experienced were lost to our industry because they took jobs as risk managers or claim administrators in the burgeoning field of self-insurance.

FURTHER COMPLICATIONS

The problem is further complicated by the fact that in the last two years our industry has done little to educate or train personnel to be streetwise property/casualty adjusters and specialists in certain lines of coverage. This is particularly true in the property field. In many instances, those adjusters who survived the cost-cutting measures were multi-line adjusters who were brought inside to further reduce operating costs.

Loss and claim handling became largely a matter of processing losses and claims by phone, correspondence and computers. Because of sheer volume, many companies were forced to expand their adjusting staffs. Instead of recalling highly experienced adjusters, they hired persons with little or no background. After a short period of train-

ILLUSTRATION BY SUSAN SCHULTE

THOMAS M. KELLY is executive vice president of operations for Michigan Claim Service Inc., an independent adjusting firm in Lansing, Mich.

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ing, the new employees were furnished with statement outlines and claim-handling procedures guides. Then they were put to work as desk or telephone claim representatives. Computers and generated statistics monitored their results. While these statistics, which could be measured on operating statements and balance sheets, showed that claim-handling costs were being reduced, the cost of losses and claims was spiraling rapidly to all-time highs.

Inside adjusters, phone and desk representatives, agents and examiners were given higher and higher adjustment and settlement authority. The result was that the majority of files were being processed and closed with little regard, if any, to the cost of the loss and claim, the coverage, the liability or the appropriateness of the costs incurred. Losses and claims in the majority of instances were being adjusted or settled and closed with no personal interface with the persons who were making the claims or their representatives. Likewise, the suppliers of services, the contractors, auto repair shops, doctors and hospitals, to mention a few, were not monitored as to the appropriateness and costs of their services.

In too many instances, the claims persons could not be faulted. They simply did not have the levels of experience, expertise, or knowledge of local conditions and practices—in short, that intuitive sense that comes from personal contact and everyday practice—to mitigate these costs.

Our industry also underestimated the intelligence, sophistication and attitudes of the consumer. Consumers were used to looking at an insurance company the same way they look at government—as a giant bureaucracy. They view an insurance company as having limitless assets, and they feel they are entitled to a share of those assets.

It was not that consumers were dishonest. They just were conditioned not to read or understand the coverage they had, simply because they had been told they had "full coverage," whatever that might mean. Further, when they did have a loss or claim, they were not concerned about coverage or cost. Instead, they relied on the adjuster to ferret out those items regarding cost, coverage and liability and, through negotiation, to adjust, settle or litigate the loss or claim. It didn't take long for consumers, their representatives and providers of services to realize that their costs were going to be accepted as submitted, so again, loss and claim costs esca for the insurer.

It didn't take long for consumers to realize that their costs were going to be accepted as submitted.

The burgeoning ranks of legal professionals found it easier and easier to get what they considered an adequate award because of the lack of experience and expertise of those responsible for handling these matters. Further, because of our industry's keen desire to avoid the legal costs of defending itself in all but the most defensible cases, lawsuits often were used to force settlements in matters which were groundless, and in some cases, almost spurious and capricious. Litigation has become the rule, not the exception, at the consumer level. Our society is a litigious one, backed by the philosophy of entitlement.

Changes in claim philosophies, streamlined procedures, changes in the laws—most of them adverse to the insurer—and no-fault schemes just are not working, and they will not work unless they are subjected to checks and balances.

TIMELY INVESTIGATIONS

Many loss and claim files that do not lend themselves to fast-track handling get lost in the shuffle and become long-tail liability exposures. In cases where no early or intensive investigation is made into liability or coverage, settlements and adjustments become more difficult to determine. Insufficient evidence and testimony is found in the file to support a defense in cases to be litigated and/or adjudicated. Such information also could be used to negotiate and mitigate damages; to produce a defense verdict; or to force plaintiffs to prove their cause and encumbent damages regarding liability and causal connection, as well as the appropriateness of the claimant's encumbent costs and the costs of the service providers.

Certainly, not all of the companies have adopted careless practices of underwriting and of handling and processing losses and claims. But the great majority have adopted them to a greater or lesser degree, some verging on reckless abandon.

Controlled studies show that, without a doubt, some losses and claims can be handled economically and cost effectively by utilizing fast-track methods, but only after they have been pre-screened by experienced personnel. The screening should be by type and reinforced over a long period of trial and error. Also, statistical records should show that the methods

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are, in fact, cost effective in both service and cost of the loss and claim.

Computers do not adjust and settle losses and claims—people do. They interface with other people and computers, which simply are machines that generate statistics after the fact and make records of what people do. These records often are misleading, depending on the accuracy of the numbers and the people who input them. It is helpful to have a high degree of knowledge about the meaning of those numbers.

INDUSTRY OVERHAUL

Our industry must return to the basics if we expect to return to financial stability and to carry out our fiduciary responsibility while still remaining profitable. To accomplish this, we must stop and take a hard, concerned look at our present position.

Losses and claims need to be painstakingly, carefully and realistically audited by exposure. We must adjust our reserves and ascertain as accurately as possible the amount of our liabilities. In light of our findings, underwriting practices should be overhauled so as not to worsen our financial status. We cannot renew or add new business that has proven to be a financial burden; if we do, rates must be adjusted to eliminate the burden so that we may continue to write the coverage.

Underwriters should underwrite only those lines which they have both the experience and expertise to write and leave the other products to those who can underwrite and handle them profitably. Checks and balances should be employed and contracts with the policyholder followed to the letter. The insured should be paid only what is proper, reasonable and required.

Through their actions, insurers should make the consumer aware that no free lunches or blank checks are available, and that costs are going to be monitored and verified. It is the consumer's responsibility to produce verification and proof of costs. Consumers also should be aware that insurers are people dealing one-on-one with the persons with whom they have contracts, whether they are written contracts or the liability imposed by laws.

Studies indicate that checks and balances, verification and establishment of proof of damages do not reduce proper and reasonable costs. These safeguards only establish the reasonableness, appropriateness and propriety of the costs, while reducing substantially those costs that are not justified. It has been demonstrated that remote handling is not as cost effective as personal contact. Even though the cost of remote handling is far less, in most instances this is completely offset by the reduction in loss and claims costs as presented and paid without checks, balances and personal interface.

In our litigious world, we have come to live with high judgments.

Studies using a controlled mix of losses and claims, batched and distributed to inside adjusters, revealed some interesting results. Some adjusters were just assigned to make a personal contact, and some were to make a personal contact that included an inspection, verification and proof of damages.

Using the results obtained by the inside adjuster and a loss or claim of $1000 or more as a base, it was discovered that a personal contact, at a service cost of approximately $100, resulted in a reduction in the claim of $100 to $200. When inspection verification and proof of damages also were required, for each $100 of service costs a reduction in loss or claims of $200 to $300 was achieved. Further, in matters involving $5000 or more, the percentage of reduction in loss and claim costs, for proportionally the same amount of service, was even higher than the amount presented in losses or claims.

The percentages were even more dramatic in those cases involving medical treatment, where all invoices were audited, after the fact, for mechanical errors, accuracy, appropriateness of treatment, causal connection to injury claimed, necessity and reasonableness of cost. Where medical management was utilized and these costs were monitored and agreed upon before they were incurred, results were further improved.

REPEAT PERFORMANCES

These losses and claims were straightforward and uncomplicated, with little or no question of either coverage or liability, but similar situations arise literally hundreds of thousands of times every day. Can our industry really afford not to look at and verify the costs claimed? In our litigious world, we have come to live with high judgments. What is even worse, we condone the practice of paying out substantial amounts in questionable cases to avoid litigation and the possibility that, if the case is litigated, undesirable precedents would be set.

All too often, these payments are made because we do not have the in-depth investigation to support our legal premise for defense, or because the cost to develop the investigation is too high. Is it any wonder that our legal costs have escalated when investigation is conducted by deposition, discovery proceedings, interrogatories, and pretrial arbitration and mediation techniques?

Certainly the defense lawyers cannot be faulted. They usually get involved after the fact when they are handed a summons and complaint and a file that contains, at best, only meager information. The lawyer's bill encompasses work we should have done ourselves.

AN ALARMING INCREASE

Our industry sweeps all of these examples under the carpet, with the rationale that the number of these cases is low. Not so; look at the records. Incidents of litigation, like loss and expense ratios, are climbing at an alarming rate. So are the costs, to say nothing of the price of either settlement or a verdict.

No substitute is known for early attention to these matters. One-on-one contact, in-depth investigation, and ongoing hard work are needed. Talented career claims persons are still out there. They know how and why to get the job done and are eager to do an outstanding job, but they must be consulted and given the opportunity. Our industry must start paying attention to losses and claims. It is the only game in town. The stakes are high, and we are on a losing streak. □

BEST'S REVIEW
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U.S. Claims—A Body Blow for Lloyd's

BY DENZIL STUART

While Murray Lawrence, Lloyd's senior deputy chairman, was underlining the London market's growing concern over the effect of U.S. liability claims at the Risk and Insurance Management Society conference in New Orleans, disclosure of 1982 results by individual syndicate groups was sending shivers through the ranks of Lloyd's members.

Attacking the U.S. legal system, Mr. Lawrence told RIMS: "Unless we take the opportunity this year to tackle the fundamental shortcomings that are all too apparent today, I venture to suggest that by the turn of the century it must be doubtful if there will be a viable, solvent, commercial market for some classes of business."

He argued that underwriters enter into contracts today with no conception of the conditions which will apply when their successors are obliged to pay claims. The courts ignore the environment and state of knowledge when the policy is written or the intentions of the parties involved.

In London, meanwhile, Merrett Syndicates, one of the largest and most respected underwriting agents in the Lloyd's market, revealed that 2500 underwriting members face losses in excess of $29 million. The losses arose primarily through reinsurance contracts covering liability business, where claims have poured in for asbestosis, pollution and chemical seepage damage.

Elsewhere, members of a syndicate managed by interests of Willis Faber could receive an interest-free loan to help pay losses of about £20 million. Proposals for the "rescue" were sent to 250 underwriting members by Willis Faber and its underwriting agent, Spicer and White.

But the biggest Lloyd's shock, after weeks of rumblings, came with the revelation that losses on syndicates managed by the former PCW Underwriting Agency have reached the staggering figure of almost $124 million. Underwriting results have piled on the agony for members following the huge losses already disclosed as a result of deliberate premium diversion.

It is the biggest loss ever incurred by a group of Lloyd's underwriting syndicates, and it has persuaded the broking group Minet—which owned PCW—to announce that Richard Beckett Underwriting Agencies, which was formed as its successor, will be closed by the end of the year. The underwriting losses arose from nonmarine business in areas such as products liability, pollution and medical malpractice in the U.S. The extra losses mean that about 1500 members of Lloyd's have until the end of July to find £60 million.

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While this unhappy situation was unfolding, Ian Davison, Lloyd's chief executive, was blaming "poor accounting practices and inadequate audits," in a tax climate that encourages secret deals, for contributing to market scandals. He said accounting reforms should mean that if things go wrong at Lloyd's, the auditors will have strict duties and powers to act if necessary. Mr. Davison also stated that the total absence of prosecution of any apparent cases of fraud in the Lloyd's market in recent years is a "matter of disgrace."

"Grandiose" Merger Plan May Unite Two Brokers

In the midst of all the Lloyd's dramas, which have continued to dominate all other insurance matters here, came the announcement that Sedgwick and Fred S. James, currently the world's fifth and sixth largest brokers, respectively, are to merge. The deal could make Sedgwick the world's second largest broker, with 12,000 staff members and revenues of more than £600 million. Transamerica Corp., which owns Fred S. James, will acquire a major stake in the Sedgwick group of 29% of the voting shares and 39% of the equity. If all goes well, the merger will be completed by the end of November. In addition to James, Sedgwick also will acquire Wigham Poland, Lloyd's brokers, the Tomen-

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DENZIL STUART of Stewart Wrightson, London, contributes a regular column to Best's Review.

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son group of Canada, and John F. Sullivan Corp., the second largest reinsurance broker in the U.S.

Both sides welcome the proposed deal, and Transamerica, which acquired James in 1982, may be looking at the new grouping to market some of its life products.

The influential *Financial Times*, which thinks the merger will put pressure on other London brokers that have not formed a close link with an American partner and could possibly stimulate further mergers, commented: "Off and on, Sedgwick has been involved in the most grandiose of insurance broking merger plans ever since the formation of megabrokers became fashionable. Indeed, its heroic attempt to cut through international taxation differences and get spliced to Alexander and Alexander was one of the first and largest deals—though one of the first to founder.

"This time round," the *Times* continued, "just as Alexander and Alexander seems to be going through a rough patch in its engagement to Reed Stenhouse, with talk of financial shortcomings on both sides, it is to be hoped that Sedgwick has at last pulled off the U.S. merger it has been looking for."

Opportunities Ahead for Specialist Broking Groups

The underpricing of insurance cover during the last six years may lead to a weakening of certain insurance carriers, and the collection of claims may become difficult, with capacity becoming an additional problem.

David Rowland, chairman of Stewart Wrightson, made this prediction in his annual statement to stockholders, but he nevertheless added that he senses opportunities ahead for specialist broking groups as market problems multiply, capacity reduces and premium rates increase.

Examining recent developments in the market, Mr. Rowland remarked that last year was a turning point after the decline in premium rating levels which began in 1978. "Towards the end of the year there were substantial increases in premium rates in almost every class of nonmarine business," he stated. "The market for 'hard to place' North American risks in the U.S. disappeared almost overnight and business has returned to London, often at substantially higher premium rates."

Mr. Rowland went on to discuss the position of Stewart Wrightson following the disposal in 1984 of the group's last non-insurance trading interests which completed a reorganisation programme that was started some six years earlier. He explained, "Stewart Wrightson has striven to become a market leader for certain complex areas which offer real prospects of present profit and future development—in aviation insurance and reinsurance, in the wide range of risks facing financial institutions, in the movement of goods of high value, in building and civil engineering, in reinsurance, in the broking and underwriting in the U.S. of excess and surplus lines business, and in direct retail insurance in certain areas—but even in these categories building on defined specialities."

For 1984, Stewart Wrightson revealed a pretax profit rise of 28.8%, from £10.74 million to £13.83 million. Earnings per share rose by 29% and total dividends for 1984 increased by 20%. Mr. Rowland predicts improved trading conditions for the group this year, and he is confident that income will rise substantially more than it has for some time.

Calvert Insurance, New York, and Associated International Insurance, Los Angeles, the group's two main carriers in North America, are doing better, and Stewart Wrightson wants them to remain flexible, moving in and out of the market. Stewart Smith, the group's North American wholesale broking arm, fared much better in the last quarter of 1984 than in the preceding nine months, and with the U.S. market turning, prospects are much brighter for the current year. The group still is writing D&O cover in the U.S., whereas many companies have pulled out of this market.

Asbestos Claims Facility Not Ideal for Reinsurers

A recommendation that reinsurers should not give blanket approval to the new asbestos claims facility in the United States but should consider their contracts individually, was made by George Nimmo, chairman of the Reinsurance Association of America, when he spoke in the UK recently at an inter-

national seminar arranged by the Reinsurance Offices' Association. Mr. Nimmo, who is also president of the Prudential Reinsurance Co. in the U.S., said the facility would dramatically reduce the insurers' claims-handling costs but increase the eventual liabilities of reinsurers on risks in the 1970s.

Despite his reservations, Mr. Nimmo said he believes the facility is a step in the right direction. The U.S. legal system cannot efficiently handle a mass action, such as the asbestos disease claims, and therefore it is essential to find a fair and nonlitigious way of compensating sufferers, he said.

He noted that many asbestos producers and their insurers signed the Wellington Agreement to set up the facility, which would give sufferers a way of presenting their claims to manufacturers without going to court. Those involved feel the claimants will receive speedier payments, and legal costs will be cut sharply, he acknowledged.

Mr. Nimmo said the insurers negotiated with producers without any official involvement from reinsurers. By agreeing to the widest possible form of cover in terms of the numbers of policies which can respond, they increased the exposure of reinsurers on risk in the latest years.

