Approved March 21, 1989
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 xx a.m./p.m. on March 14, 89, 19__ in room 531-n of the Capitol.

All members were present except:
Representative Kent Campbell, absent
Representative Hank Turnbaugh, absent

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

Conferees appearing before the committee:

Others present: see attached list

The Chairman called the meeting to order at 3:30 p.m.

A motion was made by Representative Littlejohn to approve the minutes of February 27 and 28, and March 1 and 2, 1989. Representative Bryant seconded. The motion carried.

The Committee began hearings on HB 2458.

HB 2458 -- An Act amending the health care provider insurance availability act; concerning basic coverage required to be maintained by resident health care providers; amending K.S. A. 40-3402 and repealing the existing section.

Chris Courtwright, Legislative Research Department gave a brief overview of HB 2458. He explained that the bill would amend K.S.A. 40-3402 to exempt health care providers from the basic $200,000, $600,000 mandatory professional liability requirements, if they have obtained insurance from a Risk Retention Group.

Kent Roth, Great Bend attorney representing Physicians National, testified in support of HB 2458 as a part of a comprehensive solution to the medical malpractice insurance crisis, addressing the availability and cost problems the state is now facing. Mr. Roth provided background information with respect to risk retention groups provided by the Medical Society of Virginia (Attachment 1).

Douglas Crucet, Physicians Reliance Association, Inc., provided testimony in support of HB 2458 , explaining that the Physicians National Risk Retention Group operates on the principle of pooled risk, spreading the losses of a few among many, all sharing risk in common (Attachment 2). Mr. Crucet stated that this bill would exempt health care providers who purchase coverage from a risk retention group from the compulsory insurance requirements.

There were no others wishing to testify as proponents to HB 2458 and the Committee began hearing opponent testimony.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N, Statehouse, at 3:30 xx a.m./p.m. on March 14, 19 90.

Dick Brock, Insurance Department, testified in opposition to HB 2458 explaining that the bill conflicts with the historic purpose of the compulsory requirement and in not compatible with the decision to phase out the fund over a five year period of time. Mr. Brock also, stated that risk retention groups are not subject to the same financial regulatory requirements as admitted insurers and are specifically prohibited from participation in insurance guaranty funds. (Attachment 3.)

Next appearing and an opponent on HB 2458 was Jerry Slaughter, Kansas Medical Society. Mr. Slaughter provided testimony (Attachment 4) that HB2458 seems to be a backdoor attempt to allow certain risk retention groups to sell policies in Kansas, without having to meet the regulations intended to demonstrate financial stability.

Tom Bell, Kansas Hospital Association and Harold Reihm, Kansas Osteopathic Association, also appeared in opposition to HB 2458 for reasons discussed here today.

There were no other conferees wishing to testify and hearings on HB 2458 were concluded.

The meeting was adjourned at 4:50 p.m.

GUEST LIST

COMMITTEE: ______________________ DATE: ____________

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Jeff Rockett	Topeka	St. Francis-Wichita
Douglas Cruet		
Kent Roth	Great Bend	Physicians National
JIM OLIVER	TOPEKA	PIA of Ks
Dick Brock	"	Ins Dept

I. Risk Retention Groups (Medical Society of Virginia handout)

a. Fair Premium Policy requires rating of doctors for purposes of setting malpractice insurance rates. Presently a family pracitioner who delivers 10 babies per year pays the same rate as a doctor who delivers 200 babies per year. Kansas law relating to risk retention groups provides such insurers shall be exempt from any state law which prohibits offering advantages based on loss and expense experience.

b. Estimate Policy from Physicians' National will cost less than comparable policy from St. Paul, but Committee must realize a risk retention group has the right to assess its owner-members should claims exceed the projection. On the other side of the coin, should claims fall short of the projection, each individual owner-member physician would build up an equity account with Physicians' National and actually receive a payment from this account.

c. Important to act now as House Bill 2501 will phase out Health Care Stabilization Fund allowing doctors to choose on July 1, 1989 concerning coverage. Physicians' National is willing to offer first to last dollar coverage on a $3 million dollar aggregate; $1 million dollar per incident policy, or simply offer the same type of coverage offered by St. Paul which would be the first $200,000, however; Physicians' National would be willing to offer excess coverage above what the Health Care Stabilization Fund would be willing to provide under the current provisions of House Bill 2501. The offering of excess coverage puts Physicians' National in direct competition with the mutual company the Kansas Medical Society is attempting to create, thus; the Kansas Medical Society cannot be objective on this matter.

d. Addressing concern of Insurance Commissioner's office that physicians choosing Physicians' National Risk Retention Group on July 1, 1989 would not be subject to surcharge for funding of Health Care Stabilization Fund during the five (5) year phaseout. Contact with reviser of statutes indicates that this may not be a problem, but Physicians' National has no objection to any amendment which would clarify that doctors who

purchase the first $200,000 of coverage from Physicians' National would be subject to assessment by the Health Care Stabilization Fund for the amount of coverage chosen from the fund. Perhaps there is the possibility of requiring doctors to purchase tail coverage, just as the recent House floor amendment would require doctors who leave the State of Kansas to purchase tail coverage. If so, physicians should purchase tail coverage in order to purchase from Physicians' National at same price as doctors who choose to leave the State. This is a matter for the Committee to resolve.

e. Physicians' National unwilling to become licensed in the State of Kansas as that would require a change in the plan of business of Physicians' National that might be prejudicial to owner-members in other states, should the State of Kansas require the extending of special privileges to Kansas doctors. It seems logical that the State would still have the authority to assess Kansas doctors directly for funding of the Health Care Stabilization Fund despite any concern on the part of the State Insurance Commissioner's office. Federal law allows risk retention groups to do business throughout the country based upon their incorporation and regulation in a single state.

The above is the outline for the presentation made to the House Insurance Committee on March 14, 1989 by Kent Roth, attorney at law and lobbyist for Physicians' National Risk Retention Group.

The testimony of Douglas S. Crucet, President of Physicians' Reliance Association, Inc., consisted primarily of question and answer exchange with Committee members, however; enclosed please find a reproduction of two articles from Physicians' Advocate, Spring 1988, a publication of Physicians' Reliance Association, Inc., entitled "How We Began" and "Weathering the Malpractice Crisis With the Help of Physicians' Reliance" with the understanding that much of the information provided by Mr. Crucet is contained in the enclosed articles. Should you desire further information on this matter, please feel free to contact Lobbyist Kent Roth at (316) 792-7754 or the Company President, Douglas F. Crucet at (404) 953-1330. Thank you for the opportunity to present the above documentation.

Kent Roth

KENT ROTH

Attachment

How We Began...

Dr. J. Parran Jarboe , M.D., FACS, is Senior Vice-President, and a founder of Physicians Reliance Association. He is a graduate of Georgetown University Medical School and earned a "Fellowship in Surgery" at the Mayo Clinic and a "Master of Science in Surgery" at the Mayo Foundation. He is a Fellow of American College of Surgeons and is licensed to practice medicine and surgery in Minnesota, Maryland, Georgia, Delaware and the District of Columbia. He served as President of the Maryland Chapter of American College of Surgeons. He has served on the Blue Cross-Blue Shield Review Committee, the Maryland Medical Malpractice Arbitration Panel and was a founder of the Maryland physicians mutual.

"If you doctors are so smart, why don't you take the initiative and do something positive about your malpractice predicament?"

Among the increasing number of problems facing many physicians and surgeons, especially for those who have been in active practice for more than a quarter of a century, is the most serious and threatening problem of ever-escalating professional liability insurance premium rates.

