Approved February 1, 1989
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 a.m./p.m. on January 24, 19 89 in room 531-n of the Capitol.

All members were present except:

Representative Gross, excused

Committee staff present: Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

Bill Wolff, Legislative Research Department
Representative Kerry Patrick
Ron Smith, Kansas Bar Association
Dale Pohl, President, Kansas Bar Association

Others Present: (See Attachment 1.)

The meeting was called to order by the Chairman.

HB 2047--

An Act abolishing the health care stabilization fund and eliminating the requirement that health care providers maintain professional liability insurance; establishing the medical malpractice liability liquidation fund for the purpose of liquidating liabilities of the health care stabilization fund; providing for the administration of such fund; providing for the adoption of a plan designed to amortize such liability; amending K.S.A. 40-3416, 40-3422, and 40-3423 and K.S.A. Supp. 40-3401 and repealing the existing sections.

Bill Wolfe, Legislative Research Department, gave a review of the Interim Committee Report on Proposal No. 12 (Attachment 2) which led to the formulation of HB 2047. He pointed out that the Interim Committee agreed, with near unanimous position of the conferees, that the Health Care Stabilization Fund (HCSF) should be phased out, and recommends that the 1989 Legislature enact legislation to abolish the Fund as of July 1, 1989.

Representative Kerry Patrick testified in support of HB 2047 and provided written testimony (Attachment 3)which explains the Interim Committee Bill recommending the abolishment of the HCSF and the mandate of the requirement to carry medical malpractice insurance.

Ron Smith, Kansas Bar Association introduced Dale Pohl, President of the Kansas Bar Association. Mr. Pohl testified that their experience with mandatory malpractice insurance in Kansas has not worked will. Few other states require such coverage as a condition of practicing medicine and neither should Kansas. Mr. Pohl relayed the boards overwhelming support of the phase out of the fund. (Attachment 4.)

The Committee Secretary distributed written tesimony, provided by the St. Paul Fire and Marine Insurance Company, in support of HB 2047. (See Attachment 5.)

Chairman Sprague thanked the conferees appearing and explained that because of the time, the Committee would have to take up where they left off at the next meeting, January 25, 1989.

The meeting was adjourned at 5:00 p.m.

GUEST LIST

Att.

ATTACHMENT 1

COMMITTEE: ~~Insurance Committee~~

DATE: 1/24/89

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Jeff Rockett	Topeka	St. Francis Wichita
John O. Miller	Topeka	AARP
Larry Magill	"	IIAK
Tom Bell	"	KHA
Douglas Hinkin	Manhattan	self
Bob Clawson	Topeka	SRS
Harold Riehm	Topeka	KAOM
Kerenda Mitchell	Topeka	self
[illegible] E Kelbie	McAfee	Alliance Ins Co's
RG Frey	Topeka	KTLA
[illegible]	Eureka	KDA
Ron Smith	Topeka	Ks Bar Assoc
Tony Potter	Topeka	Rep. Roenbaugh Intern
Chip Wheelen	Topeka	Ks Medical Society
Ted Fay	Topeka	KDI
Pam Scott	Topeka	Ks Ins Dept
Ron Todd	"	" " "
Jim Oliver	Topeka	Prof Ins Agts
[illegible]	"	KTLA
Gary D McCallister	Topeka	KTLA
Kevin Kelly	Overland Park	Sun
Tom Palace	Topeka	SLSI
Paul M. Klotz	Topeka	Assoc of CMHCs Ks, Inc
Sherm Parks, Jr.	Topeka	Ks. Chiropractor Assn
Glenn Cogswell	Topeka	Alliance of Am. Ins.

Attachment 1

GUEST LIST

COMMITTEE: ______________________ DATE: ______________

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
David B. Hanson	Topeka, Ks	Ks Assn Prop & Cas Ins.
Marlin Rein	KC	KU Med Ctr
Gayle Stephens		

COMMITTEE REPORT

TO: Legislative Coordinating Council

FROM: Special Committee on Commercial and Financial Institutions

RE: **Proposal No. 12 -- Abolishing the Health Care Stabilization Fund**

Proposal No. 12 directed the Special Committee on Commercial and Financial Institutions to study the desirability of abolishing the Health Care Stabilization Fund and the implications such an abolition would have on health care and on health care providers who have been covered under the Fund.

Background

In the interim of 1975, the Kansas Legislature for the first time addressed the issues associated with the availability and cost of professional liability insurance for health care providers. In that study, the driving force was the lack of availability of insurance for certain categories of providers. Pressed particularly hard in 1975 were certain medical specialties, e.g., orthopedic surgeons, anesthesiologists, obstetrician/gynecologists. The report of the Special Committee on Medical Malpractice suggested several reasons for the problem: rapid social and technological changes; patient expectations; increased numbers of patients seeing providers because of reimbursement by third party payers, e.g., Medicare, Medicaid, and private insurance; changing of the doctor-patient relationship; judicial decisions resulting in expanded rules of law in cases of medical professional negligence; and consumerism. Compounding the identified contributors to the so-called medical malpractice "crisis," the interim committee report noted, was the polarization of the positions of the interest groups associated with the causative factors. The hardening positions of the various actors in the "crisis" environment made, and continues to make, action in this legislative arena more difficult and contentious than is the case in most subjects.

The 1975 interim committee made numerous recommendations to the 1976 Legislature which were enacted by that body. Primary among those new laws were the creation of a joint under-writing authority (JUA); the creation of a Health Care Stabilization Fund (Fund); and the requirement that all health care providers, as that term was especially defined in the new law, carry a statutorily established minimum amount of professional liability insurance.

The purpose of the JUA was to make professional liability insurance available to any provider who could not purchase such insurance in the private insurance market. Costs associated with the administration of the plan of the JUA were not to be assessed to either the providers or the insurers; rather the operational costs were to be assessed to and paid by the Fund out of moneys collected from the providers and interest income earned on those dollars.

The Fund was created to provide excess coverage over the basic coverage required of all providers. In brief, the providers were required to purchase basic coverage in the amount of not less than $100,000 per occurrence, subject to a $300,000 annual aggregate ($100,000/$300,000), from private insurers or from the JUA, and for the payment

of a surcharge on the premium for the basic coverage to finance "umbrella" coverage over the basic amount from the Fund to an unlimited amount. (Later enactments of the Legislature increased the basic coverage to $200,000/$600,000 and capped the liability of the Fund at $3 million.) The initial surcharge was established in statute at 40 percent, and a $10 million cap was placed on the ultimate amount the Fund could collect. Once the Fund reached the cap, no new surcharges were collected for several years until the Legislature was made aware of the liabilities of the Fund. As demonstrated by hindsight, capping the revenues being paid into the Fund, while continuing an unlimited liability for the Fund to pay in the years 1981-83, created an actuarially unsound payment mechanism. Further, changing from occurrence policies to claims made policies in 1976, both in the private market and in the Fund, left the health care providers with no coverage for past acts or omissions, "tail coverage." Consequently, the Fund was directed to provide that coverage which, in turn, generated additional liabilities for the Fund. Currently, perhaps as much as 15 percent of the surcharge dollars collected go toward funding the tail coverage for inactive providers and other providers who have left the state.

In 1983, the cap on the size of the Fund was removed and new surcharges were imposed to build the size of the Fund so that it could pay increasing numbers of claims and larger awards, and also to make the Fund actuarially sound by funding the approximately $50 million in unfunded liability incurred during the years no surcharge was levied or collected. The unfunded liability was amortized over a ten-year period, July 1, 1984-June 30, 1994. The surcharge in effect at the time of this Committee's study was 125 percent of the basic premium and included charges to cover the current liability of the provider, the provider's portion of the amortized unfunded liability of the Fund, tail coverage for inactive providers, and, as a consequence of the Kansas Supreme Court action striking down portions of the tort reform legislation put into place in 1986, the provider's portion of the $13.856 million of savings anticipated to result from tort reform legislation found unconstitutional by the Court. The latter figure was amortized over a six-year period to avoid a precipitous surcharge increase. In summary, if insurers file and receive reasonable rates and if surcharges levied and collected reflect actual liabilities of the Fund, the Fund itself should be actuarially sound by 1994.

Finally, the mandated insurance requirement imposed by the earlier legislation, was, in part, to insure a sufficient number of providers paying into the Fund to guarantee accumulation of the $10 million level in the shortest amount of time. While a number of the providers required by the act to purchase coverage were not having problems acquiring insurance at reasonable rates, some speculated that their cost would rise in the future just as the cost for persons licensed to practice medicine and surgery had risen and, therefore, willingly joined in the requirement for insurance and agreed to make the required payments into the Fund. Under the law, authorization to practice specific health care professions was made contingent upon the purchase and maintenance of professional liability insurance at the levels established in the law and upon the payment of levied surcharges based upon the basic premium.

(For a review of past legislative actions see: Report on Kansas Legislative Interim Studies to the 1976 Legislature, Part II, January, 1976, by the Special Committee on Medical Malpractice; Report on Kansas Legislative Interim Studies to the 1986 Legislature, December, 1985, pp. 817-873, by the Special Committee on Medical Malpractice; Report on Kansas Legislative Interim Studies to the 1987 Legislature, December, 1986, pp. 565-598, by the Special Committee on Tort Reform and Liability Insurance.)

While the Legislature has amended the Health Care Insurance Availability Act several times over the years, and while the Legislature has broadened its approach to addressing medical malpractice issues through tort reform, the three basic statutory underpinnings of the Legislature's approach to malpractice summarized above were the focus

of the 1988 interim Committee's consideration. In part, legislative attention was called to these issues by the introduction of S.B. 629 and H.B. 2680 in the 1988 Session, each of which called for the abolition of the Health Care Stabilization Fund.