Another speaker warned that brokers may face a tough time placing traditional types of business next year because improvements this year were negligible. Harley Patrick, general manager of the Tokio Re, admitted that certain covers have become almost unplaceable, and contracts involving liability risks in the U.S., for example, have seen sharp premium increases. But this is not generally the case where insurers were writing a proportion of a direct insurer's whole account or fire or accident business. "A lot of this business is underrated and should have improved for 1985, let alone the future," Mr. Patrick remarked.

A speaker from the world's largest professional reinsurer, the Munich Re, urged his colleagues to take strong measures to ensure that they do not suffer more severely than the insurers who give them business. Dr. Ernst Hosp, senior executive manager, told the meeting attendees that he is looking particularly at the future of proportional business where the reinsurer took all or part of the insurer's account for the same proportion of the premium, less a commission to the direct company. He called for a reduction in this commission—if necessary to a level below the original costs.

Beyond this, Dr. Hosp said, new measures also are necessary to give the reinsurer sufficiently high premiums for the risk being undertaken. These included:

- Introduction of deductibles between direct insurer and reinsurer.
- Agreement that the reinsurer can ask for higher premium rates than the direct insurer charges—described as rated surplus treaties.
- Introduction of claims participation or loss-sharing clauses.

Dr. Hosp predicted that in primary markets the fierce rate competition will continue in the long term with more or less inadequate premiums, particularly in industrial lines. However, a future still exists for proportional reinsurance.

Leonard Marden, deputy chairman of Golding Stewart Wrightson, reinsurance brokers, recommended the use of arbitration in preference to litigation. In the wake of the enormous losses experienced in the last few years—together with an overall deterioration in the experience of all classes of business—it is not surprising, Mr. Marden said, that some companies have huge technical and underwriting losses and inadequate reserves. This has led to withdrawals from the international market—all features of a breakdown in discipline and lack of any business standards, he noted. Hence disputes occurred, in many cases, arising from a breach of what is the cornerstone of the reinsurance business—*uberrimae fidei.*

Mr. Marden also said: "Any party to a contract knowing that the conditions cannot be fulfilled is guilty of unethical conduct. It matters not whether such inability is caused by government intervention or sheer inefficiency. It is a contractual obligation and both parties must rely on the fulfillment of the terms of the contract in all respects.

"The increase in the number of disputes that we now see," he added, "is, to my mind, evidence of a lack of expertise and the apparent inability to understand the inevitable results of conscious decisions. This applies to almost every aspect of our business." Mr. Marden said he is convinced that many disputes can be resolved satisfactorily without recourse to law.

P&I Clubs Voice Optimism Despite Shipping Recession

Several of the larger P&I clubs—following the mutuals' incursions into the London and New York hull insurance markets—have added their views to the debate about the effect of the shrinking world fleet. "Clearly the shipping recession is of great concern to us all, but it does not of itself weaken P&I clubs," said the long-

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established Gard club of Norway. Gard argued that at the beginning of the latest policy year (February), it was probably in a stronger position than ever before, with a good return on investments building reserves to a record—but not excessive—level.

Entered tonnage has increased steadily in the past few years, and the latest renewal season brought in an additional one million tons gross. Last year Gard created a legal department to ensure that it has the necessary expertise to deal with the increasing number of laws affecting shipping.

Its final argument for the continuing strength of the P&I clubs within the International Group, headquartered in London, is the pooling system and massive commercial reinsurance that covers each club up to $762 million for any one claim. The clubs, generally speaking, are making themselves heard more than ever, and their aggressive stance on hull rates to capture more fleets continues to worry the traditional market.

Brief Intelligence

Insurance brokers are among those professionals being hit by heavy increases in rates for professional liability cover. Lloyd's brokers are subject to stringent requirements, with a minimum of £2 million and a maximum of £20 million, but larger brokers often buy more cover. A key factor behind the increases has been the UK government's suit against accountants Arthur Andersen, claiming $270 million for negligence in failing to detect and disclose misconduct in the operation of the De Lorean sportscar company. Since November, the market has applied a 10% coinsurance for fraud and dishonesty to E&O cover of Lloyd's broker. Rate increases have varied, with some companies paying more than 100%....In another regulatory move, Lloyd's is tightening up its rules for binders whereby an underwriter authorizes a broker or an agent to accept business on his behalf. New draft rules will require the registration of individual binding authorities through Lloyd's Policy Signing Office and approval by Lloyd's of the people who hold them....Guardian Royal Exchange, one of Britain's major composite insurers, is planning to purchase Talbot Bird and Co., the U.S. subsidiary of Armco....Austrian Insurance & Reinsurance Services, London, is a new joint venture between Interrisk, Vienna, and Nasco Insurance Brokers, London, Lloyd's brokers. The new company will provide an international service to Austrian exporters while creating the opportunity for direct access to the London market for the Austrian insurance sector....St. Paul Fire and Marine Insurance Co. obtained approval to change the name of its UK subsidiary to St. Paul Fire and Marine Insurance Co. (UK). The subsidiary will underwrite a London market account through Oberon Underwriters Ltd., part of the English & American Insurance Group. The paid-up capital will be increased to £10 million by the end of 1985....*Legal Decisions 1984* was published by the UK P&I Club and the UK Defence Club, both managed by Thos. R. Miller & Son, Bermuda. This 94-page booklet covers legal cases and matters affecting cargo claims, personal injuries in the U.S., time and voyage charters, wreck liabilities in the U.S. and arbitration. □

BEST'S REVIEW
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Insurers must recognize that today's medical liability crisis is not someone else's concern. The industry's interest is entwined in the solvency problems of the JUAs and medical malpractice carriers.

The Second Time Around

BY FRANKLIN W. NUTTER

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." This statement by the American Medical Association's Special Task Force on Professional Liability and Insurance could have been made in 1975. It was not. It was released in February 1985.

The "crisis" in medical liability is again afflicting the medical profession and the public it serves. Most physicians reportedly are practicing defensive medicine primarily to protect themselves against lawsuits, and some are withdrawing from certain specialties because of the high incidence of litigation by patients. As a result of these actions and the liability explosion cited by the AMA, the public is bearing an increasing financial burden through medical fees inflated by professional liability insurance costs, and the financial stress for medical malpractice insurance writers has been widely reported.

But, you say, your insurance company stopped writing malpractice insurance 10 years ago, and the light is finally at the end of the tunnel for medical malpractice claims remaining from the period prior to your withdrawal. The present medical liability insurance "crisis" belongs, you say, to the 20 multi-line writers and approximately 50 specialty companies writing this coverage today.

Unfortunately, your conclusion is wrong. The reason: your company still is exposed through assessments by joint underwriting associations and state guaranty fund laws. Although designed to temporarily relieve the availability problems of the 1970s, JUAs and the earlier state guaranty fund laws are still on the books and will respond to the solvency problems of today's medical malpractice writers. Regrettably, tort reform efforts in the intervening years have been insufficient to bring needed stability to the tort system that fuels today's liability problem.

The medical malpractice crisis of the mid-1970s evoked an intense and highly coordinated effort by physicians and insurers to deal with the affordability and availability problems of the period. To replace the capacity that was lost as commercial insurers withdrew from the market, new sources of coverage were developed. In 17 states, legislators created JUAs to provide professional liability coverage. This interim solution assisted physicians and hospitals where traditional markets had evaporated. In other states, such as Maryland, New York and California (and later in 24 more states), physicians joined together to create their own companies for professional liability protection.

Changes in common law doctrines on negligence and standards of care contributed significantly to the rapid growth of medical malpractice claims in the early 1970s, prompting physician and insurer-sponsored reform campaigns. In 1974-1975, the rush to enact medical malpractice tort reform legislation swept the country, leaving only the District of Columbia and the state of West Virginia untouched. By the time this movement had passed, 86% of the states had enacted three or more medical malpractice tort reform measures, and 28% had passed seven or more.

These new alternative markets and legislative initiatives dealt successfully with the existing availability problem. By 1978, approximately 150,000 physicians (roughly one-third of those practicing) were buying medical malpractice coverage from physician-financed, medical society-related mutuals. JUAs covered another large group of health care providers, especially in the heavily populated Northeast, and a small number of commercial carriers continued to compete actively for business.

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FRANKLIN W. NUTTER is president of the Alliance of American Insurers.

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The initiatives of this period also had a salutary effect on claims frequency, although state-by-state experience was highly erratic.

Nevertheless, the success achieved in curbing claims frequency did not carry over to claim severity. Between 1975 and 1978, median severity per paid claim increased at an average annual rate of roughly 30%, although the experience was not uniform for all states. During this same period, paid indemnity totaled $876 million (of which $330 million was paid during 1978), and average awards increased from $26,565 in 1975 to $45,187 in 1978, an inflation-adjusted increase of 44%.

Publicity about the medical malpractice problem declined rapidly with diminished claims frequency in the late 1970s, and the "claims made" policy and intense price competition combined to lower rates. Despite this, as early as 1979 some students of the problem were warning that (1) the benefits of tort reform legislation would be of short duration as attorneys found ways to work around the reforms and successful constitutional challenges increased; (2) the mechanisms designed to provide affordable and available coverage—JUAs, doctors' mutuals, patient compensation funds—would fall victim to financial problems from the combined effect of cash flow euphoria (i.e., inadequate rates), inadequate reserving and renewed growth in claims frequency and severity; and (3) the result would be another medical malpractice crisis in the 1980s.

These predictions proved highly accurate. The situation was exacerbated, however, by regulatory inertia or outright opposition to the setting of adequate rates redressing the severity and emerging frequency trends. In some competitive rating states, the adverse loss experience of recent years has been quickly translated into higher medical malpractice rates. In other states, however, the need for higher rates has faced stiff regulatory opposition and, in at least one instance, this issue has become highly politicized.

Based on information from the Insurance Services Office and a survey of specialty insurers conducted by the Alliance, we can document at least 20 instances when filings for an annual rate increase for physicians, surgeons and dentists were not approved by state regulators. In addition, in approximately 15 instances the regulators approved annual increases that were less than the rate requests submitted. Small deviations from the requested amounts would not be particularly troublesome, but the information suggests that these differences frequently have been 50% and more.

During the crisis of the mid-1970s, 17 states created medical malpractice JUAs to address the immediate problems of insurance availability while longer-term legislative responses were being developed. For the most part, however, the JUAs have not disappeared and continue to be an important source of coverage for large segments of the market. In fact, as of the end of 1983, only four JUAs had stopped writing business (those in Maine, New Jersey, Ohio and Tennessee) and only one—Tennessee—was truly out of the business (i.e., had no incurred losses). Unfortunately, the JUAs also have faced regulatory opposition to rate increases reflecting their loss experience.

The trade-off for the insurance industry's support for JUAs was an assurance of tort reform in the states. It was reasoned that such reform, when achieved, would allow the reestablishment of a viable private market for medical professional liability insurance. While tort reform efforts continue, the results have been mixed. In some states, reforms have been significant, and in others, the reforms have been relatively minor administrative changes.

Legislation dealing with a wide variety of medical malpractice issues was introduced in 30 states in 1984. New York and South Carolina passed legislation authorizing the continued operation of state JUAs. Medical malpractice study commissions were created in Indiana and Virginia. The

Virginia study will examine whether there is an ongoing need for the state's tort reform laws enacted in 1976.

Amendments to patient compensation fund acts were passed in Florida, Hawaii, Indiana, Louisiana and Wisconsin. In Hawaii, the legislation uncaps recovery limits and requires mandatory participation in the fund by all health care providers. Changes in the other states were confined to minor administrative matters.

Legislation providing immunity from liability for persons involved in peer review activities was passed in Arizona, Georgia, Hawaii and Kansas. In addition, Arizona passed measures requiring reporting of medical malpractice claims against pharmacists, podiatrists and physical therapists. Finally, both Hawaii and Wisconsin established higher mandatory financial responsibility limits for physicians.

Still other states enacted basically pro-plaintiff changes that will further increase the frequency and severity of medical malpractice claims. Oklahoma legislation substituted a national standard of care for a community standard; Nebraska made access to the courts easier by allowing the plaintiff to waive medical panel review and go directly to court; and California repealed its statute requiring plaintiffs to obtain a certificate of merit before filing a claim.

Three legislatures addressed limitations on recoveries. Louisiana limited awards to a $500,000 maximum but provided for payment of unlimited medical benefits. In Nebraska, the fixed cap was replaced by one that escalates as the cost of living increases, while in Kansas the stabilization fund capped recoveries at a limit of $3 million per award. The last substantive change occurred in Rhode Island, where the existing statute of limitations was changed from three years from the date of occurrence to one year following the date of discovery.

> The limits on recoveries appear to be the most significant reform in reducing claim severity.

The National Association of Insurance Commissioners previously identified certain states with serious medical malpractice problems. A review of these states today indicates that those that have "solved" the problem have certain characteristics. Five states can be singled out for their improvement: Arizona, California, Missouri, Oregon and Washington.

On the average, these states passed and kept in place slightly more tort reforms than did other states. Two of them (40%) passed legislation limiting plaintiffs' recoveries. Although three have "competitive rating" and two do not, none is noted for having rate regulatory problems. Four of the five have well-managed medical malpractice specialty writers with a significant market share. In three states, the share is more than 55% of the market. None of the five has a medical malpractice JUA in operation. Only one, Oregon, has a patient compensation fund. All have relatively short statutes of limitation running from the date of discovery.

Eighteen "problem" states can be identified on the basis of an analysis of data on adjusted statewide medical malpractice pure loss ratios, along with NAIC statewide operating ratios, evidence on the existence of financial problems in the JUAs and other available information. The significant factors vary from state to state; nonetheless, certain characteristics appear.

Fifty percent of the troubled states have JUAs, many of which are financially distressed because they lack underwriting prerogatives and, in some important instances, because they have had difficulty in obtaining rate increases. The proportion of these states having patient compensation funds is roughly the same as for the states that improved.

In the states where specialty companies operate, their market share is quite high (48%). Four of these states, however, have no specialty companies writing any business. On the average, these states have adopted fewer tort reforms than have other states. More important, none has adopted the most effective reform (recovery caps) and only three of the 18 have taken any action modifying the collateral source rule, which disallows evidence of compensation received by the plaintiff from other sources.

Of the various tort reforms enacted in the intervening 10 years, limits on recoveries (typically "caps" on the amounts recoverable for pain and suffering or punitive damages) appear to be the most significant reform in reducing claim severity. Mandatory offsets for collateral sources also are statistically significant, although not as important as limits on recoveries. Elimination of the plaintiff's opportunity to state an amount demanded in damage (i.e., the *ad damnum* clause) has helped reduce total claims cost.

Other tort reforms, such as limits on contingency fees; voluntary or mandatory pretrial screening panels to test the merits of claims; use of binding arbitration; restrictions on informed consent requirements; restrictions on the use of the *res ipsa* doctrine, which shifts the burden of proof; and provisions for periodic payments of future damages, have a significant effect on statewide malpractice experience, but not when standing alone.

The table accompanying this article shows the number of states that have enacted various tort reforms to date. It is particularly noteworthy that

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the most effective reforms also have generated the most controversy.

In 1985, numerous state legislatures introduced medical malpractice tort reform proposals. Among the most significant are the following:

- Contingency fee limitations: Arizona, Connecticut.
- Tightening statutes of limitations: Arizona, Massachusetts, New Jersey, Virginia.
- Caps on recoveries: Connecticut, Kansas, Maryland, Missouri, New York, South Dakota.
- Penalties for filing frivolous actions: Connecticut, New Jersey, New York.
- Permitting introduction of collateral sources: Connecticut, Kansas, Massachusetts, Missouri, North Dakota, Tennessee, Utah.
- Increased burden of proof: Florida.
- Creating or strengthening arbitration or review panel provisions: Hawaii, Indiana, Oregon, Utah.
- Certificate of merit requirements: New Jersey, Utah.