Many of these practitioners, myself included, have never been victimized or subjected to the emotional, traumatic stress caused by actual malpractice litigation. Possibly, this can be attributed to careful, considerate and conservative attitudes in dealing with their patients, colleagues and institutions.

Yet in spite of good and professional manners, many of these physicians have been forced out of their practices and into either employment elsewhere or premature retirement. Because they can not afford the high costs of liability insurance, their departure from practice robs the medical profession of their wisdom and experience and damages the public health by creating an unnecessary shortage of much needed physicians. I personally faced this crisis in 1984. Having had a license to practice medicine and surgery in Georgia since 1972, I considered retiring to that state and possibly relocating at Sea Island. I looked forward to enjoying a new life and being near my three grandchildren.

From time to time I had discussed my dilemma with my son, J.P. Jarboe, Jr., and with his business associate of fifteen years, Mr. Douglas S. Crucet. On one such occasion in 1985, Mr. Crucet remarked, "If you doctors are so smart, why don't you take the initiative and do something positive about your malpractice predicament?" He knew that I had much more than a passing interest in this problem.

In 1974-1975, Dr. Manning Alden and I were President and Vice-President, respectively, of the Medical and Chirurgical Faculty of Maryland. During that time Maryland physicians experienced a serious malpractice crisis. A major carrier of physicians liability threatened to pull out of Maryland unless a 50% increase in premium rates was granted immediately. This was refused and the company cancelled all their policies in the state, leaving physicians without insurance coverage.

With an enabling act from the Maryland legislature, we established the Medical Mutual Liability Insurance Society of Maryland in 1975. Dr. Alden became its first president and served until 1984. Despite noble goals and radiant expectations, this physician self-insurance plan, while making insurance available to Maryland physicians, eventually became unaffordable to some of us.

Despite noble goals and radiant expectations, this physician self-insurance plan, while making insurance available to Maryland physicians, eventually became unaffordable to some of us.

It became just like any other commercial insurance carrier, constantly raising rates and giving no consideration to senior physicians with unblemished records. I was ready to "toss in the towel".

Mr. Crucet proposed that with some creativity, imagination, a good business management plan and insurance expertise, a group of determined

physicians could provide for its own liability coverage on a national basis. By assuming and spreading the risk nationally, rather than confining it to a limited area such as a state or medical society, operating costs could be reduced. Thus, the seeds for the Physicians Reliance Association were planted, and the group was incorporated in Georgia on February 7, 1986.

Mr. Crucet proposed that with some creativity, imagination, a good business management plan and insurance expertise, a group of determined physicians could provide for its own liability coverage on a national basis.

Discussions with my colleagues were stimulating and encouraging. Enthusiastic endorsement was often tempered with such remarks as "It's too good to be true. What's the gimmick?" However, many were supportive — even offering financial and personal assistance to get this innovative concept off the ground.

There were three primary goals:
1. Organize a group of distinguished selected physicians and surgeons and set up a non-profit liability insurance program for the members.
2. Employ strict cost containment procedures, by contract where possible.
3. Concerted political action for tort reform.
How would we set up our insurance program?

Some of the ideas advanced were:
1. Form an off-shore captive casualty insurance company
2. Set up a protective trust in each state.
3. Purchase a small casualty insurance company for our own use.

Our research proved none of these ideas to be practical or realistic for our purposes and were not pursued.

In the summer of 1986, we learned that the United States Congress was considering a risk retention amendment to the "Product Liability Act of 1981". This seemed a likely resolution to our problem, so we lobbied extensively and successfully for the passage of this amendment. It was signed into law by President Reagan on October 27, 1986. This new act was entitled the "Federal Liability Risk Retention Act of 1986."

This federal act allowed incorporated groups, such as our Physician Reliance Association, to set up a self-insurance program, to be chartered and licensed as a casualty insurance company in one state, and with certain guidelines to sell liability insurance to members of the group in all fifty states.

At that time, only four states, Vermont, Tennessee, Delaware and Louisiana, were ready to license risk retention groups. The preparation costs for these filings exceeded $150,000.

The Physicians National Risk Retention Group was founded, incorporated, and became fully licensed as a casualty insurance company by the Louisiana Department of Insurance on May 27, 1987. Operating under the provisions and authority granted by the Federal Liability Risk Retention Act of 1986, we were now permitted to conduct professional liability insurance business on a national basis — ***in all fifty states!***

We are now in full compliance with the insurance rules and regulations and are doing business in fourteen states. Within five years we intend to be operating in all fifty states and territories.

We are now in full compliance with the insurance rules and regulations and are doing business in fourteen states.

In the short span of time the Physicians Reliance Association and Physicians National Risk Retention Group have been operating, we have successfully passed the tests of federal court injunctions, and numerous governmental and regulatory agency audits and investigations. Despite all these obstacles and adversities, we have emerged as a proud national leader, being the first successful and largest professional liability risk retention group — *owned and operated by and for physicians.*

Despite all these obstacles and adversities, we have emerged as a proud national leader, being the first successful and largest professional liability risk retention group — owned and operated by and for physicians.

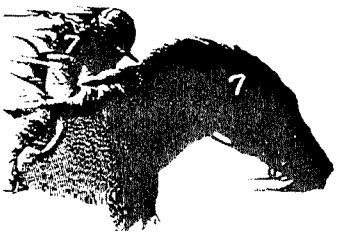
Physicians' Reliance
ASSOCIATION

Weathering the Malpractice Crisis

with the help of Physicians Reliance

Charles P. Bailey, M.D., Sc.D., J.D. is the Chairman of the Board of Directors of Physicians Reliance Association. He is a Fellow of the American College of Surgeons, American College of Cardiology, Chest Physicians, Angiology, Legal Medicine, International College of Surgeons, New York Academy of Medicine, American Association for Thoracic Surgery and others. Dr. Bailey has been awarded the Billing Gold Medal, the Hektoen Gold Medal, two Hektoen Bronze Medals, and the Shiley and Deknatel Award as well. Dr. Bailey's career and surgical instruments are part of a permanent display at the Smithsonian Institute.

"... that in some respects physicians were similar to race horses..."



At the age of 58, after a long and fairly successful career in Thoracic Surgery and pioneering in Cardiovascular Surgery, I entered night class at Fordham Law School. Having been sued on three occasions for malpractice, although each time successfully defended, I had become discouraged and thought that by going to law school I would gain an understanding of the applicable risks and problems. At the time of my graduation in 1973, I reflected that I really knew nothing about malpractice.

Further reflection brought the realization that when I had graduated from medical school 41 years earlier, I really did not know anything about the practice of medicine. I now know, after 15 years in law, that it takes about five years of actual practice in either profession before one is able to understand it.

In 1980, I was a member of a five man team which incorporated an underwriting group named Medical Quadrangle, Inc. We were able to persuade the owners of Frontier Insurance Company of New York, which was originally set up to insure race horses and other lines, that in some respects physicians were similar to race horses, and we could show them how to insure doctors for malpractice and make a significant profit while doing it.

Over the next five years we were highly successful. Our program was the only financially successful one in the state of New York. Each yea the Frontier, a stock insurance company, happily banked profits and said, "Let's do it again". By thi time I had my fill. I had hoped from the start to help my medical colleagues weather the "malpractice crisis" and began looking for another insurance program which would be both not-for-profit and capable of expanding nationally.

I then became aware of the existence and purposes of the Physicians Reliance Association. I met with the founders on September 1, 1986, and joined this not-for-profit group with the understanding that we would eventually become licensed in many states.