Committee Activity

In the course of its study, the Special Committee on Commercial and Financial Institutions received testimony from representatives of the following: the Kansas Insurance Department; the Health Care Stabilization Fund Study Group created by the Insurance Commissioner; the Kansas Medical Society; the Kansas Hospital Association; the Kansas Association of Osteopathic Medicine; the Kansas Chiropractic Association; the Kansas Bar Association; the Kansas Trial Lawyers Association; the St. Paul Companies; the Kansas Health Care Provider Insurance Availability Plan; and the Independent Insurance Agents of Kansas. The Medical Protective Company was invited to present testimony, first by a personal contact and later in writing, but no remarks were received.

The Health Care Stabilization Fund Study Group was organized by the Insurance Commissioner in response to the two bills introduced in the 1988 Session. The charge given by the Commissioner to the Group was to identify mechanical or procedural problems that might result from the termination of the Fund, not to determine whether the Fund should be abolished. The Group was composed of representatives of the Insurance Department, providers, the insurance industry, insurance agents, and the Fund. In its report to the Committee, the Group highlighted the following considerations: the Fund should not be abolished until all past and present obligations of the Fund are fully financed; mandatory insurance and participation in the Fund should be continued until all financial obligations of the Fund are met; and legislation abolishing the Fund should address the insurance needs of the University of Kansas Medical Center and its residency training programs.

While the Group was nonjudgmental in its presentation, the Insurance Department seemed equivocal in its position. Its representatives spoke of abiding by the wishes of the health care providers if they want abolish the Fund. On the other hand, information provided from an "in-house" report on the question of abolishing the Fund given to the Committee as part of the Department's testimony, seemed to raise difficult, if not unanswerable, questions about the possibility and practicality of ever abolishing the Fund. Nevertheless, the listed advantages and disadvantages of several courses of action were helpful in distilling the policy issues and identifying potential problem areas if the Fund should be abolished. Particularly, the Department representatives described the present malpractice problem as one of affordability rather than availability, but cautioned that in addressing the affordability issue by abolishing the Fund may cause severe insurance availability problems. Further, representatives of the Department and of the Independent Insurance Agents of Kansas speculated that the mandated availability of basic and umbrella professional liability coverage, the so-called "deep pocket" theory, may have come into play in the medical malpractice arena and that some legislative action to reduce the maximum liability of the Fund and to allow individual providers optional levels of coverage might mitigate against any impact the "deep pocket" perception may have in reality. Regardless of the Legislature's action, the Department was pessimistic that any change in the insurance mechanism would alter the underlying cause of medical malpractice insurance problem in Kansas, high losses. Until those losses are controlled through the judicial system, representatives of the Department said there is no chance for the medical malpractice insurance problem to be resolved.

In concert, the health care providers asked the Committee to recommend abolition of the Fund and supported the recommendations of the Group, i.e., all liabilities

of the Fund be financed in advance of its termination date. In that regard, July 1, 1994, was a date often cited as the most feasible time for ending the Fund. In the interim, the provider representatives recommended that the maximum liability of the Fund be reduced, for example, to $1 million per claim, and that providers be allowed to purchase optional levels of coverage in recognition that not all providers have the same level of exposure to malpractice claims. There was unanimity among the providers that, upon the abolition of the Fund, the mandatory insurance requirement should be terminated. Many providers reminded the Committee that no other professional group was required by state law to carry such insurance as a condition to the privilege of practicing its profession. Finally, providers reflected the skepticism of the Insurance Department in their belief that implementation of the proposed changes would solve the root cause of the malpractice insurance problem. A part of any solution, some argued, must be tort reform.

The legal profession, too, was in agreement that the Fund should be systematically phased out of operation. However, in contrast to the position of the Kansas Bar Association, the representative of the Kansas Trial Lawyers Association (KTLA) made it clear that its position is that the mandatory insurance requirement should be retained. The KTLA expressed the hope that, upon termination of the Fund, private carriers would be encouraged to enter the Kansas market. On this point the insurance agents indicated that, with the Fund in place, some companies would not come into Kansas for fear of having to contribute toward payment of existing Fund deficits.

The representative of the St. Paul Companies noted that about 1,000 Kansas providers are insured with St. Paul and that the experience of the company with Kansas providers has been unfavorable to the insurer. The Committee learned that claims experience between 1980 and mid-1987 has doubled from eight claims per 100 doctors to 16 claims per 100 doctors and that the average claim more than doubled during the same period, from $21,500 to $45,700. Notwithstanding that record, assurances were given that the St. Paul would continue its commitment to providing coverage in Kansas. That commitment was not based upon the Fund or upon the continuation of the Fund; rather, the St. Paul Companies' willingness to continue in Kansas rests on obtaining adequate rates on a timely basis. Currently, a moratorium on new business is in effect in Kansas and the removal of the Fund by itself would not trigger the lifting of that moratorium since it is in place, in part, because of the company's perception that the Kansas regulatory environment is one of the strictest environments in which it does business.

While the moratorium prevents additional Kansas providers from being insured by the St. Paul Companies, the Committee was given assurances that, if the Fund were abolished, current insureds of the company would be offered excess coverage; however, excess coverage would not be written over another company's basic coverage. The Medical Protective Company, while not participating in this study, had given notice in another forum that it would not write excess coverage, even for its own insureds if the Fund were abolished.

The segment of the insurance industry represented before the Committee pointed out that there would be certain ramifications from any phase out of the Fund. Most significant is the fact that the existing JUA expenses are covered annually by transfers from the Fund. Removing the Fund removes the financial support of the JUA which, if it is to continue, must be provided a different mechanism for covering losses and administrative expenses. In that regard, the St. Paul Companies would not oppose a JUA if it were self-supporting through a surcharge or assessment mechanism against policyholders and if there were a broad insurer assessment base for any additional deficit. The Independent Insurance Agents of Kansas, too, saw the probable necessity of continuing the JUA, but offered its support contingent upon the JUA being funded by an assessment on medical malpractice insurance companies only.

From the outset of the study, the Committee was aware that the Insurance Commissioner had contracted for the services of an actuary to determine the liability of the Fund should the Legislature decide to terminate it as proposed in the 1988 legislation and by several of the interim conferees. After hearing the testimony of the conferees, including the comments of Representative Kerry Patrick suggesting the "privatization" of the Fund, the Committee requested the Commissioner to contact the actuary regarding two early motions it had adopted, hoping that sufficient time remained for the actuary to project the liability of the Fund based on the Committee's motions. Briefly, the Committee requested the actuary to project liability should the Fund be phased out on July 1, 1994, or on July 1, 1990. The Committee requested that these projections be made based upon a 1 percent additional interest factor and upon a declining liability for the Fund from $3 million to zero over the period 1989-1994.

In late November, the Committee learned that the actuary could not make some of the projections that the Committee requested, but would furnish data for termination of the Fund as of on July 1, 1989 and July 1, 1994. Additionally, interest income and other variables were already factored into the models being used. On December 14, 1988, the Committee received the preliminary report of the actuary, DANI Associates Inc.

The following table displays the actuarial projections by option:

Estimated Costs of Funding Options
If the Health Care Stabilization Fund is Discontinued*

Funding Option One

Repeal Health Care Provider Insurance Availability Act and terminate all existing Fund responsibility for inactive health care provider tail coverage.

Discontinue As of	Estimated Fund Liabilities		Estimated Fund Balance
	Undiscounted	Discounted at 7.5%	
7-1-89	$ 131,361,000	$ 100,693,000	$ 65,466,000
7-1-94	$ 501,490,000	$ 381,838,000	$ 391,057,000

Funding Option Two

Fund closed out based on its current claims-made excess coverage and inactive tail coverage requirements.

Discontinue As of	Estimated Fund Liabilities		Estimated Fund Balance
	Undiscounted	Discounted at 7.5%	
7-1-89	$ 158,275,000	$ 118,826,000	$ 87,455,000
7-1-94	$ 610,003,000	$ 454,298,000	$ 454,298,000

Funding Option Three

Revise the Health Care Provider Insurance Availability Act to provide tail coverage for all health care providers. (The following amounts must be added to the liabilities in Funding Option Two.)

Discontinue As of	Estimated Fund Liabilities	
	Undiscounted	Discounted at 7.5%
7-1-89	$ 159,184,000	$ 109,201,000
7-1-94	$ 714,340,000	$ 490,037,000

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* Source: Data were taken from compilations completed by the Department of Insurance based upon projections made by DANI Associates Inc. The final report of the actuary will be available to the standing committees during the 1989 Session.

If the Fund were terminated under option one on July 1, 1989, including all responsibility for inactive health care provider tail coverage, there would be a shortfall in the Fund's resources versus its discounted liabilities of approximately $35.2 million. If the Fund were abolished on the same basis on July 1, 1994, the estimated balance in the Fund would cover the incurred liabilities of $381,838,000. No surcharge estimates were given to the Committee to explain how that balance would be built.

If the Fund were terminated under option two on July 1, 1989, based on its current claims-made excess coverage and inactive tail coverage requirements, there would be a shortfall in the Fund's resources versus its discounted liabilities of approximately $31.4 million. If the Fund were abolished on the same basis on July 1, 1994, there would be sufficient balances in the Fund to cover all liabilities of $454,298,000. It must be noted that the balance of $454,298,000 would be achieved by the imposition of surcharges estimated to be 130 percent, 135 percent, 140 percent, 160 percent, and 190 percent against $200,000/$600,000 basic limit premiums for the fiscal years 1989-90, 1990-91, 1991-92, 1992-93, and 1993-94, respectively.