Also notable for 1985 is the AMA's action plan which, among other suggestions, calls for "refinements on the method of awarding damages" through federal legislation providing monetary incentives for state reforms. Those include limits on pain and suffering awards; elimination of punitive damages; itemization of jury verdicts for medical expense, lost earnings and noneconomic awards; structured settlements; patient compensation funds to pay excess awards; elimination of the collateral source rule; and restriction on contingent fees.

Medical liability is not yesterday's insurance problem. Today's insurance company managers cannot turn their backs on the current medical malpractice problem or the tort reforms, rate increases and solvency studies that constitute solutions to the new "crisis." The industry's interest is entwined in the solvency problems of the JUAs and medical malpractice carriers.

STATUS OF MEDICAL MALPRACTICE TORT REFORM ENACTMENTS

Number of States

Tort Reform	Legislation Enacted	Provisions Intact	Provision Unconstitutional/ Not Severable From an Act Found Unconstitutional	Provision Repealed or Sunset
Ad Damnum Clause	33	32	1	0
Statutory Prov.—Arbitration	13	11	0	2
Collateral Source Rule	19	14	4	2
Contingency Fee Limits	24	20	2	2
Informed Consent	28	27	1	0
Screening Panels	30	22	5	3
Periodic Payments	17	15	2	0
Res Ipsa Loquiter Prohibited	12	10	2	0
Locality Rule Statute	21	19	2	0
Statute of Limitations	44	40	4	0
Recovery Limits	17	10	7	0

Most JUA laws provide for a "premium contingency assessment" when the association experiences a deficit from losses arising in a fiscal year. Under this provision, each policyholder for that fiscal year must pay the JUA an assessment based on some set percentage of the policyholder's annual JUA premium. Most laws require any deficit remaining after maximum collection of the assessment to be recovered from the member insurers participating in the plan.

Unfortunately, these same laws generally require companies writing any casualty insurance or specified lines of insurance to become members of the state JUA as a condition of their authority to write insurance in the state—whether or not they write medical professional liability insurance. In most instances, a member insurer must pay a deficit assessment based on the proportion that its net direct premiums for all lines written during the preceding calendar year bears to the aggregate net direct premium written in the state by all members of the JUA.

In addition, all state guaranty fund laws cover duly licensed medical malpractice specialty writers. Thus, guaranty fund assessments for a licensed malpractice writer in liquidation are made against other licensed companies—again without regard to whether those companies write professional liability insurance.

I am not suggesting that all JUAs or all medical malpractice carriers suffer severe financial problems that may expose insurers to these assessments. However, published financial results and reports of rate hearings and filings lead to concern, and certain actions should be taken.

To make permanent improvements in the medical liability system, it is most important that all parties support tort reforms. By supporting medical society reform efforts, insurers can help develop coalitions promoting broad-based tort reform. To improve JUAs, insurer members should recognize their own assessment exposure, vigorously appeal rate denials and reductions of necessary increases and demand timely financial data from the JUA.

Other recommended measures include the following:

- Insurers and industry organizations should promote coordination and uniformity of JUA operations.
- The NAIC and domestic regulators should (1) institute adequate financial oversight and examination of JUAs as well as medical specialty insurers, and (2) authorize adequate rates for all such providers.
- Where necessary, JUA legislation should be amended (1) to provide for a surcharge on health care providers to fully fund JUA deficits, (2) clarify that JUAs are not covered by guaranty fund laws, and (3) create a stabilization reserve to mitigate wide swings in JUA performance.
- The insurance industry should reassess current statutes which include highly volatile insurance written by single-line writers such as medical liability specialty carriers.

As was true in the 1970s, the current medical malpractice crisis does not exist in all states. Where the problem has resurfaced, however, and where it is developing, the crisis is equally intense. This time the solutions must be permanent, not holding actions. But, most important, all insurers must recognize that the crisis is theirs; it is not someone else's problem. □

BEST'S REVIEW
JULY 1985
PROPERTY/CASUALTY
INSURANCE EDITION

WORLD INSURANCE FORUM

London

GORDON T. SANDERS
Director
Stewart-Wrightson UK Group Ltd.

Moves towards a long-awaited freer insurance market in Europe are gathering momentum as the UK puts pressure on the European Economic Community to encourage an overall free market in services, throughout the community. In the UK, the service industries are growing fast and now represent more than 50% of our gross domestic product and more than 60% of our employment; hence, a sound framework for free trade in services is needed to safeguard all the interests involved, especially those of the private consumer.

London always has been a relatively free market for insurance and finds it frustrating to see the existing EEC directives on freedom for intermediaries and freedom of establishment for life and non-life business openly flouted by some of its European partners. In October, the European community's Court of Justice is to study the failure of some EEC members to fully implement these directives. In particular, the current regulations in Germany, Ireland, Denmark and France are to be examined. These countries put forward the case that their tightly controlled insurance markets should be preserved to safeguard the consumer. Within the London market there is a real fear that the stability of other European insurance markets could be undermined if full freedom of service is implemented; it comes just when world insurance markets are succeeding in reversing the recent decade's downward spiral of premium rates.

To date, the most liberalised insurance markets (the British and the Dutch) have been the most vocal in seeking freedom of services. They argue that countries that object to this freedom are doing so to prevent business from flowing out of their domestic markets to other competitors.

Logically, freedom of trade must come, but it is perhaps all too easy for established free-trade markets to overlook the enormous differences that exist among the EEC partners in contract law, taxation and supervisory controls, not to mention culture. Harmonisation must precede or at least accompany freedom of trade, it has been argued, but, if anything, the development within continental mainland countries has moved in the opposite direction, except in isolated circumstances.

In 1986 there are to be two EEC presidencies with liberal views on freedom of services—in the Netherlands and the UK. The British Insurers European Committee regards liberalisation of insurance throughout the EEC and the world as one of its principal objectives. Government appears to support this view, and it therefore is expected that the UK will press at least for final agreement on the services directives.

On a wider scale, the UK insurance industry increasingly is concerned about the inequality of treatment that exists, to its detriment, in other markets. The UK domestic market is open to all insurers, both within and outside of the EEC, that are able to compete not only for the indigenous business but also for the large amount of international business coming to the London market. Even totally nationalised or otherwise protected markets may be free to compete in the London market. While the UK does not seek reciprocity, it does not wish to see any erosion of its terms of trade in the possible future negotiations within the General Agreement on Tariffs and Trade (GATT) or within the Organisation of Economic Cooperation and Development (OECD).

With the inclusion of Spain and Portugal within the EEC, half of the OECD members will, in fact, belong to the economic community. So the more important forum for the London market could be GATT, in the longer term. Progress in the OECD is expected to occur over a fairly short span of time, whereas it is likely to be slower, but more fundamental, within GATT.

Since its formation in 1948, GATT has not concerned itself with services but has concentrated its work on reductions in the restrictions to international trade in goods. Following pressure from the United States, it was agreed in November 1982 that members with an interest in services could undertake local studies on trade in services for submission to GATT. However, it was decided that the GATT secretariat should in no way assist in this work, in light of a lack of enthusiasm from some countries and opposition from prominent developing countries.

Notwithstanding this disinterest, many national studies were prepared, including one from the UK published last June. When GATT returned to this subject last November, it did agree to a compromise to proceed with examining freedom of services—but without commitment! Further meetings take place later this year, and it seems

KAILIN TUAN, professor, Department of Insurance and Risk, School of Business Administration, Temple University, serves as the advisory editor of "World Insurance Forum."

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that activity within GATT now is sufficient to generate a new round of GATT negotiations in which trade in services may well be included. It is not expected that anything will be resolved within five or six years. Meanwhile, insurance industry barriers to the London market will increase, markets will fragment, and higher retentions will take place. New barriers are being created by both developed and developing countries.

Improvements in freedom of trade in goods clearly has led many countries to look for other methods to improve their balance of overseas trade. Currency spent abroad for insurance and reinsurance has been identified as an area where apparent savings can be made through the imposition of restrictions and the introduction of obstacles to the free movement of underwriting reserves. However, any increase in protectionism will be to the detriment of everyone and will make the functioning of international insurance almost impossible, just at a time when new technologies and the ever-increasing size of risks requires for agreement even greater cooperation between insurers and reinsurers worldwide.

MORE MEGABROKERS

Meanwhile, on the insurance broker front, London has seen gathering momentum in the realignment of the so-called megabrokers over the last few months. Before 1978, London insurance brokers had exclusive access to the Lloyd's market to which so much business was sent when insurance capacity contracted in the U.S. in the early 1970s. Since then American insurance brokers have managed to buy in or merge with London firms, and these U.S. groups now are switching their business to the companies that they now control in London. This in turn is causing other British insurance brokers to attempt to protect their own businesses.

The latest round of engagements and marriages is creating a polarisation in the London market. The big brokers are getting bigger, the small brokers are becoming relatively smaller and the middle-sized firms are disappearing. Many of the broking houses that so far have not aligned themselves to U.S. groups now will be seeking to merge with other British groups or to link up with a U.S. company. The face of the London market is likely to change substantially in the coming year.

Stockholm

DIANA W. WORMUTH
Skandia Insurance Co. Ltd.

The early months of 1985 have been dominated by speculation regarding the effect of the new insurance legislation that has partially deregulated the industry. After a government review lasting several years, the evolution of the insurance industry has been reflected in the law.

In Sweden, a license to operate an insurance company ultimately is granted by the government after other bodies, such as the supervisory authorities, have expressed their opinions. A license is issued for the individual lines to be written. The proposed new operation also must have documented intentions with regard to premium calculation and reserving practices.

Until now, applications for license have been subjected to scrutiny in light of the principles of need, solidity, equity, the policyholders' influence on the business and the principle of separation. (The latter, in practice, means that no one carrier can write both life and non-life business in the same company.) The principle of need, which was abolished at the turn of the year, originally was introduced in 1948 when the government considered the marketplace overcrowded. Two years later, the principle was extended to include foreign carriers as well.

In the ensuing decades the market has changed, and the number of Swedish insurance companies has shrunk from 1383 in 1950 to 557 in 1982, reducing the need for protectionist legislation. A few large companies account for more than 80% of the market. At the end of 1984 only five insurance concerns in Sweden (Ansvar, Folksam, Skandia, Trygg-Hansa and Vegete) offered all kinds of insurance cover; other companies offered either life assurance or selected non-life lines.

According to the new order, there will be equal conditions for competition between Swedish and foreign carriers. When the authorities review an application, they will have to determine whether or not the proposed business would impede the development of a healthy market rather than, as previously, requiring the new carrier to prove that he would supply a hitherto unavailable service.

This new criterion—the principle of soundness—is a reflection of the reality of today's insurance market. In recent years the number of foreign companies operating in Sweden has decreased, since it has been difficult for them to make inroads at a reasonable cost, a well-known dilemma for many direct insurers operating outside their own country. In the case of Sweden, the figures are eloquent. In 1950 there were 38 foreign carriers, while in 1984 there were only 15, of which one—Winterthur—withdrew during the year, having sold its portfolio to a new locally held company, Victoria. The premium income for foreign companies accounts for only 2% of the market. The new legislation is not expected to result in an influx of new capacity. Through their reinsurance operations, foreign insurers already are acquainted with the Swedish market so they know its potential and limitations.

FURTHER LIBERALIZATION

The captive sector also has been liberalized by the new legislation, and it is likely new captives will be formed, or current ones extended, although some industry observers feel that the

MEMORANDUM

TO: Special Committee on Medical Malpractice

FROM: Mary Torrence, Assistant Revisor of Statutes

RE: Recent Illinois, New York and Florida Medical Malpractice Legislation

DATE: September 13, 1985

The following is a general summary of medical malpractice legislation enacted this summer by Illinois (public act 84-7), New York (chapter 294) and Florida (chapter 85-175).

TORT SYSTEM

Substantiation of Claim

Illinois and Florida require pretrial verification by a health care provider that there are reasonable grounds for a malpractice action. A finding of no reasonable grounds results in assessment of attorney fees and costs against the plaintiff.

Cooling-off Period

Florida requires 90 days' notice prior to filing of a medical malpractice suit to give time for investigation by the defendant and an opportunity to settle or go to arbitration.

Screening Panels and Arbitration

Illinois requires that a screening panel be used. If parties agree, the panel's decision is binding. Otherwise the decision of the panel is not admissible at trial.

Florida provides for binding arbitration if the parties agree or if the court orders it on motion of a party.

Pretrial Settlement Conference

Both New York and Florida require a pretrial settlement conference to be held. In New York the trial judge conducts the conference.

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Offers of Judgment

In Florida a defendant is assessed costs and attorney fees if plaintiff's offer is refused and judgment is at least 25% more than the offer. Likewise, the plaintiff is assessed fees and costs if plaintiff refuses an offer and judgment is at least 25% less than the offer.

Expert Witnesses

Illinois and Florida codify standards for expert witnesses.

Consent to Procedures

Florida has established a rebuttable presumption that there is valid consent to medical procedures used.

Collateral Source Rule

Illinois and New York provide for deduction from verdict of all or part of benefits received from collateral sources.

Limits on Damages

Illinois allows no punitive damages.

Itemized Verdict

All three states require itemized verdicts, at least with regard to present and future damages.

Periodic Payment of Judgment

All three states provide for periodic payment of any future loss over a certain amount (Ill. & N.Y., $250,000; Fla., $500,000). Periodic payments of judgments in these amounts are either required in all cases or required on motion of a party.

Attorney Fees

Illinois limits attorney fees to certain percentages of the amount recovered, decreasing as recovery increases. New York similarly limits fees, but allows additional compensation on approval of the court or, in the alternative, a flat percentage with no additional compensation allowed. Florida limits fees to certain percentages of the amount recovered, increasing as the case progresses through the legal system.

Florida allows the court to review attorney fees at the client's request and gives statutory guidelines for determining

illegality or excessiveness.

MALPRACTICE PREVENTION

Risk Management

New York and Florida require licensed health care facilities to establish risk management programs that include review and evaluation of malpractice incidents, reporting and maintenance of records of those incidents and educational programs on prevention of those incidents. Florida has created an advisory council to establish a model risk management program and certify risk managers.

Florida further requires disciplinary action by health care facilities against staff found incompetent, impaired, negligent or in noncompliance with the risk management program. If the facility fails to exercise due care in carrying out its duties under the act, it may be held liable for injuries caused by its failure. Florida requires facilities to make annual reports to their licensing agencies, which reports must show all malpractice claims and injuries of patients that occurred in the facility, the names of staff involved and disciplinary action taken.

Florida is requiring health care providers to have five hours of continuing education every three years in risk management.

Licensure Sanctions

New York provides that disciplinary action in another state is grounds for sanctions if the basis of the other state's action would be professional misconduct in New York. Possible sanctions include fines, educational requirements and public service requirements.

Florida includes in its grounds for licensure sanctions repeated malpractice (3 or more claims over $10,000 paid in 5-year period) or an incident of gross malpractice.

INSURANCE

Rating System

New York requires a merit rating plan for malpractice insurance, based on a provider's malpractice experience.

Requirements to Obtain Insurance

Florida provides that an insurer may require its insured to be a member in good standing of a society of providers that maintains a review committee.

Condition of Licensure

Florida provides that insurance is a condition of licensure and a condition of holding staff privileges at facility.

STATE OF KANSAS

FRANK BUEHLER
REPRESENTATIVE, ONE HUNDRED THIRTEENTH DISTRICT
BARTON COUNTY
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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER AGRICULTURE AND LIVESTOCK
JUDICIARY
PUBLIC HEALTH AND WELFARE

TO: Representative Joe Knopp, Chairman
Special Committee on Medical Malpractice

FROM: Representative Frank Buehler

SUBJECT: Oral report of attendance at sub-committee meetings from Citizens Committee for review of the Tort System.

Mr. Chairman, I would like to make this oral report in an effort to convey to you and the Committee, my determination after attending two days of meetings of the sub-committees of the Citizens Committee on Medical Malpractice. I attended three meetings, the legal sub-committee meeeting, the insurance sub-committee meeting, and the peer review sub-committee meeting. The screening panel sub-committee had previously met and have made their final recommendations.