On October 27, 1986, President Reagan signed into law the National Risk Retention Act of 1986. This is federal law which covers, among other things, professional liability insurance. On May 27, 1987 Physicians National Risk Retention Group, Inc., a subsidiary of Physicians Reliance Association, was officially chartered under the laws of the state of Louisiana.

The federal act gave us the right to file in the other 49 states, and upon approval from the state insurance department, to insure members of our association for professional liability insurance. Currently, the somewhat innovative principles of insuring physicians which worked so well in New York can be applied by Physicians National to physicians in 14 states. It is hoped that the participants in this program will experience a savings over the never ending increases in rates by the carriers now providing this kind of insurance.

Basically the causes of malpractice lawsuits are two: An unsatisfactory outcome from the patients point of view, and a break-down in the physician-patient relationship. More than half of the lawsuits result from the latter issue. Other minor causes include patient avarice and the growing tendency of people to resolve their differences in the courts.

It has been estimated that 20% of the doctors have 80% of the lawsuits. If, by examining their records, this 20% could be eliminated, the remaining doctors would obviously enjoy the benefits of a much lower liability risk than they must otherwise bear. What can be done with the 20% of the "suit- prone" doctors? Some can probably not be helped. Some may be rehabilitated with intensive education.

Each year the Frontier, a stock insurance company, happily banked profits and said "Let's do it again".

As an example of a few ideas outlined in one of our recent risk management seminars, please note the following:

1. Doctors must not practice "defensive medicine". You can't justify all the expensive tests when asked in court.
2. The hospital and the office record must be our "bible". Even negative findings are important.
3. If it was not written down, the court will hold that it did not happen.
4. Never "white-out" anything in your record. Line it through, date and initial it.
5. If you give oxytocin, stay with the patient!
6. Always read the nurses' notes.
7. Care humanely for your patient and let him know it. Make your explanation and ask if he has understood what you have told him. Patients generally have only a 10% to 30% recall rate.
8. Never "bad-mouth" another doctor.

If the 80% of the "good" doctors can be educated by risk management seminars, home study courses and text books, they should experience a similar reduction in litigation which we had in our earlier program in New York - a 66% reduction in a three year period!

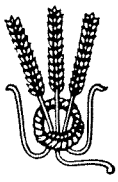
We have now laid the foundation for exactly such a program. We are happy to have you as a new or potential member and take this opportunity to say "Welcome Aboard!"■

It has been estimated that 20% of the doctors have 80% of the lawsuits.

The Truth About Insurance Company Losses

by
Delegate Bernard S. Cohen
Member, Virginia
House of Delegates

Consumer Information
presented for you by



The Physicians Reliance
Association, Inc.

THE TRUTH ABOUT INSURANCE COMPANY LOSSES

BY
DELEGATE BERNARD S. COHEN
Member, Virginia House of Delegates

Insurance companies in recent years have charged that there is a crisis in the medical malpractice field, that there is a crisis in the product liability field and that they are losing money writing these lines of insurance. They have raised premiums dramatically for these and related types of coverage.

An examination and analysis of official insurance industry reports indicate that they are actually overcharging doctors and other professionals on their malpractice coverage and businesses on their product liability coverage. The analysis also indicates that there is no crisis except the one that the insurance industry has manufactured to scare doctors, businesses and consumers into paying higher rates while insurance companies take in billions of dollars and take in profits in the multi-millions of dollars.

In order to understand how they do this and hide the true facts from the public, it is necessary to understand the accounting definitions of some terms commonly used by the insurance industry. The most important term to understand is "incurred losses." To the average person, incurred losses is thought to mean actual dollar losses paid out by the insurance companies. This is not so. The term is used to include possible future losses and report them as current losses. Incurred losses is a composite term and includes several components. The following equation and diagram will be helpful in understanding how the term "incurred losses" is used by the industry.

Incurred losses = (Claims Paid + Loss Adjustment Expense) + (Known Claims) + (IBNR) + (LAE)[1]

Incurred Losses	(1)	Actual dollars paid out for	Claims & Loss Expense to adjust those claims actually paid.
	(2)	Reserves for	Known claims which have not yet been settled, litigated or finally determined.
	(3)	Reserves for	Incurred But Not Reported (IBNR) claims.
	(4)	Reserves for	Loss Adjustment Expense (LAE)

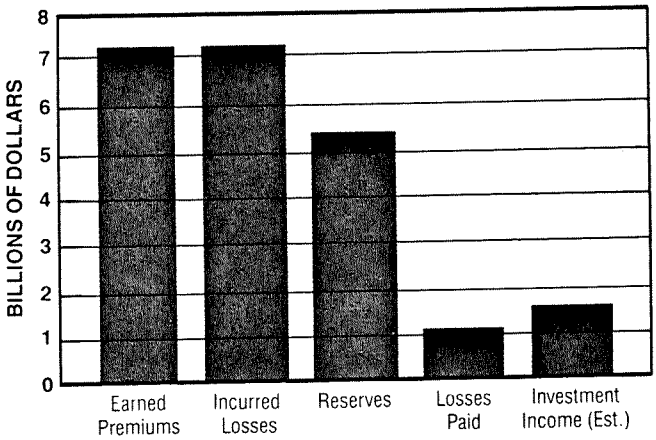
As can be seen, only component (1) reflects actual dollars paid out by the insurance companies. Components (2), (3) and (4) are "reserves" which each insurance company sets for itself. Under the present system, if an insurance company wants to hide income or report high losses, all it has to do is artifically inflate the reserve components and report incurred losses which exceed premium income.

The A. M. Best Co. of Oldwick, New Jersey, collects voluminous data from insurance companies and state insurance commissions and publishes this data. But it takes a lot of work to examine, analyze and interpret this data and it is not available in the necessary detail for each line of insurance. The following data, however, was culled from the Best reports filed by the insurance companies with each state insurance commission and serves to show how reserves can be manipulated to allow overcharges by insurance companies. From 1977 through 1982, the 85 leading property/casualty insurance companies representing 94% of the total premiums written, took in over $7.1 billion in premiums and actually paid out only $1.1 billion. Assuming a conservative 10% return on investment for those six years, *they earned more from the investment of the reserves than they had to pay out in claims.*

Figure 1

SELECTED 85 COMPANIES — 1977 - 1982

(Representing 94% of Total Premiums Written)



An examination of the data received from St. Paul Fire and Marine Insurance Company, the largest writer of medical malpractice insurance, is equally revealing. In 1977, they received $128.7 million in premiums and paid out $2.7 million in claims and expenses for occurrences in 1977, the year the premiums represent. For claims for all prior years plus 1977, plus all adjustment expenses, they paid out $5.1 million, just under 4 cents on the dollar. In 1978, they took in $131.3 million in premiums for 1978 occurrences alone and paid out $10.3 million for all claims and loss adjustment expenses, just under 8 cents on the dollar. (See Figure 2.)

All this information is contained in their Convention Statements on file with each state insurance commissioner. The reserves for losses and loss adjustment expenses were $138.1 million in 1977 and $200.9 million in 1978. The investment income for these years on their loss reserves is better than twice the claims paid and the expense of paying those claims. (See Figure 2). It is important to note that when St. Paul first reported incurred losses for 1975 in the medical malpractice line they claimed they were $38.1 million. In their 1983 statement, their current estimate of incurred losses for 1975 has been reduced to $30.3 million. Their original claim for 1976 losses was $62.6 million; by 1983, they reduced

[1] It is technically more correct to state the formula as: Incurred Losses and Expenses = (Claims Paid + Loss Adjustment Expense Paid) + change in reserves for known claims, IBNR and LAE. However, for clarity, the abbreviated formula and diagram are shown.

their estimate of incurred losses for 1976 to $25.02 million, a reduction of more than $37.6 million.