If the Fund were terminated under option three on July 1, 1989, but tail coverage continued for all health care providers, the total liability of the Fund would be $228,027,000. The balance in the Fund would be $87,455,000, for a shortfall of approximately $140.6 million. If the Fund were abolished on the same basis on July 1, 1994, the liabilities of the Fund would be $944,335,000. The balance in the Fund would be $454,298,000, for a shortfall of approximately $490 million.

The actuary's report was the first time such projections had been made for as many years into the future. In the past, the reports have covered one or two years and the data generated were used to establish the next year's surcharge on providers. The sizes of the estimated liabilities of the Fund and the estimated balances of the Fund, and the ultimate shortfall in those balances projected in the report, were startling to the Committee. Explanations of the data by the actuary supported the notion that, in the future, numbers of claims and sizes of awards and settlements and the number and amount of payments from the Fund will continue to grow.

Conclusions and Recommendations

The Committee agreed with the near unanimous position of the conferees that the Health Care Stabilization Fund should be phased out and recommends that the 1989 Legislature enact legislation to abolish the Fund. The bill being recommended by the Committee would terminate the Fund on July 1, 1989. On that date no health care provider would have excess liability coverage nor would any provider have coverage for prior acts -- tail coverage, for acts or omissions committed after that date. Further, the Committee recommends that on July 1, 1989, the mandatory professional liability insurance requirement be abolished. Accordingly, all providers would be free to choose to be insured or not and, if insurance was purchased, the amount of coverage would be left to the individual providers.

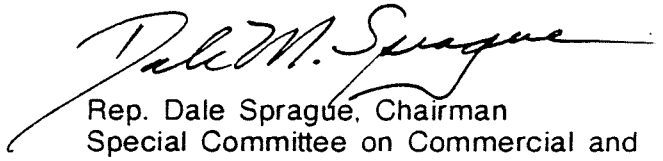
Finally, under the Committee's recommendation, all health care providers paying into the Fund on July 1, 1989, and all inactive health care providers, would continue to have tail coverage upon termination of the Fund for acts or omissions committed prior to that date. However, to insure that the outstanding liabilities of the Fund are met, liabilities estimated to be nearly $150 million, the legislation drafted by the Committee would require that the providers develop a plan by January 1, 1990, for paying the unfunded liabilities of the Fund and submit that plan to the Insurance Commissioner for his approval. If no plan is submitted, the Commissioner would have until March 1, 1990, to implement a plan for

the payment of the Fund's debts. To ensure that providers participate in paying off the debt, participation in a repayment plan would be a prerequisite to relicensure to practice in this state. In the interim period July 1, 1989 to January 1, 1990 (or March 1, 1990), providers would be required to continue to pay surcharges into a debt payment fund pending implementation of a final debt removal mechanism.

Presumably, each Kansas health care provider seeking insurance would be able to purchase that insurance at lower premiums after termination of the Fund and the implementation of the other recommendations because of lower levels of coverage and no prior experiences being included in the new rate. However, the recommendations of the Committee do not address the questions of whether the proposed changes would enhance the availability of insurance in the private market or exacerbate the availability problem, or would drive current private insurers from the market or attract new insurers into the Kansas market. Nor do the proposals address the particular circumstance of the Kansas University Medical Center and its training programs. Further, the question of whether the state should remain involved in the professional liability insurance business, through operation of a JUA to make insurance available to those providers who want to be insured but cannot purchase coverage in the private market, remains unresolved.

Abolishing the Health Care Stabilization Fund is a complex task. The Committee is certain that many ramifications of terminating the Fund remain undiscovered. Therefore, the Committee commends to the appropriate standing committees its report and recommendations as points of departure for further discussion and action.

Respectfully submitted,



January 6, 1989

Rep. Dale Sprague, Chairman
Special Committee on Commercial and Financial Institutions

Sen. Neil Arasmith, Vice-Chairman
Sen. Eugene Anderson
Sen. Roy Ehrlich
Sen. Phil Martin
Sen. John Strick*
Sen. Merrill Werts

Rep. Kenneth Francisco
Rep. Clyde Graeber
Rep. Richard Harper
Rep. J. C. Long
Rep. Kerry Patrick
Rep. L. V. Roper
Rep. Don Sallee
Rep. Tim Shallenburger
Rep. Larry Turnquist
Rep. Bill Wisdom

* Ranking Minority Member

88-314/WGW

KERRY PATRICK
REPRESENTATIVE, TWENTY-EIGHTH DISTRICT
JOHNSON COUNTY
10009 HOWE DRIVE
LEAWOOD, KANSAS 66206

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ENERGY AND NATURAL RESOURCES
LABOR AND INDUSTRY
LOCAL GOVERNMENT

To: House Insurance Committee
From: Kerry Patrick
Date: January 24, 1989

Re: HB 2047-Interim Committee Bill Recommending the Abolition of the HCSF and the mandate of the requirement to carry Medical Malpractice Insurance.

I. Introduction

I believe that this bill and its passage will be one of the five most significant pieces of Legislation that this body will consider this year. If not passed in substantially the form that is in now we are dooming Kansan°s to be provided less than the best health care in the year°s to come.

II. Abolishing the mandate of carrying Medical Malpractice insurance. WHY??

1. Decreasing the depth of the "deep pocket" and increased litigation -because the: "deep pockets" aspect that the mandate of both primary insurance and forced membership into the Health Care Stabilization Fund (HCSF), the state insurance monopoly, has simply created an ever increasing pool of money from which to pay out judgments and settlements.

2. No other group of businessman in society today is required to have the levels and kind of insurance which we mandate on health care providers today. Why? Because of the cost involved in such a mandate would clearly drive up inflation, make American produced goods even more noncompetitive in world markets and divert precious capital resources to a nonproductive use. Same argument holds true for Health Care Providers.

III. Why abolish the Health Care Stabilization Fund (HCSF) ?

1. NO ONE CAN AFFORD IT, BE IT THE HEALTH CARE PROVIDER OR THE CONSUMER/PATIENT. If the fund continues in existence the actuary projects that the surcharge will have to be raised to: 130%, 135%, 145%, 165% and 195% over the next five years so as to amortize the deficit of HCSF.

2. We're the only state in the nation to have this type of fund. It simply hasn't worked, we don't know something that all of the other states don't know.

3. The fund has simply not been run like an insurance company and this is why, according to the actuary, it is in the mess that it is in today.

I. The Actuary stated to the Interim Committee that the HCSF had been run not like an insurance business but had been run as a social welfare program like Social Security.

Prices charged to Health Care Providers to provide the insurance were initially not equated with the cost to provide it. The Fund operated on a modified "pay as you go" basis with no attempt made to assess premiums on the basis of the cost of providing the insurance product. Some examples,of it being run as a social welfare program and not as the business are:

a. For a three year period, once that $10 million in premiums had been collected, no additional premium dollars were collected so the HCSF provided free excess malpractice insurance coverage to every Health Care Provider in the state with unlimited coverage.

b. From July 12, 1976 to June 30, 1984, it provided unlimited coverage with no ceiling on amounts that could be paid out by the actions of any one Health Care Provider.

c. Until the last three years, no ongoing actuarial study had even been made of the fund and any projection on a multiyear basis as to what the accrued liabilities of the HCSF were going to be.

d. All money collected in premiums from Health Care Providers was invested by the Pooled Money Investment Board at the current 91 day T-Bill rates. This has cost the Health Care Providers millions of dollars in investment income for as the Representative of St .Paul's testified, no insurance company would invest their premium income in this manner for as safe investment vehicles exist that would generate higher rates of return. 1% increase in investment rate of return over 12 years would have made about a $5 million reduction in size of the deficit (about 15% decrease in the size of it).

e. Now provide free "tail" coverage to Health Care Providers who quit practicing for any reason yet the cost of providing it has yet to be reflected in surcharge premiums.

II. The Actuary stated to the Interim Committee that if we were sitting as the board of directors of a regular insurance company that it would be his recommendation that

we declare bankruptcy. The situation is financially unsolvable. It is time to take our "losses" and get the state out of the insurance business.

Today the fund is "legally" bankrupt in the sense that if the regular laws governing insurance companies in this State were applied to this state run insurance business, Commissioner Bell would have no option under the law but to declare it insolvent and not allow it to write anymore medical malpractice insurance.

a. Size of the deficit in the HCSF if the fund is abolished as of July 1, 1989 will be $35.2 million; if we keep it in business until July 1, 1994 the actuary projects the deficit to be over $381 million. (See page 7 of Legislative interim report)

1. In five years the size of the deficit will have grown over 1100 %. Think about, that if we wait and do nothing each year the size of the deficit grows at an annual compounded rate of over 230%.

2. If the HCSF is terminated and we provide or make available tail coverage to the Health Care Providers, the size of the deficit will be $140.6 million on July 1, 1989.

b. Actuary said his recommendations as to the what the percentage of the surcharge should be for this year was not followed by the Insurance Commissioner. To me this raises some serious questions of, unless forced to, will Commissioner Bell make the kind of tough business decisions needed to make the fund solvent if left to his own devices.

1. Ist option is given to the Health Care Providers in coming up with a plan to amortize the deficit, which is only fair since they are on the hook for it.

2. The Bill is specifically vague as to how the deficit in the fund is to be amortized. Any length of time can be utilized and any type of investment scheme can be utilized to finance the deficit.

a. Example, to finance deficit before the Commissioner through the sale of insurance to Health Care Providers as the means of securing payment through sale of some form of single premium annuities.

b. Lack of specificity was done on purpose to give the Commissioner and the Health Care Providers the widest possible latitude in coming up with the most viable proposal to finance the deficit. I don°t believe that any of us here would know how to develop such a plan so we gave carte blanche to the experts with deadlines imposed to come up with a viable plan.