Throughout the two days of sub-committee meetings, I don't think I heard anyone suggest that there should be no changes made in the tort system. On the contrary, everyone determined that there was a problem that needs to be and can be corrected. If our citizenry is to expect health care in the future. I must state that I was pleased with the effort made by the committee members to make meaningful recommendations.

Very close attention should be paid to all of the recommendations made because in several instances several of the committees agreed on the same recommendations but did not put these recommendations in their report inasmuch as they were being addressed and were asssigned different committees as a subject matter. The concept of the Indiana Plan was favored by several of the sub-committees, so it would appear to me that this plan has much merit.

The Healing Arts Board was closely examined by the peer review sub-committee, and it is my opinion that a significant amount of change needs to be made in the functions of this Board. It would seem that presently the board only functions well enough to justify its existence. Iron clad statutes should be provided to eliminate the offer of excuses for ineffectiveness.

One of the things that came to the attention of the sub-committee was that the Healing Arts Board was presently licensing some doctors who had no insurance. The explanation for this was that some physicians, even though they are no longer practicing--are inactive, still want to maintain their license. This creates an area of risk in the opinion of the committee, for they may be offering advice and consultation and adding to the exposure. I would offer for your consideration that the make-up of these sub-committees had equal numbers of people from the different interests, and inasmuch as this takes place, I would assume that the recommendations coming from the sub-committees would be a good cross-section of the citizenry and the interests of the state of Kansas.

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One of the things that was commented on several times, was that the very existence of the Health Care Stabilization Fund has created a problem. Progress should be made, in my opinion, toward a point in time when the Fund can be eliminated and carriage be turned over to a private carrier. I am satisfied that this cannot be done at the present time because, according to some of the testimony that I heard, the Fund presently has a fourty-two million dollar deficit. They figure that as if the Fund were to be closed out immediately, right now, and all claims pending were awarded, it would be forty-two million dollars more awarded than the Fund is adequately financed for. With this in mind, it would be inconcievable to eliminate the Fund at the present time.

I learned, and it was called to my attention particularly that I might want to make a note of this, the premium for a health care provider does not change individually, except if he is in the J.U.A., whereby he gets two claims filed without rate increase. If I remember right, the third claim, if twenty thousand dollars or more, the rate could increase approximately twenty percent. I would like to have it noted that these figures are not particularly accurate, but they are as I remember them as presented by Homer Cowan, who chaired the Insurance sub-committee.

In addition to attending these sub-committees, I attended a week ago today on September 6, a symposium sponsored by the American College of Surgeons and the American Medical Society, held at Stormont-Vail Hospital. There were two other members of our committee attending that symposium; Vice Chairman Senator Jack Walker and Representative Tom Walker. In addition to we three from the Legislature and from this committee, I think most of our staff were present for this symposium. One of the things that was impressed upon me was that with this crisis, even necessary vaccines that are in the discovery process are being laid aside for fear of litigation similar to the litigation involved in the Dalcon Shield. With the research being done and cures for cancer, AIDS, and other categories, it is rather fearful that if we do nothing, on any level in the United States, the citizenry are going to be affected.

I feel fortunate to have been permitted to attend the sub-committee meetings. I feel much more knowledgable in the subject that we are studying and I hope that as time progresses in the next two months in meetings that I will be able to share with you some of the things that I have learned.

You have, provided for you, copies of the recommendations that have come from the four sub-committees. Along with that and the testimony that we hear, I am certain that we will be able to make meaningful recommendations.

Thank you.

Frank J. Buehler
State Representative
113th District

FJB:jc

STATE OF KANSAS

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TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE CHAIRMAN: INSURANCE
MEMBER: FEDERAL AND STATE AFFAIRS
GOVERNMENTAL ORGANIZATION

September 13, 1985

Chairman Joe Knopp
Interim Medical Malpractice Committee
State Capital Building
Topeka, KS 66612

Dear Chairman Knopp:

This transmittal letter summarizes and encloses reports of the four sub-committees of the Citizens Committee for Review of the Tort System organized by the Kansas Insurance Department, Fletcher Bell, Commissioner. These reports were finalized on September 10 and 11, 1985 and will be rendered into a final report of the entire Citizens Committee at it's October, 1985 meeting.

These reports are attached and their major recommendations are summarized hereinbelow.

INSURANCE SUBCOMMITTEE

1. Lower the cap on awards on the Health Care Stabilization Fund to $1 million and place a cap upon amount of awards, favoring the Indiana Plan.

2. Maintain insurance company rate control within the jurisdiction of the Kansas Insurance Department.

3. Adopt the Indiana Plan as the best and surrest way to reduce Kansas medical malpractice rates.

4. Increase the support staff of the Health Care Stabilization Fund, including a competent assistant, full time secretary and a file clerk.

5. Study a merit system for surcharges for the Health Care Stabilization Fund, level the surcharges within the classifications of medical licensees, require the Kansas Insurance Department to collect the surcharges directly.

6. Direct the Kansas Insurance Department to investigate the feasibility of using a medical consultant in selected medical malpractice files handled by the Funds.

7. Maintain the Health Care Stabilization Fund under responsibilities of the Kansas Insurance Department.

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8. Once the Fund is adequately staffed, limit the use of outside attorneys whenever possible.

9. Institute a study of the civil procedure notice requirements to the Fund, requirements of primary carrier insurance companies for a surcharge to the Insurance Department, establish a legal residence for each medical licensee, reducing post--judgement interest to prevent unnecessary financial drain upon the Fund, authority to the Fund to establish an appeal bond and amend the Premium Finance Act to allow installment payments of the surcharge.

10. Require mandatory information exchange between the Fund, JUA Board of Governors and the Board of Healing Arts.

11. Study the meeting requirements of the Board of Governors, deciding whether the meetings be public or private in regard to termination of a medical provider from the Fund.

12. Clear up ambiguities between primary and excess in respect to termination of health care providers.

13. Grant the Board of Governors more autonomous authority in respect to Insurance Department handling and administration of the Fund. Make the Commission of Insurance an ex officio member of the Board of Governors, the Board to elect it's own Chairman.

LEGAL SUBCOMMITTEE

1. Exclude tail insurance coverage of an inactive health care provider, defined by Chapter 40 of Kansas Statutes, unless the health care provider has made surcharge contributions to the Fund for five consecutive years.

2. Adopt the Indiana Plan, including mandatory pre-trial screening, $500,000 cap on all damages, authority for structured settlements, abolition of punitive damages and regulation of contingency fees.

3. Set post-judgment interest rates to the treasury bill rate.

4. Adopt recommendations two through nine of the Board of Healing Arts in it's letter to the Interim Medical Malpractice Committee dated July 8, 1985.

PEER REVIEW SUBCOMMITTEE

1. Empower the Board of Healing Arts to examine and copy documents, recports or records relating to the practice of any licensee with the right of subpoena. This recommendation includes records of peer review committees, hospitals, Health Care Stabilization Fund, and insurance companies.

2. Establish a Board of Healing Arts subcommittee review committee system.

3. Increase Board of Healing Arts funding for investigators, hearing examiners, support staff and equipment.

4. Revise reporting statutes regarding impaired physicians.

5. Grant immunity to persons reporting health care deficiencies to hospital peer review committees or the Board of Healing Arts, within limitations.

6. Support medical risk management and quality assurance programs development and continuation.

7. Prohibit licensure of a medical practioner without evidence of current malpractice insurance.

8. Require all hospital employees to report suspected below standard care or unethical conduct to peer review committee with suspension of license for intentional failure to report.

9. Require hospital officals, medical staff and peer review committees report any evidence of incompetent conduct which may violate the Healing Arts Act.

10. Permit the Board of Healing Arts to order a licensee to complete further education or training.

11. Require hospitals and peer review committees to report all limitations or relinquishments of staff privileges to the Board of Healing Arts.

SCREENING PANEL SUBCOMMITTEE

1. Review all laws governing professional malpractice.

2. Adopt a screening panel statute similar to the Indiana Plan, including mandatory participation and place a cap on all damages except future medical care and custodial care (unless there was a structured settlement approved by the court).

3. Mandatory participation in the screening panel program by all physicians as a requirement to licensure in the state of Kansas.

4. Publish screening panel findings.

5. Increase annual education requirments and require special education for physicians who have had findings of negligence assessed against them.

Respectfully submitted,

Dale M. Sprague
State Representative
District Seventy-Three

DMS:jc
Attachments: All Subcommittee Reports

TO: The Honorable John Anderson, Jr.
Chairman
The Kansas Citizens Committee for Review of the Tort System

FROM: Homer H. Cowan, Jr.
Chairman
Insurance Subcommittee

DATE: September 10, 1985

SUBJECT: Final Report

Committee Members:

Stephen M. Blaes
Virginia Bozich
Lynn Johnson
John J. Jurcyk
Dee Mann

The above committee has met over a period of time and has made a diligent effort to study various component parts of the insurance mechanism as it relates to medical malpractice. This report will outline its findings and will make certain recommendations.

The Private Market: For all intent and purposes, the entire medical malpractice market of Kansas is serviced by two companies:

The St. Paul Companies
Medical Protective Insurance Company.

There is a wide variation of rates between these two companies. The reasons for this variation are:

(1) Medical Protective Insurance Company writes through their own salaried agents.

(2) The St. Paul Companies write through the Independent Agency System.

(3) Medical Protective Insurance Company is much more selective.

(4) The St. Paul Companies write on a broad base.

(5) Medical Protective Insurance Company excludes some classes.

(6) The St. Paul Companies write all classes.

With the lack of competition, the committee concluded the variations did exist and were probably justifiable -- and further, that so long as the lack of competition existed, that the public had to rely upon the Kansas Insurance Department for proper regulation.

Recommendations for Increasing Competition: Lower the cap on the stabilization fund and place a cap upon amount of awards. The Indiana Plan was favored because it had a proven tract record. Note: The committee did not study any plan, but was cognizant that limiting the amount of awards could be the only incentive for other companies to write this line of insurance.

Committee Discussion:

A cap on Health Care Stabilization Fund of $1,000,000 instead of present $3,000,000 - VOTE 4-0

A recommendation to limit amount of recovery. - VOTE 3-2

Committee Vote:

For 4 / 3 Against 0 / 2

Minority Comments:

Lynn Johnson strongly opposed limit on recovery. This should be a "last resort."

Homer H. Cowan, Jr.
Chairman

for the Minority

The JUA Operation: (The Plan) An overview of the mechanics of The Plan was disseminated to the committee as a whole. This mechanism is a "pass-through" mechanism, on a no profit-no loss basis. It is a service mechanism to write the policies, collect the premium, pay the claims and on an annual basis pass through to the stabilization fund any profits, or seek reimbursement from The Fund, of any losses.

All monies collected belong to the medical profession. There is no private money involved. Monies are held in trust and invested until time of dispersal. The Western, as servicing carrier, pays all claims with Western drafts, seeking overnight reimbursement.

The Board of Governors, who are responsible for The Plan, serve without compensation.

In respect to claims, The Fund is put on notice of any claim reserved at $50,000 or more. The maximum limits of The Plan are 200/600.

It was noted The Plan had an underwriting profit in the first two years of operation. Thereafter, it has operated at an underwriting loss. This was explained that at the inception of claims made, it took 2.4 years for any claim to mature. In the beginning, the premium level was about double of present premium levels.

Today, with premiums of approximately $700,000, two claims could use up the entire premium collected.

As a pass-through mechanism, The Plan was not designed to show a profit. It can never show a profit because of the lack of broad base, and the desire to depopulate.

Committee Discussion: OK

Committee Vote:

For _____ Against _____

Minority Comments: _____

(Minority Comments continued) None

Homer H. Cowan, Jr.
Chairman

For the Minority

Rates: After hearing lengthy discussion by the Kansas Insurance Department and a representative of The St. Paul Companies, the committee feels that the Kansas Insurance Department is in the best position to understand rates and expressed confidence in the ability of the Kansas Insurance Department.

Committee Discussion:

Committee Vote: For 4 Against 1

Minority Comments: Lynn Johnson indicated that there has not been enough evidence to verify it rates were proper and not excessive.

Homer H. Cowan, Jr.
Chairman

For the Minority

Loss Ratios: The St. Paul Companies testified that they made money in Kansas in 1978, 1979 and 1980, but have sustained losses ever since. With the present loss ratio of 165%, Medical Protective Insurance Company indicates substantial losses for the same periods. The Kansas Insurance Department advised Medical Protective Insurance Company had a new substantial rate increase before the Department at the present time. When asked if the new filing was justified and supported by data, the Department responded, "Yes".

It was interesting to note that The St. Paul Companies does include investment income in their rate filings.

The committee did not find any evidence that present rates were artificially high.

Committee Discussion:

Committee Vote:

For 4 Against 1

Minority Comments: Lynn Johnson still feels additional evidence is needed

Homer H. Cowan, Jr.
Chairman

For the Minority

Rate Making: A lengthy discussion was had involving rate making and investment income. While The St. Paul Companies include investment income, Medical Protective Insurance Company does not. However, it was explained that whenever there are underwriting losses, companies used investment income in rate making whether they wanted to or not. If the loss ratio is 115%, then the company has used up all premiums collected, and 15% of their investment income and/or surplus.

The capacity to write insurance at all is based upon surplus. With limited surplus, a company would not be permitted to write any new risks.

The committee felt the Kansas Insurance Department was in the best position to review the mechanics of rate making and make recommendations The committee did not detect any precise area to make recommendations.

Committee Discussion:

(Committee Discussion continued)

Committee Vote:

For 4 Against 1

Minority Comments:

Lynn Johnson felt there was inadequate evidence to support this conclusion.

Homer H. Cowan, Jr.
Chairman

For the Minority

Rate Comparisons: A rate comparison presented by The St. Paul Companies verified the rates for a neurosurgeon are as follows:

Kansas	25,368.00
Nebraksa	15,413.00
Indiana	18,000.00

(does not include claim surcharge nor stabilization fund surcharge)

The committee noted that both Nebraska and Indiana had "caps" on awards.

Recommendation: That Kansas adopt the Indiana Plan as the best and surest way to reduce Kansas rates. Again, this committee did not study any other plan, but noted the Indiana Plan had a ten year track record. The committee did not feel that now was the time for Kansas to "experiment" with new innovations.

Committee Discussion:

This committee clarified that its recommendation was not necessarily the Indiana Plan as it exists, but the Indiana concept as may be determined by the committee that studied this issue.

Committee Vote:

For 4 Against 1

Minority Comments:

Lynn Johnson stated that this is an unfair rate comparison and this conclusion should be struck in its entirety.

Homer H. Cowan, Jr.
Chairman

For the Minority

A recap of the minutes of the meeting covering the preceeding topics is attached.

Stabilization Fund (Excess-Layer) Administration: The committee heard testimony from Diranda Mitchell, Staff Attorney for the Stabilization Fund, and Bob Hayes of the Kansas Insurance Department. (A complete transcript is attached.). Miss Mitchell presented evidence that verified knowledge and extreme interest in The Fund.

While there may be a question of how much time is available to study each case, she had extremely good knowledge of the malpractice problems and of applicable law.

In the opinion of the committee, the support staff handling the stabilization fund matters must be increased. There is a dire need for at least one very competent assistant, perhaps a para-legal person. In addition, there is a need for one full-time secretary and one file clerk.

Committee Discussion:

Committee adopts this recommendation

Committee Vote:

For 5 Against 0

Minority Comments:

NONE

Homer H. Cowan, Jr.
Chairman

For the Minority

Surcharge: The committee was backgrounded in the history of the "surcharge" and the statutory limitations. Discussion was had in respect to the final results of the financial integrity of The Fund had the 45% surcharge never been dropped. It was concluded The Fund would obviously have more money on hand, but not nearly enough to remove the present "crisis".

Recommendation: That all future surcharges be projected by an actuary with mandatory independent audit every three years.

Committee Discussion: The committee added to this recommendation that there be a study:

1) To use the merit system for surcharge
2) To level the surcharge within the classifications
3) For the Insurance Department to collect the surcharge direct.