The following table shows that they have similarly overstated their incurred losses by millions of dollars for every year from 1975 through 1982.

Change In Estimate of Incurred Losses and Expenses Between 1975 and 1982

YEAR	CHANGE
1975	−$ 7,744,000
1976	− 37,608,000
1977	− 43,010,000
1978	− 20,884,000
1979	− 47,518,000
1980	− 39,413,000
1981	− 40,531,000
1982	− 21,227,000
TOTAL	−$257,935,000

Shouldn't the doctors and hospitals who paid premiums based upon incurred losses which St. Paul now says is more accurately $257.9 million *less* than their previous estimates get a refund? And what of the consumers who had the increased charges passed on to them in the form of higher hospital and doctor bills? How will they get their refund?

An examination of the data for general liability, which includes product liability, is also very revealing. The figures for 200 selected companies writing general liability insurance show that for the eight years, 1977 through 1984, they had income of $44.676 billion; estimated incurred losses of $35.137 billion; and claims paid, including loss adjustment expense of $17.416 billion. Reserves at the end of 1984 were $17.719 billion and investment income was $7,853 billion for those years. In 1984 alone, investment income was $1,708 billion. What a way to go broke!

Under the present system it is impossible or at least very difficult for anyone who wants to check on the fairness of rates charged by an insurance company for a particular type or line of insurance, because the insurance companies are not required to report the breakdowns of the component parts of "incurred losses" or other important details. Insurance companies should be required to report:

1. A breakdown of each of the reserve components and a rationale supporting the amount of reserves they set;
2. Premium income by type of insurance;
3. Number of claims actually made, paid or closed, specifying when the incident occurred and when the loss was actually paid or closed;
4. The dollar amount of the claims actually paid;
5. Reserve investment income.

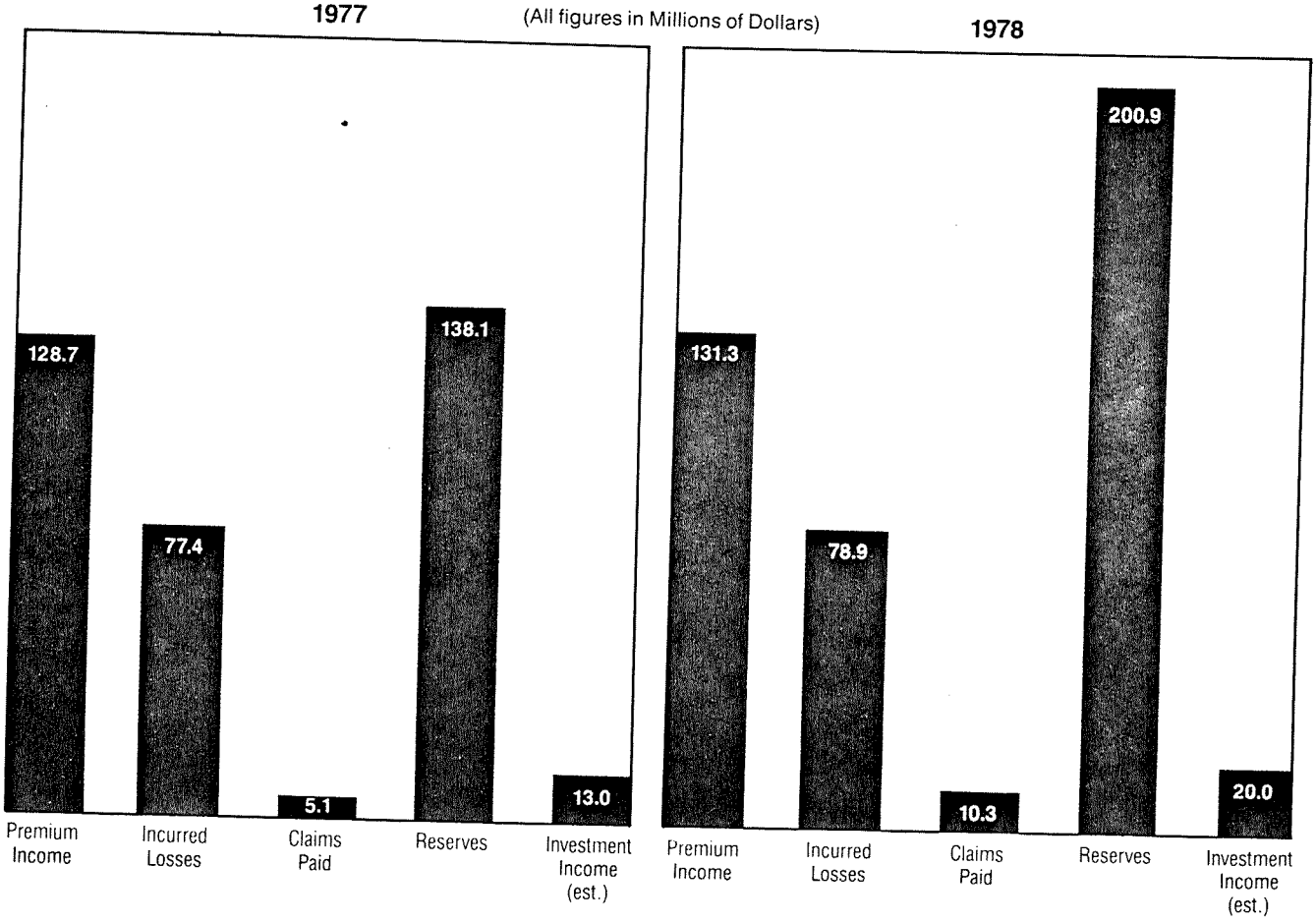
Such truthful disclosure is the least we ought to require.

Figure 2

St. Paul Fire and Marine Insurance Co.

Medical Malpractice

(All figures in Millions of Dollars)



The Virginia Experience

In November, 1975, the Bureau of Insurance prepared a report on the scope and severity of the medical malpractice insurance problem in Virginia. The report stated at pages 27-28:

> While extremely large verdicts or settlements may be a severe problem in other jurisdictions, available data indicates that verdict or settlement size has not yet reached crisis proportions in Virginia . . .

The report then documents the size of claims paid against physicians, surgeons, and hospitals from 1970 to 1975, indicating that of payments between $100,000 and $149,999 there were only five; between $150,000 and $249,999 there was only one; between $250,00 and $499,999 there was only one; and there were no payments over $500,000.

Although the November, 1975 data is now somewhat dated, later information has been made available from the Bureau of Insurance data on the disposition of *all* Virginia medical malpractice claims. The information covers the period from December, 1976 through November, 1981. The total indemnity paid out for medical malpractice by insurance companies during this period is as follows.

Amount	Frequency	Percent
Zero	2,002	73.4
$1 to $25,000	577	21.2
$25,001 to $100,000	115	4.2
$100,001 to $1,000,000	32	1.2
Totals	2,726	100.0

Since almost three-fourths of the dispositions result in the claimant getting nothing, it can hardly be said that the insurance companies are waging a losing battle. Indeed, the zero result disposition plus settlements or verdicts up to $25,000 constitutes 95% of all claims. Conversely, only 5% of all claims result in $25,000 or more to the claimant. Only 1% of the claims result in a recovery of $100,000 or more.