III. The Health Care Providers are liable for the deficit not the State.

A. 1. The Kansas Medical Society and the State Insurance Commissioner°s office both testified this summer that the Health Care Providers alone are financially responsible for this deficit.

2. The Kansas Supreme Court in the case upholding the constitutionality of this law in the case of Schneider v. Liggett, 223 Kan 610 stated the very same thing.

B. If we do not abolish the fund and make it to be effective this year and make the bill retroactive as to the cost of "tail" coverage as set forth in line 156-165 of the bill, we will run a significant number of physicians out of the state. WHY?

1. Current law provides that if a physician leaves the state for whatever reason that the HCSF will provide free of charge "tail" insurance to them.

a. So if a doctor wants to leave Kansas and practice in another state just because he/she believes they can make more money the fund will be making them a gift of $25,000 to $45,000 depending upon their speciality, of free tail insurance.

b. If we don°t abolish the fund and the knowldege becomes widespread through the medical community that the size of the fund°s deficit will grow to over $381 million by 1994, they will leave. Who wouldn°t??

And this is because the size of the deficit on a per doctor basis will be around $700,000 per physician in 1994. That°s right each doctor will have a contingent liability of over $700,000 on his/her practice. What physician would hang around if he/she could get out free now and not be liable for any part of this deficit.

2. Another point to make if you look at the law and look at the Court°s ruling on the law, a very good legal argument could be made that if you have moved and accepted the free tail coverage that the state doesn°t have the right to force you to make up any of the future deficit even if you contribute to part of it. All the present system does is penalize the physicians who want to stay in Kansas.

IV. Current system causes rural health care providers to subsidize urban ob-gyn health care providers and this is simply not right or fair.

Attachment 4

A SECOND CENTURY OF SERVICE
1882
KANSAS BAR ASSOCIATION

HB 2047
House Insurance Committee
January 24, 1989

Mr. Chairman, and members of the House Insurance Committee. I am Dale Pohl, President of the Kansas Bar Association.

Last year, the KBA did not have a position on 1988 HB 3112. That bill provided for the phase out of the Health Care Stabilization Fund over a five year period. During that phase out, malpractice insurance was still required but practitioners could choose between one of three lower levels of coverage. Current law requires $3 million be carried by every health care provider in the state, an amount exceeding all other states.

The Medical Society told the Senate Ways and Means committee last spring HB 3112's alternative lower levels of coverage would have significant impact on the surcharge charged physicians when their insurance was to be renewed. HB 3112 did not pass, but only because the Senate insisted on placing other issues in the bill. We hope you'll avoid those problems this year and deal solely with mandatory insurance and the Fund.

After reviewing the costs of a phase out, the interim committee recommended HB 2047, an immediate repeal of HCSF authority. KBA does not offer special expertise in whether an immediate repeal is more desirable than a phase out. What we would oppose is the status quo.

Our interest in the issue was initiated in a meeting with the Governor on August 22, 1988. At that time the Governor was considering support for phasing out the Fund and its mandatory insurance requirements along with other options. KBA's Board of Governors met and reviewed the issue, and on August 30th I wrote the Governor the following:

> "First you asked if we recognized that a health care problem existed as a result of escalating medical malpractice premiums, particularly in the rural areas. . . . I concurred that we are facing such a problem, and I might add it is a serious one. . . .

1200 Harrison • P.O. Box 1037 • Topeka, Kansas 66601 • (913) 234-5696

Attachment 4

"Second, you questioned the position of the KBA concerning the elimination of the Health Care Stabilization Fund as a possible solution to the problem. Third, you asked what our position would be with regard to removal of statutorily required medical malpractice insurance. After lengthy consideration our board voted overwhelmingly to support a systematic phase out of these two laws. Basically it was the feeling of the Board that significant changes have occurred since the passage of this 1976 legislation to support their repeal."

Our reasons for supporting the phase out are as follows:

1) Removing mandatory insurance requirements is the quickest way to affect medical malpractice premiums. For some there will be increased costs, others will have significant decreases in cost.

2) Many claims are narrow calls on liability. If tried, the jury could go either way. If liability is found to exist, damages are usually considerable. Having a mandatory $3 million insurance policy paid by every doctor in the state makes these difficult borderline claims more attractive to work up, thus increasing the total number of claims overall. Because medical malpractice is expensive litigation for the plaintiff, smaller claims are rarely if ever pursued. A lawyer is simply not going to finance $50,000 in trial expenses if there is only a $100,000 policy at stake. If there is a $3 million policy, the incentives are different. That may in part be why the frequency and severity of claims against health care providers is up since 1976. Conversely, reducing or eliminating required coverages may help control the number of new claims filed. Either way, we know that mandated insurance coverage has cost practitioners far too much. The status quo is unacceptable if we truly want to help practitioners with their premiums.

3) By definition, mandatory insurance means those insureds with good claims experience artificially support those with poor claims experience. This means higher than ordinary premiums for those with good claims experience, and favorable premiums for those who, in the commercial market, would be unable to get coverage at any price. Mandatory insurance provides incentives for the wrong people, and penalizes the doctors providing good medical care.

4) Some will argue hospitals will still require insurance as a condition of privileges. Prior to 1976, many hospitals required physicians to carry certain levels of insurance. If that occurs after phase out of the fund, so be it. Such decisions should be made between medical professionals and medical institutions without interference by state government. If the state wants to create a fund where physicians can acquire insurance that is unavailable in the commercial market, that is fine, but purchasing that insurance should not be a condition of licensure. (Such authority seems repetitious of the 1988 legisla-

tion empowering the Medical and Hospital Associations to create a captive insurance company for that purpose.)

5) Removing the Fund's monopoly on excess insurance allows other insurers to get into the market. St. Paul indicated last spring to this legislature they would write excess insurance for their insureds. The Medical Society is forming its captive with an eye towards writing excess insurance at some time in the future. There are other cooperative alternatives for securing adequate malpractice coverage. The attached article from the January 18, 1989 Wichita Eagle-Beacon is just one example.

KBA's primary concern is that if a phase out occurs, there be adequate funding of claims currently in the pipeline and which accrue during the phase out period. If that is adequately addressed, then the legislature will have dealt well with this important issue.

Our experience with mandatory malpractice insurance in Kansas has not worked well. Few other states require such coverage as a condition of practicing medicine. Neither should Kansas.

THE WICHITA EAGLE-BEACON Wednesday, January 18, 1989

Hospitals negotiating for doctors' insurance

By Debra Beachy
Staff Writer

Two Wichita hospitals, trying a new approach to stem the rising cost of medical malpractice insurance, are negotiating with insurance companies to offer coverage to doctors who have admitting privileges.

"We're excited about it. We think it might be something of a breakthrough for the medical staff's malpractice premium burden," said Martyn Howgill, senior vice president of marketing and strategic planning for HCA Wesley Medical Center.

Wesley and St. Francis Regional Medical Center both are negotiating contracts, according to hospital executives.

Doctors at Wesley have been told that they could pay between 10 percent and 40 percent less under such a group plan with the New York-based Continental Insurance Co. than they pay individually.

The negotiations, which would apply to as many as 600 doctors who admit patients to Wesley, should be completed by February, according to Howgill.

St. Francis also is negotiating with a large insurance company to cover doctors who admit patients, spokesman Larry Baker said. Baker gave no details, saying in a prepared statement, "It is conceivable that an announcement will be made in the near future."

Other Kansas hospitals subsidize their admitting doctors' malpractice costs, especially in rural areas. But Wesley is the first hospital in the state to negotiate insurance coverage for its admitting doctors, according to the Kansas Hospital Association.

J.G. Kendrick, Wesley senior vice president for medical and professional development, said the malpractice coverage would be tied to Wesley's quality assurance program under which doctors' performance is monitored by the hospital.

Doctors said they welcomed attempts by Wesley and other hospitals to help ease the costs of malpractice insurance.

"Anything that will help the situation will be greatly appreciated," said Paul Stein, a neurosurgeon. "Malpractice for neurosurgeons in Kansas is reaching crisis proportions. Last year, I paid $37,000 for malpractice insurance. This year, I paid $94,000. I've never had to defend a lawsuit in court. ... If it goes on at a geometric rate, there will come a point where I'll go somewhere else."

Doug Horbelt, a gynecologist, said the Wesley plan could have a "tremendously positive effect" on malpractice insurance costs by attracting more insurance companies to the Kansas insurance market.

But general surgeon Paul Harrison said that while the hospitals' new approach "may give some physicians a short-term break," only legislation will solve the problem of rising malpractice costs.

Attachment 5

Issue: Phasing out the Health Care Stabilization Fund.

KBA Position: *KBA SUPPORTS phasing out the Health Care Stabilization Fund which provides excess insurance to Kansas health care providers.*

Rationale: The Health Care Stabilization Fund was created in 1976 to provide excess medical malpractice insurance to Kansas health care providers. This was due to a lack of excess insurance availability in the commercial market.

All health care providers must have malpractice insurance to practice medicine in Kansas. But all insurance above $200,000 is purchased from the HCSF. Commercial companies which have expressed interest in writing excess coverage cannot do so because of the Fund's statutory monopoly. The Fund does not "experience rate" physicians nor do the commercial companies, yet physicians publicly denounce the system in which they pay ever higher premiums when they've had no claims against them. For several years due to restrictive legislation the Fund was unable to charge enough premium surcharge to pay for rapidly building claims and losses.