Committee Vote:

For 5 Against 0

Minority Comments:

NONE

Homer H. Cowan, Jr.
Chairman

For the Minority

Ability to Settle: Could The Fund "settle" a case prior to the primary carrier tendering the basic limit? The response was yes.

The committee was advised that The Fund received full cooperation from the private carriers.

The Fund has the power to "demand" the primary carrier to settle and to hold the primary carrier responsible for failure to do so with adverse results.

Conflict of Interest: Statutory provisions require a carrier to retain an attorney for the insured. Therefore, any conflict between the insured and the carrier would call for the retention of an attorney to represent the carrier. The committee did not find any evidence of a conflict of interest problem. When there is a conflict, it can be noted and such legal protection as is needed is utilized.

Committee Discussion:

OK

Committee Vote:

For 5 Against 0

Minority Comments:

NONE

Homer Cowan

Homer H. Cowan, Jr.
Chairman

Claim Handling Procedures:

K.S.A. 40-3409. Requires Insurance Department to monitor every malpractice case. The procedure is as follows.

(1) When suit papers are received, file is established.

(2) Coverages, effective dates, etc. are checked against records maintained in the Department.

(3) Primary carrier is requested to furnish a summary of the case and recommended reserves.

(4) Defense firm contacted; summary and evaluation requested. Comparisons between private carrier and defense firm's evaluation are made to determine if there is mutual concurrence as to the legal liability and probable value.

(5) Insurance Department now receives all copies of pleadings (depositions, etc. and notice of further discovery proceedings).

(6) Insurance Department now receives notice of reserve changes, progress, etc.

(7) Does review investigation. If any area of further investigation noted, defense counsel so notified.

(8) Outside counsel retained to review file for liability and/or evaluation if Insurance Department has any reservations about liability or evaluation of primary carrier and/or defense firm.

(9) Evaluation in on-going.

The committee felt the procedures in place were proper and adequate subject to being properly staffed.

Committee Discussion: Look into feasibility of using a medical consultant on selected files

OK

Committee Vote:

For 5 Against 0

Minority Comments: _____

Homer H. Cowan, Jr.
Chairman

For the Minority

Insurance Department Functions: The question of whether The Fund should be under the aegis of the Insurance Department or Attorney General was discussed.

The committee found that with Insurance Department expertise, The Fund should remain under the responsibilities of the Kansas Insurance Department. Not only are we talking about insurance company procedures, but a wealth of data already collected by the Insurance Department is at their disposal in respect to Fund management.

Committee Recommendations: That The Fund remain under the supervision of the Kansas Insurance Department, subject to support staff.

Committee Discussion: _____

Committee Vote:

For 5 Against 0

Minority Comments: Lynn Johnson feels some additional supervision of the Insurance Department is needed. More separation between the Insurance Department and The Fund. The Fund is an insurance company.

Homer H. Cowan, Jr.
Chairman

For the Minority

Claim Load: Approximately 400 open files. Receives notice of approximately two new lawsuits per week.

The committee felt that the Kansas Insurance Department was understaffed for the claim load.

Recommendations: To add additional staff as recommended in this report.

Committee Discussion:

OK

Committee Vote:

For 5 Against 0

Minority Comments: _____

Homer H. Cowan, Jr.
Chairman

For the Minority

Use of Outside Attorneys (Estimated Cost $500,000): The committee felt that with the addition of support staff, this exposure could be reduced.

Assuming you have confidence in the primary carrier's defense attorney, outside counsel should be retained for evaluation purposes only when there is sharp conflict of legal questions and extreme difference of opinion as to evaluation.

The committee recognizes this is a judgment matter, and the ability to have accurate evaluations must be supported. However, some constraints should be in place once The Fund is adequately staffed.

Committee Discussion: _____

(Committee Discussion continued): _____

Committee Vote:

For 5 Against 0

Minority Comments: _____

Homer H. Cowan, Jr.
Chairman

For the Minority

Other Recommendations: A Study of :

(1) Notice requirement to The Fund. (Reference K.S.A. 40-3409).

~~The savings clause under Chapter 60 impairs notice requirements. This is in respect to the plaintiffs serving notice upon the Commissioner that suit has been filed. Amendatory language will be drafted.~~

(2) ~~There apparently is a problem with the primary carrier forwarding the surcharge to the Insurance Department.~~

There is a recommendation that amendatory language be drawn to place a penalty on "flagrant" violations. It is important to remember that most companies' agency accounts are not payable for forty-five days. It is not the intent of the suggested

change to create a problem with the company-agency relationship, but to address companies who have, for other reasons, failed to send in the surcharge in a timely manner.

(3) There is a need to have the legal residence of the health care provider.

There was some discussion about looking at the applications of carriers to see if some revision could be made. There is also a possibility that the legal residence can be obtained from the Board of Healing Arts.

(4) Post-judgment interest is creating a drain upon The Fund.

It's recommended that amendatory language be drawn to make post-judgment interest the same as the interest earned by The Fund. While the committee understands and recommends this change, they recognize that at present post-judgment interest is too high in all fields of tort.

(5) The statutory language of The Health Care Act does not create the authority for The Fund to establish an appeal bond.

A change is required to amend the Act to waive the appeal bond in the case of The Fund or to establish the proper mechanism.

(6) There is a need to amend The Premium Finance Act to allow installment payments of the surcharge.

~~(7) The committee heard evidence and supported the concept of placing a cap on awards and that the cap on The Fund itself should be lowered.~~

Committee Discussion:

OK

Committee Vote:

For 5 Against 0

Minority Comments:

Homer H. Cowan, Jr.
Chairman

For the Minority

INSURANCE SUBCOMMITTEE

FINAL REPORT

Topic:

Mandatory information exchange between Fund Board of Governors, JUA Board of Governors and Board of Healing Arts.

Committee Discussion:

Committee Vote:

For 5 Against 0

Minority Comments:

Homer H. Cowan, Jr.
Chairman

For the Minority

INSURANCE SUBCOMMITTEE

FINAL REPORT

Topic:

Study the meeting requirements of the Board of Governors. Should the meetings be public or private in regard to termination.

Committee Discussion:

Committee Vote:

For 5 Against 0

Minority Comments:

Homer H. Cowan, Jr
Chairman

For the Minority

INSURANCE SUBCOMMITTEE

FINAL REPORT

Topic:

Clarification of "limiting procedures". Should there be an exclusion of coverage? How does this affect rates?

Committee Discussion:

Committee Vote:

For 5 Against 0

Minority Comments:

Homer H. Cowan, Jr.
Chairman

For the Minority

INSURANCE SUBCOMMITTEE

FINAL REPORT

Topic:

Clear up ambiguity between primary versus excess in respect to termination.

Committee Discussion:

Committee Vote:

For 5 Against 0

Minority Comments:

Homer H. Cowan, Jr.
Chairman

For the Minority

INSURANCE SUBCOMMITTEE

FINAL REPORT

Topic:

Board of Governors should have more autonomous authority in respect to Insurance Department handling and administration of the Fund. That the Commissioner of Insurance be ex officio and the Board of Governors elect its own chairman.

Committee Discussion:

Committee Vote:

For 5 Against 0

Minority Comments:

Homer H. Cowan, Jr.
Chairman

For the Minority

Recommendation of the Legal Subcommittee to the Committee of the Whole.

1. We recommend that an inactive health care provider as defined in Chapter 40, K.S.A., be amended to exclude tail coverage unless the health care provider has made surcharge contributions to the Fund for five consecutive years.

2. We recommend that this committee adopt a plan commonly called The Indiana Plan. This plan is comprised of 4 parts:

   A. Mandatory pre-trial screening be required with the results admissible in any subsequent litigation or court proceedings.

   B. A cap of $500,000 on all damages with authority for periodic structure settlements.

   C. Abolition of punitive damage in medical malpractice actions.

   D. Regulation of contingency fee agreements to provide a 15% maximum rate for awards above $100,000.

3. We recommend that the post judgement interest rates be tied to a current treasury bill rate.

4. We recommend that the Legislature adopt the general concepts found in recommendations two through nine of Don Strole's report. This report was submitted on July 8, 1985, to the Special Legislative Committee on Medical Malpractice. Don Strole is the General Counsel of the Healing Arts Board.

TM:jlle
2614

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
RICHARD A. UHLIG, SECRETARY
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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

several areas, but admitted that he informed no one at hospital about such negligence.

3. Pass SB 374 and 375 (presently in Senate Health and Welfare Committee).

a. SB 374 amends K.S.A. 65-28, 121 to require hospital's medical staff, executive board, peer review committee, etc. to report information to the Board as soon as they receive information that may constitute incompetency or other violations of Healing Arts Act. The Board must receive information as early as possible, if it is going to be at all effective in preventing future harm from occurring.

b. SB 375 allows Board to assess fines in the amount of $5,000 for 1st violation, $10,000 for second violation, $15,000 for third and subsequent violations of Healing Arts Act. Hopefully, this would deter some doctors from doing unnecessary surgery, overprescribing drugs, or other quasi-intentional actions. It may also make the doctor more careful in doing certain procedures, i.e., prevent some reckless disregard.

4. Pass legislation which allows Board to use and defer to the Impaired Physicians Committees of private associations of the Healing Arts. Such legislation would improve the Board's ability to deal with possibly the most dangerous type doctors. The legislation should also make absolutely confidential any information received by the Committees and grant immunity to them. It should also allow the Board to enter into binding agreements with the impaired licensee regarding treatment and monitoring. The Board should be given the discretion to decide whether such agreements will be made public.

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

to review to ensure that hospital medical staffs and support staffs are doing adequate peer review. This committee should work closely with the Hospital Association, the Medical Society and the Osteopathic Association to improve the quality of peer review.

10. The Professional Services category in the budget of the Board should be greatly increased to allow the Board to contract with or employ a part-time basis investigators, law clerks, medical assistants, consultants, expert witnesses, hearing officers, etc. At all stages, a case can and usually is quite complex. This kind of support help is essential for the Board to handle cases effectively and quickly. Legal and medical assistants are essential to analyze all the information that will be received. If more information is received, as contemplated by the other recommendations, obviously more people are needed to analyze it.

A hearing officer or examiner is also necessary in most cases for at least two reasons: (1) it is not feasible to have Board Members who volunteer their time to spend numerous weeks in a hearing on a complex case; (2) many due process problems regarding bias, legal rulings, separation of functions, etc. are cured by use of a hearing officer. The Board does have statutory authority under the Administrative Procedures Act to employ a hearing officer.

DGS/pd

REPORT OF PEER REVIEW SUBCOMMITTEE DRAFT

The Peer Review Subcommittee has heard from health care providers and their associations, hospitals and regulatory boards concerning peer review. We have learned that extensive peer review is required by several hospital accreditation agencies. Further that it is a process that consumes considerable time of physicians, and therefore, is expensive for all concerned.

The status of peer review in Kansas is difficult to measure. Following are some of the factors which make it difficult to evaluate:

a) The presence of the existing peer review process undoubtedly has some deterrent effect on below-standard care. Even though few incidents actually run the entire course of any of the peer review processes to decision, the fact that it exists is seen as beneficial in limiting below standard care.

b) Peer review is presently handled informally at both the Board of Healing Arts and hospital staff levels. There is no tabulation or reports made when informal resolution closes a case file. It is therefore difficult to quantify how much the peer review process actually results in limiting privileges and/or curtailing certain practices on the part of physicians. We are told that informal agreements often prescribe additional educational training. Again, no one knows the number or extent of these agreements, including the Board of Healing Arts.

c) The peer review environment for health care providers is plagued by lack of public confidence, the same as any other professional peer review process, e.g., the foxes are watching the chicken house syndrome. There are several special problems involving peer review in the medical profession, however, which deserve special notes, e.g., the medical community is relatively small, even at large hospitals in urban areas. Local peer review committees are asked to judge not only "peers" but co-workers and friends. A competition among health care providers is an economic reality which some believe impacts on the peer review process. Specialists must receive referrals from other physicians. Hospitals also depend upon physicians for their referrals. A stringent peer review process at a hospital

or by physicians who look to those being reviewed for their livelihood mitigates against aggressive action for financial reasons.

Members of peer review committees live in fear of almost certain legal action over their decisions, ranging from administrative appeals at one end of the spectrum to federal civil rights-anti-trust lawsuits at the other. State law is unable to deal with this problem.

While the peer review process is mandated, it is handled informally and done by volunteers. There are no requirements that detailed minutes or records be kept. The Board of Healing Arts is not advised of complaints or informal resolution of complaints and on occasion it has been denied access to peer review records.

d) Some concern has been expressed by physicians that much peer review is conducted by physicians who are not truly peers, e.g., that they do not possess the same training and experience as physicians, and they are called upon to review. This occurs in hospital staff committees and at the Board of Healing Arts level.

e) The Board of Healing Arts must be vested with more resources and statutory power to more effectively impact on the peer review process. While most peer review must be conducted at the hospital level, the Board of Healing Arts should not be legally estranged from aggressive investigation of complaints. Further, adequate staffing and office facilities are necessary to insure an effective agency.

The Board of Healing Arts is presently being denied information by omission (ignoring incidents) and commission (failure to disclose suspected deficiencies or complaints). Present laws should be amended to encourage reporting of suspected violations as soon as they are known to hospitals and/or their peer review committees.

The Committee does not believe that the Board of Healing Arts should or be expected to delay investigations or hearings until lawsuits or other pending matters are resolved. We realize that this policy will at times be in conflict with the economic or personal interests of individuals (or their insurers) however, the public interest in good medical care should be paramount.

The Peer Review Subcommittee did not have time to discuss or give study to the performance audit of the Legislative Post Auditor. A review of this study, however, reveals consistent conclusions and recommendations with our work, although arrived at independently.

The following are our recommendations which we believe will make the peer review processes stronger, resulting in improved medical care and fewer malpractice incidents.

1. The Board of Healing Arts should be empowered to examine and copy documents, reports or records relating to the practice of any licensee. This includes the rights to issue subpoenas, enforceable through the District Court.

This recommendation is specifically intended to include records of peer review committees, hospitals, the Health Care Stabilization Fund and insurance companies and follows the Arizona statutes. (See A.R.S. 32-1451.01). The Committee believes that concealment of malpractice perpetuates malpractice and may result in more claims in the long run.

2. It is recommended that the present Board of Healing Arts statutes be amended to provide that upon conclusion of an investigation by its staff the report first be presented to a review committee of three (3) persons who possess similar training and practice to the licensee being investigated. The review committee will make the initial determination from the investigative report whether or not the case should be referred to hearing or closed. Either the staff or party being investigated may request the entire board review (without hearing) the investigative report and review committee decision on whether or not a case should be referred to hearing.

The three (3) member review committee would be appointed by the Board of Healing Arts from a list of physicians provided by the specialty society for a term of three (3) years. Membership should be staggered. The Board of Healing Arts should be directed to form review committees from the twenty-three (23) recognized medical specialties and for D. O. and chiropractic specialties. In areas of ambiguity or when sufficient members cannot be recruited, the Board should be authorized to appoint a licensee whose practice is generally similar to the person being investigated.

3. The Board of Healing Arts should be funded for more investigators, hearing examiners, support staff and equipment which is necessary to undertake the program outlined in these recommendations. We acknowledge that some improvements have recently been made in the Boards funding, effective investigation and processing of complaints requiring much more. Funding should come first from monies generated by

licensing fees, to be supplemented by the general fund, if necessary. We believe the public will support this expenditure.

4. Impaired physicians committees that are formally recognized by the Board of Healing Arts should receive exemption from the reporting statutes and have confidentiality in their work. These exceptions should not extend beyond the first referral for each physician.

5. A specific statutory civil equitable cause of action should be enacted to give protection to persons who report deficiencies to a hospital peer review committee or the Board of Healing Arts. The concern here is to prevent retaliation by physicians or hospital management against persons who in good faith report malpractice or unethical conduct. The equitable relief would permit a court to order reinstatement with back pay if it is established that discharge or adverse action was due to filing the complaint and a civil penalty of up to two times the amount of back pay could be levied by the Court.