Analyzing in more detail the 32 dispositions of $100,000 or more shows the following results:

Amount	Frequency
$105,000	1
$115,000	2
$120,000	2
$124,386	3
$125,000	3
$130,000	1
$154,549	1
$182,000	2
$200,000	5
$250,000	1
$275,000	1
$285,386	1
$340,000	2
$350,000	1
$475,000	1
$525,000	1
$724,000	2
$750,000	2
Total Claim	32

Thus, we see that there were only twelve dispositions over $200,000; only five were over $500,000. The total dollar amount for these claims is less than $8.8 million in this five-year period.

Additional figures available from the Bureau of Insurance for the period covering 1981 to 1983 are also very enlightening. While they indicate that the *frequency* of claims have gone up (there are now more doctors), most of the claims (78.7%) still result in a zero recovery for the claimant. The figures for the largest claims actually paid (those falling between $100,000 and $1 million), show a total payout of less than $5.5 million during this three-year period.

The distribution of *all* 1981-1983 closed medical malpractice claims by size of payment is as follows:

Amount	Frequency	Percent
$0	3,275	78.7
$1,00 to $25,000	678	16.3
$25,001 to $100,000	180	4.3
$100,001 to $1,000,000	27	.7
TOTAL	4,160	100.0

The breakdown of the 27 closed claims in the largest category totals $5,489,953 and shows a median value of $200,000 and a mean value of $203,332. The actual claims listed in ascending order are:

$100,083	$ 204,446
100,250	212,500
100,807	214,421
100,839	220,865
101,315	225,000
105,643	225,007
108,431	230,000
113,536	292,179
125,000	292,179
125,000	300,000
126,634	319,046
200,000	387,147
200,000	559,625
200,000	
Total:	$5,489,953

It is interesting to note that of the 4,160 closed claims, the St. Paul Insurance Company has 2299, or 55%; the Virginia Insurance Reciprocal has 1182, or 28%. Thus, the two largest medical malpractice insurance writers in the state had 83% of all the closed claims. Since only 16 companies reported any closed claims for the three-year period, it is apparent that there is very little competition in the medical malpractice underwriting business in Virginia. This enables St. Paul to control the market.

The figures in the largest category also show that capping claims at $1,000,000 is unjustified and has *no* effect on the insurance premiums paid by health care providers.

Remember, these figures are a census of *all* closed claims in Virginia for the periods shown; they are not samples or surveys. During this three-year period the carriers writing Medical Malpractice in Virginia earned premiums totaling in excess of $100 million. Even if we assume that the 885 cases in which something was paid were at the top dollar amount shown in each category range (we know it is actually less), their earned premiums are two and one-half to three times their payout. Examination of A. M. Best's Casualty Loss Reserve Development Tables shows that nationally the ratio of total claims paid to total premiums earned is only 24.7%

for St. Paul in the medical malpractice line. Compare these reality figures with the premiums being charged by the carriers and you can readily see that they have created the fiction of a malpractice crisis enabling them to overcharge health care providers and their patients.

The 1986 "Crisis"

In 1986 the casualty insurance industry again claiming dramatic losses and they are demanding that claimants' rights be limited and in some cases be abrogated. But close analyses show that they have used the same accounting methodology to manufacture the crisis and are attempting to mislead legislators into enacting unfair measures to curtail victims' rights, so that they may move onto even greater profits. That is not to say that their profits did not go down in 1985. They went from years of astronomical profits to a year or two of ordinary profits which would be the envy of almost any other business.

But, the cause of the drop in profits was not excessive jury verdicts as they would have you believe. Rather, several factors combined to cause profits to decline. First, there was the dramatic decline in interest rates. The premium reserves which the insurance companies set aside to pay claims were able to earn enormous sums during the era of 15% to 21% interest rates. Now that yields on government securities and certificates of deposit are down to 7% to 9%, their investment income has been dropping dramatically. Second, during the high interest rate period the carriers were competing to get premium dollars quickly so that they could earn the unprecedented income available from high interest rates. Some carriers were not as careful in selecting the risks they would write nor did they charge the premiums which their underwriting department said was necessary to cover the risks they were writing. As interest rates fell and as claims increased from the poorer risks they wrote, underwriting profits declined. Instead of responding with careful consideration, the industry over-reacted, engaged in wholesale cancellation, refusals to renew and renewals with premium increases of 200% to 500% and even more.

Another factor also added to the crisis of unavailability. The London reinsurers put the squeeze on the American carriers by refusing to reinsure the risks they were writing. Reinsurance is an essential part of the insurance business whereby insurance companies spread the risk of their exposure by reinsuring part of the risks they have written with other carriers who specialize in reinsurance. Lloyds of London is the most well known of these reinsurers. The London reinsurers let it be known that they wanted the American tort system changed to curtail the principles of liability which we have carefully put in place in this country to give full access and real justice to persons injured by another person, company or product. The American companies, eager for ever-greater profits, seized the opportunity to change the system to curtail the rights of injured persons. They joined together to cripple the tort system, blaming high verdicts, judges, juries and important principles in the American system of jurisprudence for their declining profits. To the uninitiated who do not understand that "incurred losses" is a prediction shifting on the stands of time, this presented the insurance industry with a golden opportunity to again add insult to injury by attacking victims' rights.

In January of 1986, a trade group for the insurance industry, the Insurance Information Institute, claimed that the industry would lose $5.5 billion in 1985. But an analysis made by Robert Hunter, former Federal Insurance Administrator in the Ford and Carter administrations, showed that the claim was "misleading and fraudulent" because the industry did not include $6.5 billion of realized and unrealized gain on its investments, nor did it include federal tax credits of $3.5 billion. With a straight face the industry even included in losses, $2.1 billion paid out in dividends.

Abba Eban once said that "propaganda is the art of persuading others of what one does not believe oneself." The insurance industry is a prime example of this. The sophisticated investor and the stock market evidence the industry's profitability while the industry sheds crocodile tears over their "incurred losses." Investors are not fooled by this accounting system which counts the prophecy of tomorrow's "losses" as today's payout. During the last ten years the index of the leading property/casualty insurance stocks rose by almost 500%, while the Dow Jones Industrial average did not even double. In 1985 the index of insurance stocks rose more than 50%, twice as much as the Dow Jones Industrial average.

One of the most effective ways to combat these overcharges is to require the insurance carriers to report actual loss data on a closed claim basis. Also, health care providers should consider suing the carriers to recover the overcharges; in 1981 this strategy resulted in a recovery by California doctors from Travelers Insurance Company on a breach of contract basis. Recovery for one year was $6 million and a reasonable estimate is that eventually more than $50 million will be recovered.

Concerned health care providers and legislators should resist the impulse to tackle the problem of high insurance rates through legislation which would deny or limit recoveries by injured victims. Denying fair compensation to those who are the victims of malpractice merely adds insult to injury, nurtures ill will and hostility between professionals and their patients, and does not comport with any sense of fairness, justice and equity.

Postscript—February 1988

During the past four years this paper has been edited and updated each time more data and information became available. The paper has been widely distributed to doctors, lawyers, legislators, insurance industry executives, state insurance commissioner staffs and others. Hundreds, perhaps even a thousand, copies have been distributed with permission to duplicate and distribute at will.

I have received many comments, criticisms and questions concerning the content of the paper and I have responded to all of them. I would like to share with you the criticisms and questions, as well as my responses.

Question—Doesn't your own data show a substantial increase in the number and size of malpractice claims between 1970 and 1983? For example, the number of claims in the $150,000-$250,000 category went from 1 to 8, and large claims increased from 8 to 32.