Health care providers use the Fund insurance surcharges to help socialize the cost of providing tail insurance to practitioners retiring or leaving Kansas. But to do so they provide a financial incentive to leave Kansas before retirement. In short, as Chief Justice David Prager wrote, "[T]he presence of the Fund has done little to stabilize claims or the severity of claims. Both continue upward since 1976." Our public experiment with a state solution to gaps in medical malpractice coverage has not worked.

There are other private market alternatives today that did not exist for health care providers in 1976. Captive insurance companies specializing in malpractice insurance are in formation. The existing commercial market is a narrrow group of insurers, but those remaining are strong and solvent. Federal Risk Retention groups have formed, and more sophisticated methods of risk management, including self-insurance, now are available for large group practices. Some Kansas hospitals are now owned by for-profit hospital "chains," many of whom are Fortune 1000 companies. There are other alternatives to the provision of medical malpractice insurance than government involvement in the insurance industry.

Issue: Removing the Requirement for Mandatory Medical Malpractice Insurance.

KBA Position: *KBA SUPPORTS phasing out the requirement that physicians carry malpractice insurance as a condition of licensure.*

Rationale: Mandatory insurance was a requirement of the 1976 legislature in order to insure participation in the Health Care Stabilization Fund. Only through mandatory insurance, its proponent argued, was the base broad enough to provide enough premium income for the Fund to pay the larger verdicts.

Few states require health care providers to carry malpractice insurance as a condition of practicing medicine. Kansas compounds this problem by not only requiring insurance, but requiring health care providers to carry higher medical malpractice insurance coverages than any other state. Costs artificially inflate in an already-volatile area of insurance.

No other profession is required to carry malpractice insurance as a condition of licensure. By requiring professionals to help insure their profession's hitherto uninsurable risks, the costs for everyone artificially increases, and ordinary market forces on litigation costs and expectations are subverted. Returning the medical profession to a voluntary system of insurance obtained either from the commercial marketplace or other risk-spreading devices is the better and preferred alternative.

Attachment 7

St. [illegible] Fire and Marine Insura[illegible]e Company
385 [illegible]ashington Street, St. Paul, [illegible]nesota 55102
Telephone (612) 221 7911

The St Paul
Property & Liability Insurance

By Federal Express

January 23, 1989

Representative Dale Sprague
Speaker Pro Tem
State Capitol
Room 330 N.
Topeka, KS 66612

Dear Representative Sprague:

Last week I was notified of the opportunity to testify on House Bill 2047. Unfortunately due to scheduling conflicts, I am unable to be present. I have enclosed my testimony before the Interim Committee which reflects The St. Paul's position. Please incorporate the statement in your committee's record.

Sincerely,

Kimberly A. Yelkin
Senior Government Affairs Manager

KAY/bp

Encl.

ABOLISHMENT OF HEALTH CARE STABLIZATION FUND

SUMMARY OF TESTIMONY

SEPTEMBER 14, 1988
BEFORE THE
INTERIM SPECIAL COMMITTEE ON COMMERCIAL AND FINANCIAL INSTITUTIONS

St. Paul Fire and Marine Insurance Co.
Kimberly A. Yelkin
Senior Government Affairs Manager

Good Afternoon. My name is Kim Yelkin and I am Senior Government Affairs Manager at The St. Paul Companies. The St. Paul has been part of the Kansas medical liability marketplace since 1960. We currently insure approximately 1000 physicians and surgeons in the state or 24% of the market.

As you know, the state of Kansas established the Health Care Stabilization Fund in 1976. Within this structure, The St. Paul provides policy limits of $200,000 for each injury reported by a policyholder and $600,000 for the policy period. This means that the St. Paul pays the first $200,000 of a claim and the Fund provides additional coverage for claims that exceed $200,000.

The St. Paul participated in the Study Group formed by the Commissioner of Insurance to consider the mechanical aspects of the deactivation of the Fund. We concur with the conclusions reached by the study group.

The question I expect that you have is: "Will The St. Paul lift their moratorium on new business if the Fund is deactivated?

At this time, we have lifted the moratorium in 26 states on a limited basis for physicians and surgeons liability insurance. To illustrate, all new business will be written on a deductible basis for groups of four or more practitioners. The factors which we considered for re-opening in a given jurisdiction were as

follows: 1) adequate rates; 2)favorable regulatory and legislative climate; 3) favorable historical experience, and 4) our internal ability to service the business. We have no current plans to lift the moratorium in Kansas.

In our opinion, Kansas is one of the strictest regulatory environments in which we operate. During the 1987 Kansas legislative session, I testified in opposition to the Insurance Reform Act of 1988. At that time, I said that the enactment of the Insurance Reform Act of 1988 would not address any market availability or affordability problems in Kansas and would, in fact, further hinder the ability of insurers to operate in a competitive environment responding promptly to changing market conditions. No change in the rating law can alter the basic economic facts--loss costs drive the price of insurance.

Our historical claims experience in Kansas has been unfavorable. The claim frequency doubled between 1980 and mid-1987 from eight claims per 100 doctors to 16 claims per 100 doctors. Likewise, severity of the average claim increased more than two-fold during the same period from $21,500 to 45,700

More specifically, from our perspective, the existence or non-existence of the Fund is not the issue. We will continue our long-standing commitment to the State of Kansas with or without the Fund's existence as long as we obtain adequate rates on a timely basis.

The real key to the deactivation or phase-out of the Fund is availability of coverage. Who will provide the excess coverage the Fund now provides?

Our position has been the same for years. We are unwilling to provide excess coverage over another company's primary limits. The rationale underlying this position is that we would lose all control of claims handling and we feel it is essential, for our insureds and our shareholders, to maintain control of defense of claims. We will however write excess coverage over our own primary layer assuming we obtain adequate rates and can select a current retroactive date.

As part of the deactivation of the Fund, the medical malpractice joint underwriting association or the Plan, will also be deactivated. The question arises whether legislation is necessary to replace this residual market mechanism currently in place.

A joint underwriting association is a mechanism to provide medical malpractice coverage to health care providers unable to obtain coverage in the private market. Most medical malpractice joint underwriting association laws provide that if the association experiences a deficit from losses arising in a fiscal year, each policyholder for that fiscal year shall pay to the JUA a premium contingency assessment of some specified

percentage of their annual premium paid to the JUA. Should there be any remaining deficit after maximum collection of the premium contingency assessment or surcharge, most laws require that such deficit be recovered from member insurers participating the the association. Member insurers are defined as those companies writing property/casualty insurance in the state. This provides the broadest possible assessment base.

The St. Paul does not oppose the formation of a medical malpractice joint underwriting association to respond to an availability problem as long as 1) it is self-supporting by the policyholders through a surcharge or assessment mechanism; and 2) there is the broadest possible insurer assessment base for any additional deficit.

I appreciate the opportunity to testify before you today. If you have any questions, I would be happy to respond.

MEDICAL MALPRACTICE

KIMBERLY A. YELKIN
SENIOR GOVERNMENT AFFAIRS MANAGER
ST. PAUL FIRE AND MARINE INSURANCE COMPANY
SEPTEMBER 14, 1988

INTRODUCTION

Over the past several years, the medical liability marketplace has been in a state of turmoil. Some writers of medical liability insurance withdrew entirely from certain classes of medical liability coverage, while others did not seek to write new business. Legislators and regulators responded by closely examining the causes of the medical malpractice crisis, reviewing the business practices of medical liability insurers, and searching for solutions to medical liability problems.

Recently, however, there have been signs of improvement in the medical liability insurance market. A decrease in the frequency of claims reported, along with indications that rates may be approaching adequate levels, led The St. Paul Companies to seek the lowest average countrywide rate increases for medical liability coverage for physicians and surgeons in five years. Whether this improvement in claims trends will continue remains to be seen.

Because The St. Paul Companies (The St. Paul) is the largest national provider of medical liability insurance, many of the statistics cited below refer to The St. Paul's experience in the medical liability line of insurance.

HISTORICAL PERSPECTIVE

THE AVAILABILITY CRISIS OF 1975:

Prior to the mid-1960s, medical liability insurance was a relatively stable line of insurance, but, by the early 1970s, it became apparent that this stability was vanishing. The frequency and severity of reported claims began to escalate sharply, a product of society's increased expectations of the medical profession, economic and social inflation, and changes in legal doctrines. Malpractice insurers, at that time primarily

multi-line commercial companies, responded by dramatically increasing insurance rates.

As the number and cost of medical malpractice claims began to skyrocket, fewer commercial insurance carriers were willing to risk their capital by writing medical liability insurance, and an exodus of commercial carriers from the medical liability insurance market resulted. This constriction of the marketplace ultimately led to an availability crisis and many health care providers were unable to purchase professional liability insurance at any price.

The crisis led to the creation of new organizations to fill the void left by the departing commercial carriers. Physicians and hospital associations formed their own non-profit medical liability companies to solve the availability crisis. These companies, generally fashioned as mutual insurance companies, were established primarily as single-line companies delivering medical liability insurance directly to the insured and limiting their writings in a given state.

In addition, joint underwriting associations (JUAs) were legislatively established to make medical liability insurance available to the health care community. Seventeen states legislated JUAs during the mid-1970s, designed as temporary measures, until the market stabilized.

These two phenomena, formation of JUAs and society- or association-owned or sponsored companies, ultimately relieved the insurance availability crisis of the mid-1970s.

DEVELOPMENT OF THE CLAIMS-MADE FORM:

The 1970s also brought recognition of the "long-tail" effect of medical liability insurance and the need to develop an insurance product to the reduce the effect of the "long-tail."