6. The state, through the Health Department as to hospitals, and the Board of Healing Arts as to physicians, should become actively involved in supporting medical risk management and quality assurance programs. The state should undertake through its agencies research to identify problem areas, facilities and practitioners. A state supported effort should be instituted that focuses on quality assurance.

7. The Board of Healing Arts should be prohibited by statute from renewal of a license of a person in active practice in Kansas until it is in receipt of evidence of current malpractice insurance. The statute should further specifically provide that the burden to show current malpractice insurance (eligibility for renewal) is on the licensee.

8. Amend reporting requirements for less than minimum standards of care to provide that all hospital employees are required to report suspected below standard care or unethical conduct to peer review committees. Intentional failure to do so can result in suspension of license by the Board of Healing Arts.

9. Require hospital officials, medical staff and peer review committees to report any evidence of incompetent conduct which may violate the Healing Arts Act to the Board of Healing Arts within a reasonable period of time. Authorize Board to assess fines or suspend for failure to act.

10. Specifically permit the Board of Healing Arts to order a licensee to complete further education or training.

11. Hospitals and their peer review committees are required to report all limitations or relinquishment on staff privileges to the Board of Healing Arts, whether voluntary or involuntary.

SCREENING PANEL SUBCOMMITTEE RECOMMENDATIONS

The Screening Panel Subcommittee believes there currently exists substantial discrimination between personal injury verdicts resulting from medical negligence and similar injuries resulting from other types of individual negligence. A study conducted in 1983 by the Rand Corporation of Chicago revealed that verdicts in medical negligence cases were on the average 4 times higher than verdicts in automobile negligence cases involving the same injury.

The Screening Panel Subcommitee recommends that all laws governing professional malpractice including legal malpractice, engineering malpractice, etc. should be totally re-examined by an extension of the Citizen's Committee on Tort Reform.

In the area of medical malpractice specifically, the Screening Panel Subcommittee unanimously recommends the adoption of the principles contained in the Indiana Screening Panel Statutes. The Indiana statute provides for the establishment of medical review panels to review all proposed malpractice complaints against health care providers. The opinion of the panel is admissible in court if a party is not satisfied with the panel's finding and wishes to proceed with a court action. Additionally, the Indiana plan requires mandatory participation by all licensed doctors in the review panel process.

In addition, the subcommittee approves the inclusion of the following in a screening panel statute:

(a) Participation by plaintiffs and defendants in screening panel procedures should be mandatory and neither party should be able to produce any evidence or facts in court that were not properly and fully presented to the panel; however, if a court determines that at the time of the screening panel decision such facts were not reasonably discoverable, they may be admitted within the discretion of the trial judge.

(b) That there should be a limit on the total amount of recovery in any given case, with the cap covering everything except future medical care and custodial care; unless there was a structured settlement approved by the court.

(c) That the principle of structured settlements should be specifically endorsed and encouraged by the Kansas Legislature.

(d) That consideration should be given to any reasonable recommendation by Plaintiff's attorneys to ensure fairness to Plaintiffs in these cases, provided the recommendations are not made to hinder the effective adoption of these recommendations.

(e) That there should be mandatory participation in the screening panel program by all physicians in order to be licensed to practice in Kansas.

(f) That the results of the screening panel findings should be: KS Register 1) published in the Kansas State Medical Journal, 2) submitted to the Kansas Board of Healing Arts and 3) submitted to the Kansas Bar Association.

(g) The panel recommends an increase in the annual educational requirements of all physicians, with emphasis on the relevancy of education and special requirements for physicians who have had findings of negligence assessed against them.

WORKING PAPER

September 12, 1985

TO: Special Committee on Medical Malpractice

FROM: Kansas Legislative Research Department

RE: A Working Paper on Medical Malpractice Issues

The Special Committee on Medical Malpractice will have met for a total of eight days as of September 13. The Committee will have heard from a number of persons expressing diverse points of view and have been exposed to numerous articles, reports, data, and statistics.

The purpose of this memorandum is to list the issues that have been raised prior to September 12, briefly state the positions taken by the conferees on the issues, and note what data, statistics, or other information have been presented to support the position or that have relevance to the issue.

The memorandum will begin with a discussion of what seems to be the basic issue of whether there is a medical malpractice problem or crisis at this time. The issues then will be categorized under three major topics, i.e., tort reform; insurance issues; and health care provider issues, including peer review, risk management, and disciplinary oversight. The format will be a general heading, then a Roman numeral followed by a statement of the issue, a general statement of the position of conferees, and information noting the statistics, data, or studies which are relevant to the issue.

9/12-13/85
Attachment XLIII

GENERAL

I. Is there a medical malpractice problem or crisis that now exists in Kansas?

Testimony and Material Presented to the Committee. Representatives of the Kansas Medical Society, other health care provider groups, and the insurance industry have said there is a crisis and that it is one of affordability rather than availability. It is alleged that the high cost of malpractice premiums is causing providers to curtail medical practices and procedures, to practice defensive medicine, and to even consider quitting. Some say that the problem is said to be especially acute in rural areas. The culprits are said to be the increasing frequency of claims and the growing size of jury awards and settlements.

Representatives of the Kansas Bar Association and the Kansas Trial Lawyers Association dispute there is a problem of affordability, stating the cost of premiums represents about the same percentage of a physician's income as it did ten years ago. They contend that the problem, if there is one, is that malpractice is being committed and the health care professions need to better police their members. They also note that health care providers received unlimited excess coverage for three years (1981-83) free of any charge. They urge caution to assess the impact of recent legislative changes (1985 S.B. 110) and no further changes unless the cost impact of the changes on health care provider insurance premiums is known.

The number of claims filed against the Health Care Stabilization Fund has increased steadily. For example in FY 1983 there were 156 claims filed compared to 230 in FY 1985. The surcharge assessments for the Fund have been as follows:

Fiscal Year	Percent
1977	45
1978	45
1979	40
1980	15
1981	0
1982	0
1983	0
1984	50
1985	80
1986	110

Source: Kansas Insurance Department materials presented July 1 and 2, 1985.

Data compiled by the American Medical Association from physician-owned insurers shows the average paid loss going from $20,396 in 1979 to $72,243 in 1983. (See "What Legislators Need to Know About Medical Malpractice," National Conference of State Legislatures (NCSL), August, 1985, p. 7). Note also page 6 of the same publication which shows that for 1978-83 the malpractice premiums earned by insurance companies were $7.3 billion, insurance company reserves were $5.8 billion; insurance company investment income was $1.7 billion, incurred losses (meaning actual plus estimated losses) were $8.6 billion, but actual losses paid were $1.4 billion.

The mean insurance premium rate level for Kansas physicians and surgeons for the Medical Protective Company went from $2,394 in 1982 based on $100,000/$300,000 coverage to $6,815 in 1985 based on $200,000/$600,000 coverage. St. Paul Fire and Marine rates for 1982 were $4,599 and for 1985 were $14,022. The Insurance Department estimates the average premium paid by Kansas physicians now is $5,743 for primary coverage, $6,317 for the $3 million excess coverage, for a total average premium cost of $12,060.

The average physician's income for the West North Central states (Kansas, Nebraska, Missouri, Iowa, North Dakota, South Dakota, and Minnesota) was $110,500 annually in 1983, compared to $106,300 annually nationwide, according to the survey conducted by the AMA. See the memorandum distributed to the Committee.

An article in the February 6, 1984, issue of Medical Economics which has been made available to the Committee shows information regarding the median expenditures for major expense items including medical malpractice insurance in 13 states (Florida, Texas, California, Ohio, North Carolina, Illinois, Georgia, Pennsylvania, Michigan, New Jersey, New York, Massachusetts, Virginia) as a percent of the doctors' gross income for 1982.

Data from the NCSL's publication "What Legislators Need to Know About Medical Malpractice" (page 9) indicates that physicians' malpractice insurance rates rose at a rate considerably less than other health care cost components (hospital room prices, medical care price index, consumer price index, and average loss per claim) from 1976 until 1983.

Before proceeding, several thoughts seem appropriate. First, if the Committee concludes there is a medical malpractice insurance problem, then it may be

useful for the Committee to discuss what objectives they would like legislation to accomplish. Are the legislative objectives which are listed in the NCSL publication on pages 15-16:

1. tc reduce medical malpractice premium costs;

2. to deter negligent practice and improve the quality of health care;

3. to assure consumer access to needed care;

4. to control health care costs;

5. to promote reasonable patient expectations;

6. to assure equitable and adequate patient redress for negligent injury;

7. to encourage timely resolution of malpractice suits;

8. to discourage frivolous, nuisance, or groundless claims; or

9. to develop legislation that can withstand constitutional challenge.

Second, it is important to note that Kansas and a number of other states responded to an earlier medical malpractice crisis in the mid 1970s by passing a number of tort reforms and other measures designed to insure malpractice insurance availability. The new NCSL publication notes (page 13) state legislation in the mid 1970s was effective in solving malpractice insurance availability problems but the effect of tort reforms on claims and recoveries is far less clear. Two studies are noted in the above cited publication including one done by Frank Sloan, economist of Vanderbilt University, who concluded that the results of his study give no indication that state legislative actions have had their intended effects on premiums.

A study by Dr. Patricia Danzon for the Rand Corporation analyzed closed claims by insurers in the mid to late 1970s. Her conclusions were that caps cut the average settlement by 25 percent, raised the proportion of cases dropped from 43 to 48

percent and reduced slightly the number of cases going to verdict. Her study concluded collateral source changes appeared to reduce settlements although the statistical significance of this finding was low. Finally, limits on attorney fees cut the average settlement by 9 percent, raised somewhat the number of cases dropped without payment and slightly reduced the percentage of cases going to verdict.

Finally, a representative of the Medical Protective Company at an earlier meeting noted a $500,000 overall cap on awards would have no immediate effect on primary insurer malpractice premiums since they are now limited to $200,000 per claim but after several years the impact of the cap would be felt.

The Committee has not had any actuarial information presented to date on the effect of any proposed tort reforms.

TORT REFORM

I. Should a cap be established on damage awards in medical malpractice cases?

Testimony and Material Presented to the Committee. Representatives of health care providers and insurers are in general agreement that a cap on damage awards will decrease the size of such awards, hopefully reduce medical malpractice premiums and possibly have the effect of discouraging the filing of claims by reducing the so called "lottery atmosphere."

Not all groups are in agreement regarding the type of cap that should be imposed. For example, a representative of the Medical Protective Company proposes an overall cap of $500,000 on all damages, whereas, a representative of the Western Insurance Companies has advocated a $500,000 cap on nonpecuniary damages with no cap on actual damages. St. Paul Fire and Marine has recommended a $100,000 cap on pain and suffering but no cap on pecuniary losses or future medical expenses. It would be well for the Committee to get clarification from the various interest groups as to exactly what kind of cap they advocate.

The two lawyer groups and the judges who appeared opposed caps on awards saying that large medical malpractice awards are rare and that when they occur they are justified due to the extent of the injuries. They argue that large awards do not drive up malpractice insurance costs but malpractice does.

The Medical Protective Company presented charts showing that the average loss severity per claim paid in Kansas by Medical Protective in 1984 was $32,478 or more than twice the amount paid in Indiana ($14,125). The company representative said the $500,000 cap in Indiana plus the mandatory screening panel provision in that state were factors accounting for the difference.

The lawyer groups argue there is no need for a cap and point to the 135 claims (as of July 1 of this year) paid by the Health Care Stabilization Fund (HCSF) since its inception in 1976. They note the average claim award of $261,298 and the fact that only 12 jury awards have been sustained against the Fund with the average jury award slightly more than $500,000. Claims paid by the HCSF represent the more severe injuries or deaths attributed to medical malpractice.

The NCSL publication (page 20) indicates Indiana has a $500,000 cap and Nebraska and Virginia both have $1 million caps on the total recovery a malpractice victim may receive. Illinois and North Dakota have ruled caps on total recoveries unconstitutional. The American Medical Association's (AMA) "Limits on Liability" (April, 1985) publication notes 17 states have enacted some type of limit on awards in malpractice actions. The publication notes a total of five states have found the limits unconstitutional but limits have been upheld in three states.

II. Should a cap be established on attorneys fees in medical malpractice cases?

Testimony and Material Presented to the Committee. Representatives of various health care provider groups and the Medical Protective Company have advocated a cap on contingency fees for plaintiffs' attorneys. Medical Protective has proposed a 15 percent cap on contigency fees on awards above $200,000. A representative of Western Insurance Companies has proposed plaintiffs' attorneys be paid at a "contract" price or hourly rate. United States District Judge Patrick Kelly stated plaintiffs' attorneys should not be partners in a case and stated a 50 percent contingency fee was too high, but one-third was fine. All judges who appeared indicated no one had ever complained about a contingency fee in a medical malpractice case and the fees had been routinely approved as required by statute.

Proponents of a limit say the current system is unfair to successful plaintiffs who have to share too much of their recovery with their attorney, and encourages the filing of questionable suits.

Representatives of the legal profession oppose statutory limits on attorneys fees and point to an existing statute which requires the judge to approve only reasonable fees in medical malpractice cases. Both groups point to the dual purpose of the tort system as one of compensation and deterrence and say the contingency fee is an integral part of this system. They note that only one in four plaintiffs is successful at trial and the contingency fee system permits the spreading of costs of litigation over both successful and unsuccessful plaintiffs. They also argue that a limit would be an unfair advantage to the defense bar who would not be so limited.

Testimony from the Medical Protective Company indicated that approximately 28 percent of the premium dollar it collected goes to plaintiffs' attorneys and 30 percent to the defense bar. Other testimony has indicated plaintiff and defense legal expenses are approximately equal.

Five states, according to the AMA publication, "Attorneys Fee Regulation" (April, 1985) provide a sliding scale for plaintiffs' attorneys fees in malpractice cases.

III. Should the appointment of screening panels be made mandatory with the results made admissible at trial?

Testimony and Material Presented to the Committee. Representatives of health care provider groups and the Medical Protective Company support the appointment of mandatory screening panels. Medical Protective advocates the Indiana system where the panel consists of three health care providers and a nonvoting attorney serving as chairman. Proponents say these panels will weed out questionable claims and encourage the settlement of clear cases of malpractice.

The Kansas Bar Association, St. Paul Fire and Marine and several judges questioned the use of mandatory screening panels saying they feared added costs and more lengthy litigation would result.

Twenty-three states, including Kansas, currently have some type of screening panel. The screening panels in Kansas are permissive as they are in eight other states and the decisions are not admissible into evidence in Kansas or in ten other statutes. Five states have found these panels to be unconstitutional while they have been upheld in eight states according to the AMAs publication "Pretrial Screening Panels" (April, 1985).

IV. Should settlement conferences be mandated for all medical malpractice cases?

Testimony and Material Presented to the Committee. Judge Patrick Kelly, U.S. District Judge, supported the use of settlement conferences but did not support making this mandatory in all courts although they are mandatory for all cases before his

court as part of a pilot project. Several Kansas district court judges thought mandatory settlement conferences would be beneficial.

Two district court judges indicated mandatory settlement conferences were not needed since most cases (95 percent) were settled before trial anyway.

Judge Kelly stated 13 out of 22 cases which were heard by a magistrate were settled and five out of ten which were heard by a mediator were settled. He noted each of five medical malpractice cases filed since January in his court has been settled.

V. Should periodic payments or structured damage awards and settlements be required?

Testimony and Material Presented to the Committee. The Kansas Medical Society and other health care provider groups and several insurers have supported this idea. A representative of the Kansas Bar Association has expressed reservations saying this would lead to endless litigation and the representative of Providers Insurance Company said the Legislature should not mandate structured settlements but should leave the structuring of settlements to private industry.

Eighteen states, including Kansas, have enacted periodic payment provisions. K.S.A. 60-2609 permits the court to require damages to be awarded by installment or periodic payment in malpractice actions according to the AMA publication "Periodic Payments" (April, 1985). New Hampshire found a periodic payment provision unconstitutional. Other courts, including California, North Dakota (entire act found unconstitutional, however) and Wisconsin have upheld those provisions.