Answer—An increase of claims from 1 to 8 is technically a 700% increase, but the real significance (or insignificance) of such an increase is properly understood

when you compare the dollars paid out to earned premiums and make adjustments for inflation and doctor/patient growth. From 1971 through 1975 the carriers collected approximately $86 million and paid out the one claim of $200,000 (assumed because it is the midpoint of the category) representing 2/10 of 1% of earned premiums. For the period 1977 through 1981, the earned premiums were $111.6 million. Again, using the midpoint of the category, the claims would total $1.6 million or 1/4 of 1% of earned premiums.

There were 4.7 million people in Virginia in 1970 and 5.6 million in 1984 and a population of 5,200 Virginia doctors in 1970 and 9,750 doctors in 1982, and a total increase of 24 large claims (8 to 32). Adjusting for this growth in doctors and patient population, you would expect an increase to 15 claims. The growth from 15 to 32 is slightly over a 100% increase and not a 300% increase. However, the biggest adjustment needs to be made for "bracket creep" due to inflation. The medical care costs index in 1970 was 120.6 (base year-1967); in 1975 it was 168.6 and in 1984 it was 379.5, an increase of over 300%. Since medical care costs represent a significant portion of malpractice claims (and personal injury claims, too) inflation caused many smaller claims to rise from one bracketed category to another. Calculating a precise figure is difficult, but a rise of about one-third to one-half in the number of claims in the "over $100,000" bracket is conservatively due to inflation. Now that the data required by law will become available after 1988, I feel certain that it will show only modest or no increases after adjustments for population and inflation. But, there is presently available a method of calculating significance which is meaningful.

A real measure of significance is the total dollars paid out relative to "gross earned premiums" or "written premiums." (These are terms of art in the insurance industry and are slightly different.) The following gross earned premiums for medical malpractice insurance in Virginia was:

1976	$19.7 million
1977	$20.5 million
1978	$21.2 million
1979	$23.3 million
1980	$22.4 million
1981	$24.2 million
1982	$34.1 million
1983	$36.0 million
1984	$38.2 million
1985	$50.8 million

If you were to use all of the claims shown from 1976 to 1981 and assume that all of them were to be paid at the highest dollar amount in each bracket (we know it is much less than that), then the *total* payout for those six years is only $10 million. The gross earned premiums exceed $111.6 million for the same period. Even after adding an adjustment factor for loss adjustment expense of 50% (1/3 is more realistic), you can see that there are tremendous profits in this line.

Using "written premiums" (a better measure of cash flow to the insurance industry) shows equally profitable results for the period 1975-84. (See the chart, Figure 3.) In Virginia written premiums for medical malpractice were $277.8 million and total losses paid during the same period were $57.5 million or a payout of 21 cents on the written premium dollar. Adding a loss adjustment expense of 1/3 to 1/2 of the paid losses, brings the payout up into the vicinity of 31 cents on the written premium dollar.

Question—If medical malpractice insurance is so profitable, why aren't more insurance companies rushing to write it?

Answer—In all states a handful of insurance companies (sometimes only 1, 2 or 3 carriers) have cornered the business. Usually it is the St. Paul Companies and a physician-owned mutual or reciprocal that have over 90% of the business. Other carriers know that a medical society-sponsored carrier has the edge and that doctors are reluctant to switch from the sponsored carrier or the one they have been with. Also, the expertise needed to set up the services for this special line means that a carrier will not sell the coverage unless it can be reasonably sure of getting an adequate number of doctors to subscribe. The number of doctors in each state (and in each specialty) is small, making it difficult for another carrier to break into the market no matter how competitive they are willing to be.

Question—Why do certain specialties such as OB/GYN and neurosurgeons pay $40,000 to $80,000 per year in premiums while some doctors only pay $2,500 or less?

Answer—Insurance companies (with the complicity of some doctors) have played a game of divide and conquer because the smaller they can keep each universe of insureds (once they are writing a line) the more they are able to charge for that universe. Here is how it works. In 1976 the approximately 7,700 Virginia doctors paid a total of $20.5 million in premiums, or an average of $2,550 each. In 1982, the 9,749 physicians paid a total of $34.1 million in premiums, or an average premium of $3,497. This shows that the crisis in medical malpractice insurance is *not* an overall cost problem; it is an insurance allocation problem related to the small numbers of doctors in some of the highest risk categories. For example, there are approximately 90 neurosurgeons in Virginia and 500 OB/GYNs. These are both high-risk categories with some of the largest verdicts.

Question—Do you have a proposed solution to the problem?

Answer—Yes. The solution is multi-faceted. First, the Bureau of Insurance and the Attorney General must use the tools created by the legislature and closely and quickly regulate the carriers to prevent excessive rates. Second, the medical profession must help find a fair method of allocating the cost of high-risk specialties among some of the doctors who do the referring to these specialties. After all, if these high-risk specialties take many of the high risks "off the hands" of the general practitioners and others, wouldn't it be fair for these other physicians to participate in spreading some of the costs now falling on the shoulders of the high risk specialties? If the approximately $50 million in premiums were spread evenly over the 10,000 physicians in Virginia, the cost per physician would be $5,000 per year.

Even taxicab drivers are paying an average of more than $2,000 per year, per vehicle. Nationally, medical malpractice premiums represent eight-tenths of one percent of the total health care costs for the nation. As you can see, the crisis in medical malpractice insurance is *not* an overall cost problem, it is an insurance allocation problem related to the small number of doctors in some

Property/Casualty Insurance Industry Written Premiums and Paid Losses
TEN YEAR TOTALS (1975-1984)