In medical liability insurance, a time lag exists between the occurrence of an incident and the date a claim is reported and its settlement. These time lags, the "long-tail" of medical liability, determine how much money to set aside to pay for claims yet to be reported and make it difficult to accurately set insurance rates.

Until the mid-1970s, insurers sold medical liability insurance on the "occurrence" policy form. These policies cover all claims resulting from services performed while the policy is in force regardless of when claims are reported. For example, if a doctor left a sponge in a patient in 1980 and it was discovered in 1990, an occurrence policy would cover the claim under the terms of the 1980 policy--ten years after the date of the occurrence.

As the number of claims increased, the cost of defending and paying those claims soared, and awareness of the uncertainty of the "long-tail" grew, many insurers found they could no longer price occurrence policies. In 1975, in response to this problem, The St. Paul introduced the "claims-made" policy form for doctors and hospital liability insurance.

The primary difference between a claims-made and occurrence policy is one of timing--when claims are covered by a given policy. Claims-made policies cover claims reported while a policy is in force, provided the incident leading to a claim took place after the date when the claims-made coverage was first begun. Although use of the claims-made policy does not eliminate the long-tail, it does help to control its effect. Reserves--money set aside to pay claims--are based only on claims reported during the current policy year. As a result, claims-made pricing reflects the most current changes in the legal, social, and economic climate.

(Since 1975, The St. Paul has exclusively utilized the claims-made form for physicians and surgeons and hospital medical liability insurance. Today, the claims-made form is the

exclusive policy form for virtually all of The St. Paul's medical liability insurance. Many other malpractice carriers, including physician-owned companies, also utilize the claims-made form.)

THE LATE 1970s AND EARLY1980s:

Following the availability crisis of the mid-1970s, the composition of the medical liability insurance market changed significantly, with a growing dominance of provider-owned or operated mutual companies. By 1985, approximately 60 percent of medical malpractice insurance coverage was provided by mutual insurance entities which were owned, operated, or sponsored by health care professionals.

As a result of the emergence of these new insurer organizations, there was relative stability in the medical liability marketplace during the late 1970s and early 1980s. Despite this calm, insurers remained reluctant to enter the medical malpractice insurance marketplace and the number of insurers engaged in writing medical malpractice liability insurance remained limited.

THE MID-1980s:

Until recently, the medical liability marketplace has been in a state of flux, characterized by market withdrawal, limited capacity, disruptions in reinsurance, restricted underwriting activity, and rapidly rising premiums.

Withdrawal from the medical liability market varied geographically and by type of health care provider. Insurers withdrew from providing coverage primarily because of a lack of confidence in their ability to price medical malpractice products in a rapidly changing claims environment. Lessened availability of reinsurance--insurance that insurance companies purchase to spread risk--also contributed to insurer withdrawal in this market.

Limited capacity--the amount of risk an insurer is willing or able to accept--was another characteristic of the medical malpractice market over the past several years. Much of the "capacity crunch" was due to the unavailability of reinsurance.

Many and varied changes in underwriting also occurred. There was movement away from the occurrence form of coverage to the claims-made form. Some companies avoided insuring high-risk specialties, such as obstetricians, and some withdrew from high risk geographic areas. Companies began to issue six-month policies, rather than one-year policies, and increased their use of coinsurance and deductibles. Companies also more carefully reviewed applications for insurance and claims records of the applicant.

Poor medical liability results led medical liability insurers to seek dramatic increases in rates in recent years. Pricing--or rating--of medical malpractice premiums is based on the frequency (the number of claims per 100 doctors or 100 hospital beds) and severity (average cost per claim) of loss. Malpractice rates are calculated to cover the cost of the policy sold and provide a reasonable profit for the risk accepted. As frequency and severity of loss increased, malpractice rates increased as well.

From 1982 to 1986, the frequency of claims reported to The St. Paul increased from approximately 13.5 claims filed per 100 physicians to 17.2 claims. Even when claims costs were limited to $100,000, countrywide claim severity for physicians and surgeons (including both paid and reserved claims) increased by 69 percent from 1982 to 1986. Medical malpractice premium rates for physicians rose an average of 15-20 percent from 1980-1983 and increased 25-30 percent from 1984-1986.

THE CURRENT MALPRACTICE SITUATION:

More recently, rate increases have moderated and, in many states, no longer reflect the meteoric increases experienced from 1984-to mid-1987. What contributes to the moderation? The number of claims is decreasing and rates now appear adequate to support current losses levels in many states. Rates must, however, continue to keep pace with losses. Thus, while recent experience is encouraging, it is still too early to be certain that this trend will continue.

The improvement in medical malpractice has also resulted in the entry of some new commercial insurance companies and specialty insurers. Risk retention groups and risk purchasing groups have added another new dimension to the market. Passage of the Liability Risk Retention Act of 1986 has also prompted some additional medical specialty societies to develop their own professional liability programs.

In addition, many insurers, including The St. Paul, have offered new and more responsive approaches to professional liability insurance. One alternative includes attending staff physician programs which combine physicians and hospitals in a single insurance program. In another approach, a managed care system may make professional liability coverage available for affiliated physicians.

Because of improved results, the combined countrywide effect of rate adjustments for physicians and surgeons insured by The St. Paul, beginning July 1988, is an average increase of 5.5 percent.

The 5.5 percent average countrywide increase is the combined effect of three factors:

(1) An average 2.9 percent decrease in rates at the basic level of $100,000 per claim and $300,000 per year. This is due primarily to a decrease in claim frequency.

(2) A 9.4 percent average increase in rates for increased limits factors which determine premium for liability in excess of the $100,000/$300,000 levels. This reflects the continuing increases in the severity or average cost of claims.

(3) Adjustments in the relativity factors for the different physicians' and surgeons' rating classifications. The rating classes group physician and surgeon specialties according to their relative susceptibility to medical liability loss.

It is important to note that these rate adjustments, combined with the many other factors making up an individual's own premium, cause the effects of these changes to vary widely.

FREQUENCY AND SEVERITY:

The frequency of claims reported against The St. Paul's insured doctors, countrywide, declined from 17 claims per 100 doctors in 1986 to 15.4 claims in 1987. (Both past and current countrywide frequency and severity data reported exclude Florida.) Claim frequency reached a high of 18.1 claims per 100 doctors in 1985, the current 15.4 claims is the lowest since 1982.

Although the frequency of claims has declined, the severity, or average cost of reported claims, capped at $200,000, increased from $35,660 in 1986 to $41,456 in 1987. Severity figures include claims paid, claims closed without payment, claims that remain open and defense costs. (Because more and more losses have exceeded the $100,000 level, The St. Paul recently began capping losses at $200,000, rather than $100,000, to report severity.)

Paid losses for both primary and increased limit coverages have also continued to increase. The average paid medical liability claim against The St. Paul's insured physicians and

surgeons, with losses capped at $1 million (including defense costs), reached $120,300 in 1987, up from $98,275 in 1986, and nearly 80 percent higher than the 1983 level of $66,935.

The number of medical liability claims involving St. Paul insureds resulting in loss payments of $1 million or more is also increasing. Of the 32,817 medical liability claims reported from 1983 through 1987 by physicians and surgeons, 45 have been paid with combined loss and defense costs of $1 million or more. Another 40 claims, each with an expected loss in this range, remain open.

While these claims represent a small percentage of the total claims, the number of large losses continues to increase. In 1987 alone, 21 percent of the claims paid exceeded $100,000. In the five-year period, The St. Paul will pay or expects to pay in excess of $100,000 on nearly 4,700 claims.

A profile of all medical liability claims involving St. Paul-insured physicians and surgeons and hospitals, reported between 1978 and 1987, reveals that 80 claims have been paid with combined loss and defense costs of $1 million or more. Of this total, 61 claims were reported during the last five years--from January 1, 1983 to December 31, 1987. In addition, another 50 claims with an expected loss of $1 million or more remain open. All but one of these open claims were reported in the last five years.

Similar trends are reported by Jury Verdict Research (JVR), which reports that average awards for plaintiffs in medical liability cases are higher than awards for other claims of personal liability. Higher medical malpractice awards, which averaged $1,478,028 in 1986, are granted, despite the fact that plaintiffs in medical liability cases recover awards less frequently.

JVR, in Current Award Trends, 1988 Edition, indicates that 446 of the 2,294 verdict awards of one million dollars or more from

1980-1987 went to plaintiffs alleging medical malpractice. The medical liability awards of a million dollars or more rank second behind the 541 awards in the products liability category. These two areas account for 43 percent of the million dollar awards in the last seven years.

Based on current data, JVR found that the average award in medical liability cases reached an eight-year high in 1986, as did the number of million dollar awards. JVR includes initial jury verdicts rendered for a given injury. Some cases included in their statistical analysis may have been reversed or appealed. Reductions in awards are not calculated in their analysis of awards.

RATEMAKING:

Frequency and severity--two key indicators--provide the basis for determining rates for professional medical liability insurance, as well as for other lines of insurance. As indicated, for physicians and surgeons, frequency is the actual number of claims reported per 100 physicians and severity is the average cost per reported claim. Frequency includes claims paid, claims closed without payment and open claims. Besides these, severity also includes loss and defense costs.

Since these average costs are continuing to increase, The St. Paul currently uses data that limits the loss on an individual claim to $200,000. The limit used for determining rates is kept low to prevent large claims from distorting indicated rates. Because of significant increases in the average cost of claims, it was necessary to increase the cap from $100,000 to $200,000 to ensure that rates are not too low to cover losses. In 1975 when The St. Paul introduced the claims-made policy, three percent of the claims paid exceeded $100,000. Today, 21 percent of the claims paid exceed $100,000.