VI. Should expert witnesses be limited to those from Kansas or the surrounding states?

Testimony and Material Presented to the Committee. The Kansas Medical Society, a representative of the Western Insurance Companies, and several others have advocated limiting expert witnesses to those persons residing in Kansas or the surrounding states. Their argument is that Kansas health care providers should be

judged by those familiar with standards of practice here and should not be subject to scrutiny from so-called experts from large urban centers or universities far from Kansas. Some such experts are said to make their livelihood from court testimony.

Representatives of the legal profession and others argue that the standards of medicine practiced in Kansas should not be different from those in any other area, that often local experts are unwilling to testify against colleagues and there is a national standard for physician providers who are board certified.

Eleven states according to the AMA publication "Standard of Care and Expert Witness Qualification" (April, 1985) have statutory provisions regarding expert witnesses. Tennessee, for example, requires experts to be from that or a continguous state and to have been engaged in the active practice of medicine during the past year. Ten states, according to the NCSL's publication (page 23), have established qualifications for the use of expert witnesses in malpractice actions.

VII. Should the Legislature define the legal standard of care for health care providers or should this be left to the courts? (See also Providers Issues Section, XII.)

Testimony and Material Presented to the Committee. A representative of the Western Insurance Companies and several others have supported "tightening up" jury instructions regarding the standard of care by legislation. An argument made is that the current Pattern Instructions for Kansas (P.I.K.) are too broad, lead to confusion, and facilitate a finding of negligence.

Representatives of the Kansas Bar Association and several district judges have pointed out that PIK instructions can and often are supplemented by jury instructions tailored for a particular case, that the PIK instructions are based on case law and that this area is properly the province of the judiciary and not the Legislature.

Twenty-one states statutorily set out the medical standard of care according to the AMA's publication "Standard of Care and Expert Witness Qualification" (April, 1985). According to the NCSL publication (page 23) there are 18 states which have by statute established a medical standard of care. The same publication suggests that the adoption of prospective paying systems, i.e., diagnostic related group (DRG)

based reimbursement and utilization review systems as well as expansion of health maintenance organizations (HMOs), primary care networks, and preferred provider organizations (PPOs) which incorporate utilization review and quality control may bring about more uniformity in standards of care. .

VIII. Should juries be required to itemize awards?

Testimony and Material Presented to the Committee. There seemed to be general consensus that requiring itemization by juries was either a good idea or would not create problems.

IX. Should the Legislature enact other reforms such as no fault, arbitration, requiring plaintiffs' attorneys when filing a malpractice petition to certify they have an expert's opinion that malpractice has occurred, panels of judges, mandatory summary judgment and directed verdict rulings, and modification of the standard for utilizing remittur.

Testimony and Material Presented to the Committee. There seemed to be little enthusiasm or little discussion by any of the conferees on the above suggestions. Several district judges pointed out state constitutional problems with arbitration of claims. A plaintiff's attorney noted in most cases a medical expert's opinion has been obtained prior to filing a petition by his law firm.

Eleven states have laws permitting arbitration of medical malpractice cases according to the AMAs publication "Arbitration" (April, 1985). The Kansas Constitution Bill of Rights §5 provides the right of trial by jury shall be inviolate. Apparently this provision would not permit arbitration short of a constitutional amendment.

INSURANCE

Introduction

Issues and questions related to insurance are among the most prevalent encountered in discussions of the medical malpractice "crisis." To the extent that the well-documented escalation in medical malpractice insurance premiums has been the catalyst spurring physicians to approach state legislatures in many states, the most basic question might well be:

I. Why have medical malpractice premium rates risen so dramatically?

Testimony and Material Presented to the Committee. It is undisputed that premium rates have risen, but conferees have provided differing explanations as to the reasons. The legal community suggests that physicians have deviated from the appropriate standard of care and have caused harm, leading to claims, which result in premium increases. It has also been alleged that the insurance industry has generated this crisis.

The insurance industry has expressed the opinion that the higher rates derive from an environment of increased frequency and severity of claims, as well as increasing defense costs.

The National Conference of State Legislatures' (NCSL) 1985 publication "What Legislators Need to Know About Medical Malpractice" includes an overview of how medical malpractice insurance functions generally (see especially pages 4-6) and traces recent trends in medical malpractice premiums, claims, and awards (see pages 7-11). The report points out that the frequency of claims, the size of awards, and the cost of insurance have steadily increased and suggests explanations to account for this trend, including greater awareness of the potential for legal remedies, new developments in health care technology, and changes in patient-provider relationships.

Another informative overview is found in "Kansas Medical Professional Liability Insurance," prepared by the Kansas Insurance Department, March 13, 1985.

This report reviews the availability crisis that led to the passage by the Kansas Legislature in 1976 of the Health Care Provider Insurance Availability Act, traces the recent premium and loss experience of the major medical malpractice insurers in Kansas, and describes the ratemaking procedures applicable to professional liability insurance in the state.

II. Should some form of geographic rating, merit rating, or both be instituted in determining premium rates for health care providers?

Testimony and Material Presented to the Committee. Insurance companies reported that territorial pricing is done in some states (New York, Florida, Illinois, Michigan, Texas) but that claims and loss experience in Kansas would not justify such a practice because there is no apparent distinction between the claim/loss experience in urban and rural areas of the state.

It was also pointed out that geographic factors are sometimes indirectly included in ratemaking, because physician classifications tend to reflect the difference between, for example, a general practitioner who delivers a small number of babies and an obstetrician delivering many babies, in the sense that the OB/GYN specialist is more likely to be practicing in an urban context.

Representatives of the Kansas Bar and some Committee members have suggested that the claims and loss experience of individual practitioners should be taken into account in setting their premium rates, especially since this is the practice in the case of other professions including attorneys. In addition, the Joint Underwriting Association (JUA) employs individual provider claim and loss experience as a factor in its determination of physician insurance costs. The JUA insures those providers, approximately 250 doctors at this time, who are not able to obtain coverage in the private market.

A position paper submitted on behalf of the Kansas Bar Association supports merit rating for physicians as a possible means of assuring stablized premium rates for most Kansas physicians. The paper includes the observation that a de facto merit or experience rating system already exists because of the underwriting practices of the major medical malpractice insurers operating in Kansas. It also suggests the kinds of

statistical information that might be useful in evaluating merit rating as a possible insurance reform.

A report issued by the National Conference of State Legislatures in July, 1985, indicates that no state has enacted experience rating of physicians for malpractice insurance premiums (see "What Legislators Need to Know About Medical Malpractice," p. 26). The same publication states that most hospitals and health maintenance organizations (HMOs) pay premiums based on malpractice experience (pp. 27-28).

The insurance industry has testified that merit rating of physicians would create a breach of trust and good faith in the insurer-insured relationship making communication difficult and encumbering the defense of the insured. The medical community has indicated it is against merit rating because it has a negative effect on the sense of unity and solidarity of the medical profession. It is also argued that number of claims may not correlate directly with competence. Rather, the type of claim is of more significance.

The concept of "deviation type rating" described in Medical Malpractice Insurance in Pennsylvania (the Nye report) assumes the integrity of malpractice claims experience as a factor in the ratesetting process. Under this sytem, emphasis would be placed on the estimated risk of an individual physician rather than on a specific classification of activity. It is argued that such experience rating will increase the cost allocation efficiency of losses due to malpractice claims and that premium rates for most physicians would be lower, not necessarily in dollars, but as a reflection of the fact that the losses of a few practitioners would be paid for more by those responsible than by all physicians. (See p. xii of the summary report.)

III. Should investment income be considered by insurance companies as a factor in the ratemaking process or by the Insurance Commissioner as part of the review of rate filings?

Testimony and Material Presented to the Committee. The Insurance Department indicated that in Kansas there is no statutory requirement that investment income be included in the ratemaking process or in review of rate filings, although the

Commissioner has supported the idea. Some insurance companies do include these data in their ratemaking procedures, but the practice is not uniform.

Those opposed to inclusion of investment income in the documentation in support of rate filings urge that this income should be looked upon as distinct from underwriting.

Insurance company representatives pointed out that investment income is not a significant factor in Kansas, because policies for professional liability insurance are issued on a claims-made basis, thus permitting only a short time for investment earning potential. Companies use investment income as a buffer against underwriting losses.

It was noted that a task force of the National Association of Insurance Commissioners (NAIC) recently adopted a report recommending that investment income remain independent of the ratemaking process. The alternative, it is claimed, would lead to premium rate dependence on either the interest rate or rate of return on investment.

A roundtable discussion among five insurance company officers, contained in Report No. 2 of the publication "Professional Liability in the '80s," published in November, 1984 by the American Medical Association Special Task Force on Professional Liability and Insurance, includes a brief discussion concerning insurance company investment income and the relationship between investment income and loss ratios (page 5).

IV. Should the Joint Underwriting Association (JUA) or the Health Care Stabilization Fund or both be abolished?

Testimony and Material Presented to the Committee. It has been suggested that perhaps the state should not be engaged in the business of insurance.

A representative of Western Insurance Companies, the administering carrier of the JUA, indicated that if the JUA were eliminated, additional professional liability insurance providers might do business in Kansas. He also testified that the JUA is probably keeping afloat some providers who would otherwise be uninsurable.

It is likely that if the Fund and the JUA were eliminated, both availability and affordability would be implicated because physicians would determine the extent of their primary and "excess" coverage; there would be no automatic excess carrier and there would be no guaranteed availability.

The report on the Board of Healing Arts done by Legislative Post Audit indicates that the annual number of claims filed against the Fund, the number of claims paid by the Fund, and the average amount per award have increased each year since 1980. Because there is no statutory limitation on the amount that may be assessed as a surcharge by the Insurance Commissioner, physicians must pay whatever percentage of premium is assessed, currently 110 percent. Actuarial estimates envision that the assessment will remain at approximately 100 percent over the next two years. The medical community has expressed concern about what it perceives to be an unending spiral of high surcharges that, coupled with increasing premiums, poses affordability threats to many health care providers. The Kansas Medical Society has suggested that these high rates also threaten access to health care, because some physicians are restricting their practice or retiring early from practice, especially in rural areas.

Reports No. 1 and No. 2 of "Professional Liability in the '80s," published in November, 1984 by the American Medical Association Special Task Force on Professional Liability and Insurance, contain information related to availability and affordability of physician malpractice insurance. Part 1 notes: an increase in medical malpractice litigation over the past 40 years; the withdrawal of many insurance carriers from the malpractice insurance market; medical community response in sponsoring alternative insuring mechanisms for physicians and in encouraging tort reform legislation; increasing frequency and severity of claims by physicians and by hospitals; escalation in malpractice premium rates; and the impact of all of these trends on health care costs generally. Part 2 includes an informal roundtable discussion among insurance company officers as to ways to approach the medical malpractice problem. No conclusion is reached, but it is suggested that "[T]here probably is no single remedy."

V. Are health care providers required to participate in the Health Care Stabilization Fund as a condition precedent to practice in Kansas?

Testimony and Material Presented to the Committee. This issue has been raised by Committee members and a request for an Attorney General's opinion was discussed but no request has been made.

This question arose during Committee discussion addressing the issue of whether the Board of Governors of the Health Care Stabilization Fund should be more aggressive in terminating fund liability for providers who present "material risk of significant future liability to the fund." (See minutes of this Board, November 27, 1984, pp. 2-3.) Committee members expressed concern that such action by the Board could raise serious due process questions if fund participation were seen to be required as a condition for practicing medicine in Kansas.

VI. Should insurance companies be required to provide coverage to a wider group of insureds?

Testimony and Material Presented to the Committee. The Insurance Department has pointed out that insurance companies have a "right of underwriting" by which they may select those they wish to insure, eliminating any person or groups they do not wish to insure.

The Medical Society indicated that the Pennsylvania Casualty Company will not write malpractice insurance if there are fewer than five physicians in the group and that Medical Protective is very restrictive on physicians in high-risk practices. The representative of Medical Protective stated that in Kansas that company writes only medical doctors, dentists, and, to a limited extent, osteopathic practitioners.

The osteopathic doctors pointed out that they face an availability problem because of the restrictive practice of Medical Protective, which will insure only those osteopaths who are in practice with a group of medical doctors. Although St. Paul Fire and Marine will insure osteopaths, that company's premiums are higher than those of Medical Protective, and the availability problem becomes one of affordability as well.

VII. Should procedures for defense of the Health Care Stabilization Fund be improved?

Testimony and Material Presented to the Committee. Several judges, a plaintiffs' attorney, and others have complained about the Fund's legal representation. Some have said that at times those representing the Fund had not cooperated with defendants in settling cases or had not become involved in cases until the time of trial. It was also noted, however, by several judges, that the quality of Fund defense seemed to be improving, and that the Fund is currently receiving good quality representation. It was recommended that the Fund be represented, perhaps by being named as a party in a case, and that counsel for the Fund have some control over the defense as early as discovery and during the time of a settlement conference.

Minutes of the July 5, 1984 meeting of the Board of Governors of the Fund include the suggestion by one Board member that occasionally the interests of defense counsel, the primary carrier, and the Fund are different and that it might be advisable to have the Fund represented at an earlier stage of any claims proceedings to determine which cases should be settled rapidly and which were more serious. The same Board member expressed his opinion that it might be worthwhile to explore hiring claims management personnel to evaluate claims for the Fund.

The Insurance Department testified that independent counsel is hired to review claims to determine potential Fund liability and to ascertain whether there might be a conflict of interest between defense of the Fund and of the private insurer. A representative of the Fund pointed out that a claims review position has been requested to monitor the paperwork and oversee proper reserve maintenance. She also indicated that those working on Fund defense feel capable of handling their responsibility, although there is a need for additional clerical staff. Fund staff also pointed out that attorneys appointed to evaluate cases are well qualified and experienced in medical malpractice. Also, files are reviewed every 30 days by the Fund, and attorneys are requested to provide ongoing evaluation of a case on a regular basis. (See handout "Defense of the Health Care Stabilization Fund.")

VIII. Should professional insurance liability for health care providers continue to be required as a condition for practicing in Kansas?

Testimony and Material Presented to the Committee. Although no testimony has been presented directly addressing this question, there has been an underlying

assumption that both frequency and severity of claims against doctors are strongly influenced by the legal environment, one element of which is the "deep pocket" point of view held by a number of potential plaintiffs. Because it is known that insurance is mandated for physicians, persons may present a claim simply because the insurance is "there."

Both the Health Care Stabilization Fund and the JUA exist as corollaries to the mandate, providing excess coverage and availability, respectively, to Kansas health care providers. No such mechanisms exist for other professional groups in the state, and one might speculate as to whether the public needs protection from uninsured physicians more than from, for example, uninsured attorneys.

The insurance industry generally argues that any mandated coverages increase premium costs. This cost is, presumably, at least partially passed on to the consumer, adding to the already problematic high cost of health care.

PROVIDER ISSUES

I. Should hospital medical staffs be required to report to the Board of Healing Arts whenever (1) they receive information that a licensee may have committed an act which is or may be grounds for disciplinary action; and (2) whenever licensees voluntarily surrender or limit their hospital privileges while under formal or informal investigation by the hospital?

Testimony and Material Presented to the Committee. The above items were recommended in Performance Audit Report: Board of Healing Arts, pages six through 8, agreed to by Board of Healing Arts in its response to the audit, and recommended in a memorandum from Mr. Strole dated July 8, 1985. The Federation of State Medical Boards in a 1985 publication recommends the reporting of any information which appears to show that a licensee "is or may be medical incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safety in the practice of medicine." The AMA report, "Professional Liability in the '80s, Part III" states on page 16 that the AMA will ask physicians to be alert to procedures and physicians who do not conform to appropriate standards of care and to be active in reviewing their peers. Hospital medical staffs, in particular, can be most effective in self-regulation according to the report. At the August 15-16 meeting, the general counsel for the Board recommended that the law be amended to require hospitals to report resignations from the medical staff. See page 6 of minutes.