NOTE: 000's Omitted

	General Liability		Medical Malpractice		ALL LINES		Ratio
	Written Premium	Losses Paid	Written Premium	Losses Paid	Written Premium	Losses Paid	of LP to WP
AL	$ 723,423	$ 265,650	$ 147,834	$ 36,349	$ 10,905,815	$ 6,624,721	61%
AK	250,877	134,774	23,366	7,326	3,037,772	1,509,111	50
AZ	723,264	330,735	256,823	72,596	10,027,248	5,300,252	53
AR	381,005	139,378	70,785	17,161	7,078,392	4,319,136	61
CA	8,612,973	4,153,388	2,545,230	837,401	113,536,235	60,072,869	53
CO	789,595	300,468	232,134	75,078	10,875,591	6,350,193	58
CT	1,394,579	460,094	330,521	111,737	15,396,364	7,810,503	51
DE	178,615	47,984	57,328	14,945	2,371,923	1,241,696	52
DC	331,313	127,193	126,699	68,142	3,243,007	1,673,573	51
FL	2,429,907	1,243,213	545,577	259,018	38,230,024	21,557,471	56
GA	1,022,775	302,839	266,489	72,210	17,959,915	10,382,997	58
HI	328,575	129,539	59,922	13,740	4,003,058	2,183,460	55
ID	232,553	93,479	47,993	13,391	3,267,867	1,897,968	58
IL	4,995,436	1,956,364	1,083,985	363,517	48,729,554	27,826,243	57
IN	1,297,138	417,760	238,372	47,041	16,915,185	9,651,343	57
IA	1,016,750	356,484	168,559	40,702	11,233,811	6,020,146	54
KS	568,360	203,661	90,116	44,126	9,506,444	5,272,824	55
KY	678,257	171,818	177,980	48,766	11,545,649	6,277,204	54
LA	1,626,233	807,436	190,979	39,804	19,301,557	11,373,147	59
ME	223,209	74,818	47,626	14,916	4,049,691	2,186,044	54
MD	996,989	347,870	319,371	113,605	15,705,590	8,401,091	53
MA	1,714,564	700,213	75,505	44,063	26,493,310	15,404,650	58
MI	4,148,023	1,171,300	738,983	381,455	37,343,647	21,230,407	57
MN	1,390,686	648,216	254,976	57,840	18,317,309	10,518,646	57
MS	458,046	161,838	73,850	22,074	7,230,072	4,370,810	60
MO	1,311,659	580,901	307,827	124,479	17,117,457	10,226,621	60
MT	173,376	79,063	51,825	13,978	2,931,450	1,774,676	61
NE	440,837	134,384	69,099	10,165	5,973,992	3,166,411	53
NV	231,784	159,185	43,445	17,727	3,443,824	2,828,359	66
NH	256,283	91,065	18,875	18,422	3,969,064	2,151,394	54
NJ	2,795,628	1,104,544	616,226	319,655	36,293,431	20,593,827	57
NM	286,577	86,726	22,700	16,416	4,185,097	2,429,625	58
NY	7,404,985	2,938,177	1,912,235	969,157	74,921,478	40,903,678	55
NC	740,527	202,780	166,274	45,021	15,558,756	8,773,377	56
ND	171,177	53,880	40,951	15,715	2,479,531	1,115,302	45
OH	2,691,008	968,066	777,812	196,079	35,006,301	19,261,360	55
OK	844,533	289,033	121,443	45,429	11,796,763	7,013,943	59
OR	762,744	263,105	209,769	72,004	10,271,073	5,376,064	52
PA	3,663,673	1,566,303	792,713	308,574	45,782,139	24,870,488	54
RI	240,111	93,138	13,318	9,299	3,814,359	2,123,157	56
SC	418,780	144,517	21,220	8,922	9,091,797	5,169,911	57
SD	147,841	57,268	41,062	7,177	3,040,851	1,791,042	59
TN	889,216	263,382	222,621	48,131	14,037,963	7,922,823	56
TX	4,849,806	1,902,374	558,125	146,780	62,848,637	36,610,303	58
UT	263,072	82,943	65,224	25,363	3,820,195	2,014,823	53
VT	130,492	45,434	33,462	8,724	1,921,938	962,342	50
VA	1,003,608	303,587	277,847	57,494	16,861,082	8,783,917	52
WA	1,123,526	440,603	319,983	132,209	13,456,711	7,413,770	55
WV	316,033	118,097	128,421	46,176	4,657,081	2,705,294	58
WI	1,381,200	505,611	117,684	45,169	15,561,820	8,392,768	54
WY	143,748	61,515	19,156	11,519	1,696,138	948,110	56

Source: A.M. Best's Executive Data Service, Report A2, Experience by State

of the highest risk categories.

Question—Isn't there a general litigation explosion and aren't the juries handing down outrageous verdicts?

Answer—The newspapers always report large outlandish verdicts, but rarely report the checks and balances in the system which result in those verdicts not being paid. These checks and balances include the judge's power to reduce (remittitur) or set aside the verdict; the system of appeals which frequently reverse the large verdict; the compromise settlement after verdict whereby a lesser amount than the verdict is paid; or the unavailability of assets or insurance to satisfy the judgment.

Also, the public perception of a "lawsuit crisis" is based upon a well-financed insurance industry propaganda campaign to mislead the public and legislators. However, studies of available data by *objective* observers conclusively refutes the industry's claims. For example, the Institute of Civil Justice of the Rand Corporation said, "Our research shows that juries are usually sensible and that their decisions have been remarkably stable over 20 years."

The National Center for State Courts in a recent study found "no evidence to support the existence of a national 'litigation explosion' in state courts." The National Association of Attorneys General found, "The facts do not bear out the allegations of an 'explosion in litigation.'" Professor Marc Galanter of the University of Wisconsin Law School analyzed federal and state caseload filing data and concluded that, "We are *not* faced with an inexorable exponential explosion of cases."

An article entitled *"Civil Jury Awards Are Not Out of Control—And Here is the Data"* published in the Judges Journal, Winter 1987, by Stephen Daniels and Joanne Martin, researchers with the American Bar Foundation, found that data on jury verdicts "gathered in our study shows that civil jury awards are generally modest . . . [and] there is some reason, then, to be skeptical about the efficacy of the current round of civil justice reform as a remedy for the insurance crisis. This skepticism should lead us to a closer examination of the crisis rhetoric itself and to consideration of alternative explanations for the insurance crisis."

Before you join a risk retention group, READ THIS.

How do risk retention groups differ from commercial insurance carriers?

1. Risk retention groups are owned by their member/subscribers. If the group suffers a shortfall of reserves, each member can be held responsible to help make up the difference. If the group performs well, its members may build up equity.

2. Federal law allows risk retention groups to do business throughout the country based upon their incorporation and regulation in a single state. Accordingly, a risk retention group incorporated in another state may market to Virginia physicians without undergoing the type of scrutiny applied by the Virginia Bureau of Insurance to commercial carriers.

3. Members of risk retention groups lose the protection of the Virginia Property Guarantee Association Act.

4. Some risk retention groups may operate without reinsurance. Operating without such reinsurance reduces operating expenses but also creates greater exposure for the owner/subscribers of the company.

What should you ask before joining a risk retention group?

1. What type of expertise and experience does the group's management team have?

2. Does the group have sufficient financial resources to maintain an adequate reserve fund?

3. How many members does the group have?

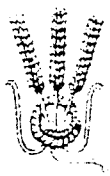
4. How will the group be marketed?

5. What is the group's underwriting criteria?

6. Does the group have the ability to require further assessments from its owner/subscribers in the event of a shortfall? If so, is there any limitation on such assessments?

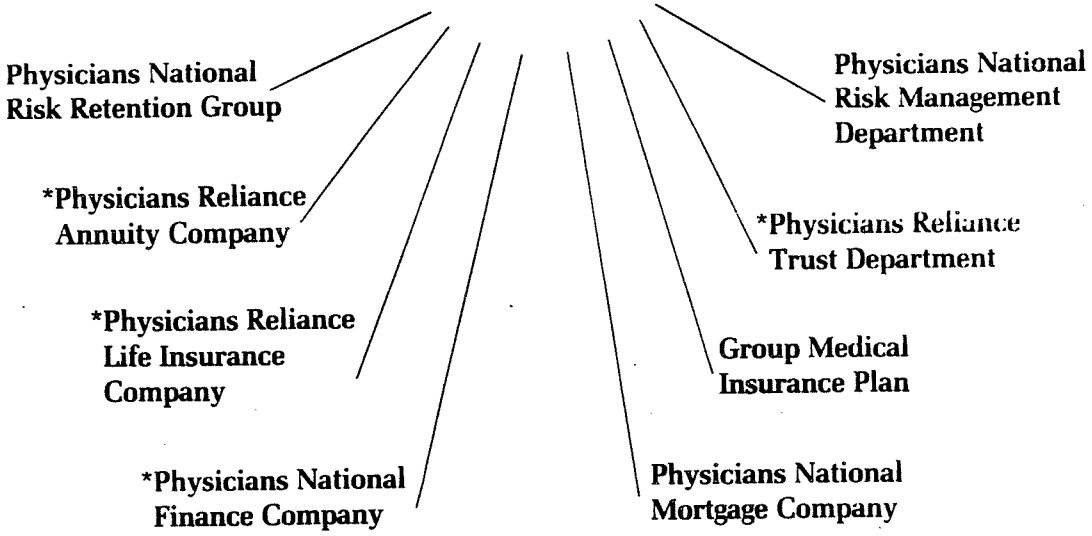
—SANDRA L. KRAMER, MSV Counsel

The Medical Society of Virginia has not taken an official position with respect to risk retention groups. Whether or not to participate in such a group is an individual determination. The information provided is intended simply as background information to assist you with your individual analysis; it is not intended, and should not be used, as a substitute for consultation with legal counsel.