Previously, The St. Paul included only the first $100,000 of individual losses for the basic limits rate analysis. For the

increased limits rate analysis, The St. Paul considered the portion of individual losses greater than $100,000. The analysis now includes the first $200,000 of individual losses in the basic limits review. The portion of losses above that figure is still included in the increased limits review.

Because medical liability insurance for physicians and surgeons is written on a claims-made basis, premium rates are based upon known, reported claims. During a rate review, analysts review five years of experience for all states to determine a current trend. Analysts also determine the pure premium, or the dollars required to cover the average loss per physician, on a state-by-state basis.

The pure premium, which is based on five-year frequency and severity experience, is projected to account for anticipated losses that will be reported during the term of the policy. General and administrative expenses are added to the projected pure premium to give a Class 1 rate indication. The relativity factors are then applied to the indicated rate to determine the actual rate for each class of physicians and surgeons.

Investment income earned on the premiums collected for physicians and surgeons medical liability insurance is also considered when setting rates. The St. Paul bases rates on the assumption that for every dollar of revenue collected during a policy year, approximately $1.06 will be paid in claim costs and administrative expenses. It is expected that investments will earn the difference and return a profit to shareholders. As a result, this total return pricing results in lower premiums for insured physicians and surgeons.

RATING CLASSIFICATIONS:

A recent analysis of medical liability claims shows a shift in the susceptibility of loss among The St. Paul's insured doctors. Claims against some physicians included in the lower-rated

classes are increasing at a faster pace than against physicians included in the surgical specialties. The growing incidence in the number of claims alleging failure to diagnose may contribute to this shift.

Doctors have different susceptibility to loss depending on the area of medicine in which they practice. Medical specialists performing similar types of procedures are grouped together in classes. Each class is assigned a relativity factor, based on actual experience. Class 1 is used as the base.

For example, the amount that will be paid by each of The St. Paul's eight classes of doctors is determined according to their percentage of losses. Newly-created Class 1A doctors pay the lowest rates; class 8 doctors the highest. Examples of doctors in Class 1A are allergists and psychiatrists. Class 8 doctors include neurosurgeons--the specialty that produces the highest losses. Because loss experience varies by geography, the process is repeated in each state.

The causes of differences between geographic areas are sometimes difficult to pinpoint. Certainly the cost of living is a factor. It costs more to care for an injured party, wages of a disabled plaintiff are greater, and lost income of a deceased worker are more in Chicago than in Little Rock. These factors cause loss severity to be greater in one geographic area than another.

An intangible factor is what can best be described as "social inflation"--the belief that one is entitled to certain results and that society, through a jury, will ensure compensation for an injured party if those results are not achieved. This affects both frequency and severity.

As medicine moves from a cottage industry to a corporate one, the personal relationships which once may have deterred patients from suing their doctors may be diminished. Further, with the explosive advances in medical technology and

knowledge, patient expectations have increased significantly. This corporate, "high-tech" practice of medicine is more likely to be present in large, urban, tertiary care centers. Accordingly, more urbanized areas tend to reflect greater frequency and severity and, as a result, higher rates for medical liability insurance.

For example, if The St. Paul's proposed annual rates, after July 1, 1988, are approved, average annual premiums will range from $7,068 in North Carolina to $51,439 in Chicago for a Class 4 physician purchasing liability limits of $1 million/$3 million on a mature claims-made policy. The Class 4 rate reflects the average premiums paid by physicians and surgeons insured by The St. Paul

LOSS RATIOS:

Insurance companies use combined ratios to reflect their underwriting losses. The combined ratio measures how each $1.00 of premium is used to pay losses, loss expense and the company operating expenses. A combined ratio under 100 generally indicates an underwriting profit, while a combined ratio over 100 shows an underwriting loss.

A.M. Best, independent analyst of the insurance industry, estimates the 1987 combined ratio for the industry's medical liability line (including physicians, hospitals, and other health care providers) will be 121. This is an 18-point improvement over the 150-and-above combined ratio which the industry began experiencing in 1982 and which reached 166 in 1985.

REINSURANCE:

Reinsurance plays a major role in an insurer's capacity to cover large losses. Simply stated, reinsurance is insurance purchased by insurance companies for protection from large losses. It is a mechanism to spread risk--just as a homeowner does when purchasing an insurance policy. Reinsurance enables insurers

to write policies for higher limits than they could otherwise write and also to write more policies--this leads to increased capacity--the amount of insurance an insurer can provide.

INCIDENCE OF MALPRACTICE:

Although malpractice claims against doctors, hospitals, and other health care providers have risen in number and cost over the past five years, there is no evidence that these increases reflect a rise in the incidence of medical malpractice. Experience has shown that up to two-thirds of medical malpractice claims are eventually closed with no indemnity payment. It is important to remember, however, that even when claims are closed without an indemnity payment, considerable legal and other expenses may be incurred.

Causes other than diminished quality of health care are attributable to the increased number and severity of claims. In fact, the high quality and sophistication of health care today has led to ever-increasing consumer expectations which cannot always be met. Although there is no doubt that some patient injuries do occur as a direct result of negligence on the part of health care providers, the key question remains as to how many injuries are actually the result of negligence.

This issue was the subject of intensive study during the 1970s and is currently the subject of renewed investigation. Although no definite answer exists, a 1973 study prepared for the Department of Health, Education, and Welfare's Commission on Medical Malpractice, estimated that 7.5 percent of all patients discharged from a hospital suffered iatragenic (provider-induced) injuries and 30 percent of those were believed to be due to some negligence which could be demonstrated. The study noted that only 1.7 percent of those patients filed malpractice claims.

QUALITY ASSURANCE:

Subjectively, scrutiny of the quality of care has improved over the past decade. Prior to the 1970s "crisis," industry standards for ongoing review of the quality of care provided for patients were limited. Medical staffs have traditionally had some role in reviewing and critiquing patient treatment based on outcome, but this was more an academic exercise than a quality assurance mechanism.

Over the past ten years, quality assurance and risk management have become essential elements of the health care industry. Hospitals and individual providers have implemented these programs independently or in response to mandates of regulatory bodies, the Joint Commission on Accreditation of Hospitals (JCAH), and pressure from insurers.

The evolution of formal risk management and quality assurance procedures have allowed for the development of programs and informed medical staffs which enable an organization to verify the competency of staff members on an adverse occurrence if the program functions efficiently.

The Health Care Quality Improvement Act of 1986, enacted by Congress, mandates the establishment of clearinghouse to serve as the national source of information on physicians, dentists, and other health care practitioners concerning payments made as a result of medical malpractice actions or claims; adverse licensure actions, and adverse actions of clinical privileges. The information is considered confidential and will be disclosed only under specified circumstances.

Once the clearinghouse is operational, health care facilities must report, to the licensing board in their state, actions that adversely affect a provider's clinical privileges for more than 30 days. The state boards must also report the information to the clearinghouse. Insurance companies and health care facilities must report judgments or settlements resulting in a payment and other pertinent information relating to the

settlement or judgment to the clearinghouse and the state licensing board.

Hospitals and other health care facilities will be required to request information from the data bank concerning a physician, dentist or health care practitioner at the time the provider applies for a position on the medical staff or for clinical privileges. Hospitals must check this information every two years.

As is evident, there is increasing emphasis on risk management efforts, and sound risk management and quality assurance efforts can be effective in reducing the number of claims related to the quality of care. These programs must, however, have complete commitment from hospital management and medical staff. The quality of care must be assessed by medical staff and recommended improvements implemented. Effective risk management and quality assurance programs can help reduce patient injuries and provide a level of documentation necessary to improve defensibility against claims which may still occur.

PHYSICIAN NEGLIGENCE:

Allegations are often made that a small group of doctors are consistently to blame for most medical liability claims, forcing the majority of doctors to subsidize a few "bad apples." The St. Paul's experience does not, however, indicate that in any given year, a minority of doctors is responsible for a majority of the claim dollars paid. As a result, the problem is predicting who will have claims filed against them in the future.

The St. Paul's past policyholder claim experience shows that over a six-year period, every doctor insured will have, an average, at least one claim filed against him or her. That is a statistical average and, in reality, many doctors will have no claims and many will have more than one--usually those doctors practicing high risk medicine are more susceptible to

medical liability claims. That is expected and why their insurance premiums are correspondingly higher.

CLAIM ALLEGATIONS

Surgical issues account for the highest number of reported claims, while diagnostic issues account for the greatest percentage of medical malpractice costs in claims filed against The St. Paul's policyholders during 1986 and 1987. The number of surgical claims shows a slight decrease compared to 1985-1986. At the same time failure to diagnose claims shows an increase in number.

Failure to diagnose pregnancy problems and improper birth-related treatment, along with claims alleging failure to diagnose cancer, are the primary diagnostic and treatment allegations made by claimants. Postoperative complications dominate the surgical allegations that are made.

Birth-related claims and failure to diagnose cancer appear in both The St. Paul's frequency and severity analyses. Claims alleging failure to diagnose cancer account for nearly 6 percent of all claims reported to The St. Paul during 1986-1987, compared to 5 percent during 1985-1986. Surgical issues are the most frequent allegations, with 2,775 claims followed by treatment issues with 2,044 claims, and diagnostic issues with 1,533 claims.

The average cost per claim has increased by more than $20,000 since 1985-1986. Birth-related claims have replaced anesthesia claims as the most costly and account for more than $141 million in total incurred claim expenses. Diagnostic issues account for more than $137 million in total claim expenses.