K.S.A. 65-28,121 currently requires the reporting by the medical staff of any firm, facility, corporation, institution, or association which has granted practice privileges to any person credentialed by the Board when the medical staff recommends that practice privileges be terminated, suspended, or restricted for reasons relating to professional competence. In addition a report must be made when the medical staff finds that an individual has committed an act which is a ground for disciplinary action under a practice act administered by the Board.

II. Should licensees of the Board of Healing Arts be required to report whenever they receive information that another licensee may have committed an act which is or may be a ground for disciplinary action by the Board?

Testimony and Material Presented to the Committee. This recommendation is found at page eight of the audit report and references K.S.A. 65-28,122, a statute that requires reporting by licensees in the healing arts who possess knowledge not subject to the physician-patient privilege that another person licensed to practice the healing arts has committed an act set out in K.S.A. 65-2836 (grounds for disciplinary action against a licensee) to the Board. The statute further requires the reporting licensee to fully reveal such knowledge on request of the Board. See also other materials referenced under I and the July 8, 1985 memorandum from Don Strole.

III. Should the Kansas Healing Arts Act be amended to provide penalties, such as fines, for organizations or licensees that fail to report to the Board when required by law to do so?

Testimony and Material Presented to the Committee. The recommendation appears at page nine of the audit report which notes the Federation of State Medical Boards' Guide to the Essentials of a Modern Medical Practice Act recommends specific penalties for failure to report. See also other material noted under I. Under K.S.A. 65-28,122 licensees in the healing arts are currently required to report certain acts to the Board of Healing Arts. Thus, failure to report is a violation of the act and constitutes a ground for the suspension, revocation, or limitation of a license or the imposition of a misdemeanor penalty. No civil penalties are authorized by the act.

While hospital and other institutional medical staffs are required to report by K.S.A. 65-28,121, there is no penalty which accrues to the medical staff as an entity since the "medical staff" is not subject to regulation by any agency of the state, but only by the hospital or organizational governing body. Who or what agency would impose a penalty against what is essentially a private function or, in the case of county and district hospital boards, a governmental entity?

IV. Should other state agencies, law enforcement agencies, and medical associations be required to report to the Board of Healing Arts concerning licensees who may be incompetent, impaired, or otherwise in violation of the Kansas Healing Arts Act?

Testimony and Material Presented to the Committee. See page eight of the audit report for the above recommendation. Note also that K.S.A. 65-2898 already provides immunity for reporting for any person who in good faith, reports alleged incidents of malpractice or information relating to the qualifications, fitness, or character of or a disciplinary action against a person credentialed by the Board. The Kansas rules of statutory construction provide that "person" as used in K.S.A. 65-2898 includes other than natural persons.

V. Should professional liability insurance carriers be required to report incidents of medical malpractice to the Board of Healing Arts or other appropriate state agencies?

Testimony and Material Presented to the Committee. This question arose from Committee discussion and questions at the July 18-19 meeting. Representatives of Medical Protective and the Western Insurance Companies responded that insurers could report incidents of medical malpractice they are aware of if immunity is provided to insurance companies. Note the discussion of K.S.A. 65-2898 under IV, and note further that under the Kansas rules of statutory construction "person" includes corporate persons.

VI. Are the current laws which give qualified immunity to persons and organizations that report incidents of alleged malpractice or alleged incompetency or impairment sufficient to encourage reporting?

Testimony and Material Presented to the Committee. It has been noted that persons who participate in peer review or reporting of incidents of malpractice or professional incompetency which result in a practitioner losing medical staff privileges or a license may be subject to actions alleging restraint of trade or constitutional claims relating to due process. See article attached to memorandum from Don Strole to the Committee dated July 8, 1985. Professions are now subject to challenges on restraint of trade. See Goldfarb v. Virginia State Bar, 421 U.S. 773, (1975). There are several cases that pertain to judging violations of antitrust laws which could be reviewed for applicability in Kansas and, in its recommendations (No. 15) in Professional Liability in the '80s: Report 3, the AMA agreed to work with government

agencies such as the Federal Trade Commission in regard to self-regulation and peer review. The AMA could be contacted in regard to additional legal issues.

VII. Should hospitals be required by state law to maintain medical staff peer review programs and to report on such programs annually to the licensing agency?

Testimony and Material Presented to the Committee. In testimony dated July 2, 1985, the Kansas Hospital Association reported that the Joint Commission on the Accreditation of Hospitals (JCAH) requires accredited hospitals to maintain an ongoing quality assurance program designed to monitor and evaluate the quality and appropriateness of patient care and to pursue opportunities to improve patient care and resolve identified problems. JCAH accreditation is voluntary and thus does not apply to all Kansas hospitals. Additionally, Medicare participation requires that hospitals meet standards set by the Health Care Financing Administration relating to quality assurance in order to be certified as a Medicare and Medicaid provider. Would state statutory directives and supervision of hospital quality assurance programs by the state licensing agency strengthen the positions of governing boards and committes in respect to suits alleging antitrust violations? Would statutory requirements strengthen the state's ability to discipline committees or governing boards that fail to report?

VIII. Should the Board of Healing Arts be required by statute to review the practice of healing arts licensees who have a specified number of malpractice petitions filed against them in a specified time period?

Testimony and Material Presented to the Committee. In their report, the auditors recommend (see page 25) that the Board of Healing Arts give high priority to investigating and taking disciplinary action against doctors who have had multiple malpractice petitions filed against them, or who have allegedly committed an act of gross negligence. A Florida Governor's Task Force on Medical Malpractice, for example, recommended that when an individual licensee has three claims paid in excess of $10,000 over a five-year period, the professional regulatory agency be required to treat that as a complaint against the provider and conduct an investigation. There appears to be agreement among conferees that there should be a mechanism established to trigger a review mechanism of a provider's practice when there is evidence of

negligence and agreement that multiple malpractice claims may be one indicator that a licensee's practice should be upgraded or investigated. Testimony presented to the Committee indicates that only about 10 percent of claims filed go to trial and that between 60 and 75 percent of all malpractice claims are settled in favor of the defendant. This testimony indicates consideration should be given to whether it will be cost effective to conduct a full investigation and review each time a professional liability action is filed.

IX. Should failure to carry basic coverage or to participate in the Health Care Stabilization Fund be a ground for revocation, suspension, or limitation of a license?

Testimony and Material Presented to the Committee. The above question arises from the recommendation of the auditors that the Board of Healing Arts should seek legislation making it a violation of the Kansas Healing Arts Act for an active licensee to fail to comply with liability insurance requirements established by law. See pages 25 and 26 of the audit. It should be noted that K.S.A. 40-3416 requires any state agency that receives a report of a violation of the Health Care Provider Insurance Availability Act to: (1) make an investigation and take any official action it deems appropriate, and (2) notify the Attorney General or county attorney who, upon notice, must institute an action to enjoin the health care provider from rendering professional services in Kansas.

X. Should the Board of Healing Arts be authorized to levy fines against licensees who have violated the Kansas Healing Arts Act? (See also III this section.)

Testimony and Material Presented to the Committee. The post audit study of the Board's disciplinary activities resulted in the above recommendation found on page 26 of the audit report. Similar legislation was requested by the Board of Healing Arts in legislation introduced in 1985 as noted in the memorandum dated July 8, 1985 from general counsel for the Board.

XI. Should additional public members be added to the Board of Healing Arts?

Testimony and Material Presented to the Committee. The suggestion that additional public members be added to the Board is found in the audit report at page 26. The auditors found that public representation on the Kansas board is less than the average of similar boards in other states. See page 23 of the audit.

XII. Should the Board of Healing Arts be given authority to adopt rules and regulations or guidelines establishing minimum standards of medical practice in particular areas? Should the Board be exempt from some or all of the provisions of law concerning rules and regulations in such case? (See Tort Reform Section, VII.)

Testimony and Material Presented to the Committee. The above recommendation is from the memorandum from Don Strole, General Counsel of the Board of Healing Arts to the Committee and dated July 8, 1985 "What Legislators Need to Know About Medical Malpractice," notes that 18 states have statutes establishing a medical standard of care. The AMA paper entitled "Standard of Care and Expert Witness Qualification" (April, 1985) lists 21 states which statutorily set out a medical standard of care and notes that state legislation has often sought to define the locality upon which the applicable standard is based. Arkansas, Florida, and Virginia statutes are discussed in the AMA paper as are court decisions concerning the Alabama, Idaho, New Hampshire, North Dakota, and Washington statutes. The Florida statute, for example, [§768.45 (1)] defines the standard of care as that level of skill, care, and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances. This type of statutory definition is designed to reflect differences in the resources available in different communities and can change over time to reflect changes in medical practice. Maryland's law sets out 30 acts that constitute professional misconduct, and Arizona lists 20 acts that constitute professional misconduct.

In Kansas, K.S.A. 1984 Supp. 65-2837 defines professional incompetency and unprofessional conduct. The former includes one or more instances involving gross negligence or repeated instances of ordinary negligence. The Legislature has also set practice standards in K.S.A 65-2836 which sets out grounds for the revocation, suspension, or limitation of a license, including failure to inform patients with breast abnormalities of certain alternate forms of treatment. In K.S.A. 1984 Supp. 65-3237a,

the entire statute sets out standards for ordering, dispensing, administering, selling, or supplying certain amphetamines or sympathmimetic substances. Thus, there is a precedent for statutorily prescribing minimum standards of care rather than using rules and regulations in what may be a very sensitive area in which different points of view and practice should be represented.

It is assumed that the General Counsel's recommendation that any standards be exempt from provisions of the rules and regulations statutes refers to exempting any standards adopted by rules and regulations from the definition contained in K.S.A. 77-415(4) which would result in the Board's acting pursuant to K.S.A. 77-421a and thus exempt the Board from filing the rules and regulations, from legislative review, from the statutorily prescribed effective dates, and from review by the State Board on Administrative Rules and Regulations as to the need for temporary rules.

XIII. Should legislation be enacted which requires licensees of the healing arts to report to an appropriate person in the hospital any hospital staff member, regardless of health care occupation, who falls below a minimum standard of care? Should failure to carry out such reporting result in the Board being able to suspend the license of the healing arts licensee immediately?

Testimony and Material to the Committee. The General Counsel for the Board of Healing Arts recommended the above noted actions in a memorandum to the Committee dated July 8, 1985. No other recommendations or material supporting the above noted type of legislation has been submitted to the Committee.

XIV. Should legislation be enacted which allows the Board of Healing Arts to use and defer action to impaired physician committees of private associations of the healing arts and to make any information received by such committees absolutely confidential?

Testimony and Material to the Committee. See Memorandum from Don Strole to the Committee dated July 8, 1985, page two.

XV. Should legislation be enacted to authorize the Board, upon probable cause, to require a licensee tn take a competency examination approved by the Board and, in the event of failure on the examination, to require the licensee to attend courses in the area of the deficiency or to take other disciplinary action?

Testimony and Material Presented to the Committee. See Memorandum from Don Strole to the Committee dated July 8, 1985, page three.

XVI. Should legislative action be taken to require hospitals to submit peer review records on doctors when the hospital makes reports pursuant to K.S.A. 1984 Supp. 65-28,121?

Testimony and Material Presented to the Committee. See Memorandum from Don Strole to the Committee dated July 8, 1985. See also K.S.A. 1984 Supp. 65-4915, particularly subsection (e).

XVII. Should a special committee be established to review peer review records submitted to the Board and any other records it chooses to review?

Testimony and Material Presented to the Committee. See Memorandum from Don Strole dated July 8, 1985. Apparently the purpose of this recommendation is to see that institutional medical staffs and others are doing adequate peer review. In this context see VII, and note that the JCAH reviews quality control (peer review) programs in the larger hospitals in Kansas (60 beds and over), that the Professional Review Organization (PRO) is supposed to do patient care quality reviews of all hospital patients that are Medicare related and that the Department of Health and Environment, the hospital licensing agency, also does inspections for licensing purposes. Is this the appropriate agency to adopt regulations concerning and review of peer review activities in hospitals?

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nidwest perspective

ILLINOIS LAWYERS RUSH TO BEAT NEW MALPRACTICE LAW; FILE 1,000 SUITS

By RICHARD J. DONAHUE

On the three business days before Illinois' new medical malpractice law took effect on Aug. 15, nearly 1,000 malpractice suits were filed in Cook County Circuit Court in Chicago.

From Aug. 15 through Aug. 19 only 12 malpractice suits were filed, reflecting the abhorrence trial lawyers have for the new legislation which requires them to submit all new filings to a pre-trial screening panel, composed of a judge, attorney and physician, before the suit can go to trial. If the panel decides unanimously that the suit is without merit, and the plaintiff goes to court and loses, then the plaintiff and his attorney become liable for court costs and the defendant's legal fees.

A court challenge of the new law already has been filed at the request of the Illinois Trial Lawyers Association. Other constitutional challenges are expected.

Even if the new malpractice legislation prevails, it is not expected to have a dramatic impact on insurance premiums in the near future. A spokesman for Illinois State Medical Inter-Insurance Exchange, which provides malpractice insurance for more than 9,000 Illinois doctors, said the new legislation may moderate the rise of insurance premiums.

A spokesman for St. Paul Fire & Marine, which provides malpractice insurance for 2,800 Illinois doctors, said the new law is a step in the right direction. "It's too early to evaluate the impact the law will have on malpractice insurance rates on a long-term basis, but clearly the law is better than nothing," said Tim Morse, senior marketing officer in St. Paul's medical services division.

A leveling effect

Medical Protective Co., Fort Wayne, Ind., which provides malpractice coverage for approximately 3,000 Illinois physicians, said the new Illinois law should have a leveling effect on the number of claims (lawsuits) filed in Illinois and also have a moderating effect on the cost of claims.

"It's too early to tell, but we're hopeful," said Bob Miller, vice president for consumer affairs at Medical Protective. He said his company writes medical malpractice insurance in about 15 states, mostly in the Midwest, and that Illinois and Michigan lead in lawsuit activity.

The spokesman for Illinois State Medical Inter-Insurance Exchange said the new law does not go far enough because it does not put a cap on pain and suffering awards, which sometimes run into the millions of dollars. The Illinois State Medical Society, which pushed the malpractice reform law, first asked for a $100,000 pain and suffering cap, then a $250,000 cap, and got nothing.

Features of the law considered beneficial to doctors and their insurers include the elimination of punitive damages, the requirement of structured settlements for judgments in excess of $250,000, and limitations on the fees of plaintiff attorneys: 33 percent for the first $150,000, 25 percent on settlements of $150,000 to $1 million, and 20 percent on any payout over $1 million.

From Jan. 1 to Aug. 15 this year, a record 2,979 medical malpractice suits were filed in circuit court in Chicago, which probably makes Cook County, Illinois, one of the most litigious jurisdictions anywhere, said Max Sonderby, editor of the Cook County Jury Verdict Reporter. In anticipation of the new law, 95 suits were filed on Aug. 12, 210 on Aug. 13, and 637 on Aug. 14, according to Mr. Sonderby. At one time, lawyers or their clerks were reportedly lined up four abreast in the court clerk's office at Daley Center in downtown Chicago.

Before the new law went into ef-

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ILLINOIS LAWYERS RUSH TO BEAT NEW MALPRACTICE LAW

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fect, lawyers had nothing to lose by filing non-meritorious malpractice suits, a spokeswoman for the Illinois State Medical Society said. "They merely threw them into the court hopper with little or no research," she said. "The result was that 80 percent of cases were resolved without payment to the plaintiff, but still they involved large sums of money for litigation expenses."

The spokeswoman said pre-trial screening panels for malpractice suits have been tried and tested in many other states, with varying results. "One of the most successful models is the Wisconsin system," she said, "which includes many features of Illinois' new approach. In Wisconsin, only one in 10 cases proceed to trial after the screening panel has reached its decision."

Operational mechanics of the Illinois screening panel system are yet to be determined by the state supreme court. However, under the law, panels will have a time limit of 120 days to convene after two parties are joined in a lawsuit. An additional 180-day extension is available.

9/12-13/85
Attachment XLIV