Nearly 68 percent of all physician and surgeon claims occur in a hospital setting and these claims account for 70 percent of the total costs.

THE TORT SYSTEM

As has been demonstrated, the medical liability system is driven by the interaction of the legal system, the health care system, the insurance industry, and the medical consumer. In addition, the American liability system has undergone dramatic and unpredicted change, creating liabilities not anticipated at the time policies of insurance were drafted and underwritten. Insurance underwriters must predict not only the conduct of their insureds, but also changes in our scientific, social, economic, and legal systems. Unfortunately, given our legal system, the ability to predict loss has frequently been hampered.

Clearly, a goal of our civil justice system must be to fairly compensate those parties who are truly injured as a result of another person's negligence. Some question whether our civil justice system is achieving that goal. Increased expectations of the public have extended our legal system and, in many cases, there is a belief that any unintended adverse result should be compensated--despite traditional theories of negligence requiring actual wrongdoing and a causal connection between the negligent act and the injury. The liberalization of the doctrine of liability has certainly increased the number of medical malpractice awards, as well as their severity.

Rapidly changing developments in the health care delivery system have also had a major effect on the medical liability market. Sophisticated medical technology has led to new legal problems that insurers have frequently found difficult to predict.

Additionally, the legal and administrative expenses associated with providing liability coverage (actually part of the insurance product) have increased in recent years with such expenses now constituting 30-35 percent of the total loss payments.

Limitations on medical reimbursement rates, imposed by federal and state governments, have led certain medical specialists (obstetricians) and some hospitals to restrict available medical treatment. This, coupled with other financial pressures, has led to unavailability of certain medical services, public outcry and legislative attention.

Each of these factors combined have caused regulators and legislatures to focus their attention on the medical liability system, searching for ways to address these problems.

PROPOSED LEGISLATIVE CHANGES:

Over the past six years, virtually every state legislature in the country, as well as Congress, the General Accounting Office, the Department of Health and Human Services, and various non-profit organizations have recently undertaken a review of the tort liability system to determine what, if any, modifications should be made which would help reduce the number of lawsuits instigated, more fairly compensate injured parties, reduce the cost of malpractice insurance, restore predictability, ensure the delivery of services, and return the concept of fault to the courtroom. Legislators, regulators, and governors are searching for changes in the civil justice system to serve the interest of all concerned parties--the public, health care providers, insurance companies, and the legal community. Many legislatures have enacted tort reform measures or other changes to the tort system and it is expected that this trend may continue.

The following measures have most frequently been proposed as recommended changes to the tort system:

** Caps on non-economic damages;

** Elimination or modification of the collateral source rule;

** Limitations on attorneys' contingency fees;

** Penalties for bringing frivolous lawsuits;

** Elimination of joint and several liability;

** Requirements of periodic payments or structured settlements;

** Requirements of periodic payments or structured settlements;

** Specification of elements of damage;

** Strengthened disciplinary procedures;

** Strengthened state-of-the-art defense;

** Strengthened standards of care defense;

** Elimination or modification of punitive damages;

** Establishment of no-fault systems;

** Establishment of birth injury funds;

** Subsidization of certain specialists;

** Establishment of patient compensation funds; and

** Development of private arbitration agreements

THE ST. PAUL'S PERSPECTIVE ON TORT REFORM:

When scrutinizing the constitutionality, effectiveness, or desirability of changes in the tort system, legislative bodies and the courts have historically focused on two key issues:

First, will the proposal save money?

Second, will it be equitable to all elements of society?

In balancing those two concerns, which are not always compatible, the key test has been whether those injured, and society as a whole, have been provided with a quid pro quo. It is the position of The St. Paul that only society as a whole, through its elected representatives, can make that determination.

The insurance industry can, however, advise society and legislators whether a given change will reduce the cost of the system and what other impacts on society would likely occur. Since The St. Paul is in the asset protection business, we are in special position to provide available information to help evaluate the major changes taking place in the reparations system and the impact of those changes on both benefits and costs. As the nation's leading insurer of health care providers, The St. Paul has a unique understanding of how the reparation system works for this line of business and is ready to share our knowledge and serve as a constructive advisor to policymakers concerned about the cost of the civil justice system. However, even with The St. Paul's experience and data, it is not possible to estimate, with any degree of precision, the potential cost savings for any suggested change in the tort system.

TORT REFORM SAVINGS

A number of studies have been conducted, in recent years, detailing the potential savings which might be achieved from enactment of various tort reform measures. In addition, some observers of the medical malpractice liability market have noted that changes in the tort system may be responsible for the recent reduction in the number of medical malpractice claims reported.

When reviewing any tort reform cost savings analyses, it is important to keep several facts in mind:

**Most of the proposed reforms which have been analyzed deal only with court awards. It is difficult to presume that those estimated savings would necessarily translate proportionally to cases settled before going to court. As indicated, the vast majority of claims are settled prior to trial. In light of pressure to quickly dispose of cases by settlement, many perceived savings on court awards would not necessarily translate to other settlements.

**Many tort reform measures will be subjected to court challenges that may take years to conclude. Only when these reforms have been successfully defended will they take effect and it may be several additional years before any impact on cost will be realized. Moreover, reforms that have been successfully defended in one state may not be upheld in others--state courts and constitutions vary widely.

**Because there are relatively few claims each year with non-economic damages in excess of $250,000, restricting non-economic damages to this amount will have limited effect on costs. Limits on non-economic damages may, in time, have an effect on the willingness of individuals with limited economic losses to pursue claims in the hope of recovering windfall non-economic damages. There is some concern that limitations on non-economic losses will lead juries to over-inflate economic damages to compensate for the reduction in non-economic awards. Finally, there is a possibility that caps on non-economic awards may ultimately become a target, rather than a ceiling for awards.

**Insurers have used the concept of structured settlements for nearly ten years and continue to maintain

that, through the purchase of an annuity or some other long-term funding instrument, structured settlements are an effective means of providing for the maintenance of an injured individual while potentially reducing payout costs to the system. There is, however, concern about proposals which would mandate the use of structured settlements in all situations. This concern focuses on the fact that structured settlements, mandated before trial, might limit an insurer's ability to innovatively handle claims during the settlement/negotiation process. Proposals which specify the investment vehicle, payout pattern, and other factors would further limit the ability to utilize structured settlements. Finally, many legislative proposals mandate the use of structured settlements for court awards over a certain dollar amount. Such proposals may have little, or no, impact on settlements and, as a result, the cost savings to the system which are realized may be limited.

**Proposals to create alternative compensation systems, frequently "no-fault" in nature, often fail to balance the number of additional claims brought into the system against any expected savings in loss payments. As a result, the funding mechanisms for these systems may be inadequate and projected savings may be seriously overstated.

Even with a great deal of experience and data, it is not possible to precisely estimate the potential cost savings for every suggested change in the tort system. While available data may not always permit insurers to quantify the impact on cost, logic will tell us that certain changes are likely to reduce claims cost, while other will not provide any significant savings.

THE FUTURE OF THE MEDICAL LIAIBLITY SYSTEM

A number of issues loom large in the debate over the future of health care in America and may have a profound impact on the

medical liability system. Among those that are expected to figure prominently in the future of our health care system are the following:

**Will medical liability results continue to improve? Following the "malpractice crisis" of the mid-1970s, frequency stabilized and experienced improved, only to deteriorate later. Current experience very sharply resembles the 1976-1977 period. The current decline in the number of claims may be influenced by physicians practicing more defensive medicine, as well as the results of risk management and loss prevention efforts. It may also be that society is more aware of the effects of medical liability claims on the cost and delivery of care. Or, as some suggest, it may be part of the early effects of tort reform.

**How will financial incentives impact on the quality of care? Some observers believe that cost concerns have negatively impacted upon the delivery of quality medical care. Others disagree, believing that cost discussions lead to establishment of minimum threshhold or predetermined standards of care--better defining the medical liability risk.

**How will various medical, ethical issues be resolved? New ethical dilemmas, spurred by quality, cost, and technological advances will have a profound impact upon the scope and level of services provided and the degree of medical risk assumed. Many of these issues will face health care providers, their insurers, the legal system, state and federal government, and the public over the next few years.

**What are the implications of AIDS? Medical liability implications resulting from the AIDS virus are already emerging. Claims have alleged or will likely allege the failure to diagnose or misdiagnose, breach of

confidentiality, failure to warn other third parties, refusal to treat and abandonment, assault and battery or testing without consent, deficient blood testing and supply procedures, and expanded corporate liability beyond the more obvious issues of workers' compensation and employer liability.

**How will advanced technology further alter the practice of medicine and the liability system? Advanced technology will not only alter the practice of medicine further, but will also change the medical liability risk inherent in various specialties and procedures. These advances can, however be a two-edged sword. For example, anesthesiologists, at the forefront of the first malpractice crisis, substantially reduced their risk by integrating advanced technology into their practices. Conversely, technological breakthroughs in the care and treatment of newborns has increased the medical liability risk for obstetricians.

**What are the implications of ambulatory and ancillary care? The liability implications of these types of care are still developing, but it is expected that they will present new exposures yet to be identified.

**What will be the impact of federal regulations on the liability system? The implications of the Health Care Quality Improvement Act (previously described) and the Consolidated Omnibus Budget Reconciliation Act remain to be seen. New standards of care will undoubtedly be mandated that will have liability implications for physicians who deviate from the regulations.

It is clear that the future will present medical liability insurers with many challenges. In order to meet those challenges, insurers must anticipate trends, develop proactive risk management and loss prevention remedies, and implement appropriate insurance options.