PHYSICIANS RELIANCE ASSOCIATION, INC.

PROGRAM BENEFITS FOR THE MEMBERS OF THE PHYSICIANS RELIANCE ASSOCIATION



*Scheduled to begin operations in Spring, 1989

This brochure is intended as an introduction to the business concept of Physicians Reliance Association and Physicians National Risk Retention Group. The reader should not rely solely upon this material for a complete and thorough understanding of business. We request that all prospective members read Physicians Reliance Association's memorandum to members.

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The Physicians
Reliance Association, Inc.
A Not For Profit Association

Dear Doctor:

I was one of the pioneers of cardiac surgery. My thirty years of practice were exciting and profoundly gratifying. During the early period of my career I was much criticized for my theories and procedures, yet I won two gold and two bronze medals from the American Medical Association and, today, my surgical instruments rest on display in the Smithsonian Institute in our Nation's capitol.

Now, I am a pioneer in another field of endeavor which I feel is equally rewarding although it is one which has also exposed me to criticism by those doubting Thomases who always seem to resist innovations, particularly in the established insurance industry. I have chosen to direct what remains of my life to the financial reform of the insurance programs upon which we doctors rely so heavily. They are programs that I believe have exploited the medical community for generations.

My interest in financial affairs did not arise overnight. Nor did it arise from any personal experience I had as a result of medical liability. In 1968, I laid my surgical instruments aside and enrolled in Fordham University's law school. After graduation, I practiced medical malpractice defense law for five years. It was during these years that I became interested in improving the practitioner's odds against litigation by educating the physician in risk management and damage control. As a result, I left active defense work to become the chief underwriter and a member of the board of directors of what became New York's most successful insurance operation—perhaps the only profitable insurance operation in the State of New York. Through the efforts of my staff, the costs of claims and litigation was controlled and profits doubled yearly. The stockholders smiled and said, "Let's do it again."

Frankly, I had little interest in stockholder profits. Quite naturally, my interest lay with the doctor's plight. Year after year I watched the increase in the public's propensity to sue and the corresponding burden placed upon the physician for professional liability insurance. It was apparent to me that what our medical community needed was a national, nonprofit, medical liability association. One which would return unused premiums and investment income, not to stockholders, but to the people laboring under the burden of those increasing premiums. In 1987, with the help of over 1,000 other physicians, I had the

opportunity to found just such a program: The Physicians National Risk Retention Group.

WHAT DOES INSURANCE REFORM MEAN?

To us, it means the absolute control of our own funds. By that I mean control vested with the policyholder by corporate law. We recognize that losses from negligence must be paid as cost of doing business, that lawyers who defend us must be paid and that someone has to keep the books. The balance, however, should belong to policyholders, not management, not stockholders, not future generations of policyholders as with our current mutuals, but with each and every policyholder who contributed by a formula based upon contribution. I call it EQUITY.

An insurance industry composite statement reports that, historically, the total actual losses paid to claimants for medical malpractice amounts to $5,688,937,000*. If this figure was divided among the 500,000 physicians practicing today, it would amount to a mere $11,400 for each physician.

What is equally interesting is the amount of reserves versus annual losses from claims paid. Total industry reserves for medical malpractice amount to $15 billion*. With yields available on U.S. Government bonds at 9% or more at year end 1988, the industry can reasonably expect an income of $1.4 billion in 1989. A review of past losses and loss expenses paid reveals that the most the industry has ever paid out in any single year is $1.2 billion. So that the highest year's losses thus far are $200,000,000 less than could be earned on income from reserves.

From the above analysis, it is apparent that premiums are accumulating in ever increasing amounts so that interest income will pay claims. The snowball gets bigger and bigger without benefit to current policyholders.

PHYSICIANS NATIONAL — THE ASSOCIATION'S PLAN OF BUSINESS

If you were looking for cheap insurance, you wouldn't find it here. Yet you wouldn't pay more either. As a new insurance operation, we use the same experience factors everyone else does. In time, we hope to reduce our premium costs relative to other carriers by our innovative approach to management.

*Published by A.M. Best, The Insurance Industry Reporting Service. 1987

Our Association and its insurance subsidiaries neither purchase nor rent any buildings, nor do we employ any staff. All services are contracted out on a fee for service basis. What remains constitutes our membership's beneficial ownership interest in loss reserves.

HOW YOUR OWNERSHIP EQUITY WORKS

As a member of Physicians Reliance Association, you are an owner of beneficial interest by virtue of your participation in the Physicians National professional liability program. You must contribute to capital, as well as loss reserves, and the expense of operations.

CAPITAL CONTRIBUTION

Ten percent of your premium amount must be contributed by you to Physicians National's surplus capital (surplus). No expenses other than that of standard financial brokers' fees are deducted from these funds. Your capital contribution will be managed for you by a major brokerage firm and you will receive an annual statement reflecting the investment returns on this account. We will return your capital contribution subject to the approval of governing regulations. Furthermore, our brokers will give you investment alternatives from time to time with respect to this account. See further details in our memorandum to members.

After the expense of operations are deducted from your premium, the balance will be deposited in our loss reserve account. We will keep you informed each month as to claims filed, losses paid and the investment performance of our funds. At the end of each year, we will publish the total of losses, expenses and income for each year. The balance remaining shall constitute members' equity. See our memorandum to members for equity payout.

We know of no other professional liability insurance operation which gives policyholders true equity in capital and reserves.

ILLUSTRATION OF PROPOSED ANNUAL STATEMENT

ACCOUNT SUMMARY

Investment	Total Surplus Contributions To Date[1]	01/01/88 Opening Market Value	This Quarter's Allocation[2]	03/31/88 Closing Market Value
Government Securities Portfolio	$2,000	$2,170.39	+$95.30	$2,265.69
Total	$2,000	$2,170.39	+$95.30	$2,265.69

(1) Footnotes language to follow

(2) Footnotes language to follow

THE LIABILITY RISK RETENTION ACT OF 1986

The sale of insurance and the operation of insurance companies is regulated by each State. In order to do business in a particular State, an insurance company must be licensed in that State. Licensing requirements address not only the insurance to be sold but also the financial status of the company. Most States require a company to maintain a minimum amount of assets in that State. The individual States also require the filing of detailed financial information regarding policies issued and claims filed annually, auditing of any company books, and contributions to insurance company insolvency guarantee funds.

While an insurance company is headquartered only in one State and subject to that State's incorporation laws, it must be authorized to do business in every State where it issues a policy. Therefore, the insurance company must meet the asset requirements of not just one State, but many.

The Liability Risk Retention Act of 1986 is designed to make it easier for individuals and businesses to form "captive insurance associations" to insure their liability risks and issue policies to their members in various States. Without the Liability Risk Retention Act of 1986, individuals who wish to pool their liability risks with others for the purpose of insuring themselves would be subject to the same requirement in each State as commercial insurance companies. This has previously made forming such groups prohibitive.

The Liability Risk Retention Act of 1986 provides exemptions from certain State insurance laws for groups that meet the Act's definition of a "risk retention

group". In order to qualify for the exemptions from State law provided by the Act, a risk retention group must have the following characteristics:

(A) Primary activity consists of assuming and spreading the liability risk exposure of its group members;

(B) Organized for the primary purpose of assuming the liability risk exposure of its group members;

(C) Chartered or licensed as an insurance company in one State;

(D) Does not exclude any person from membership to obtain a competitive advantage over that person;

(E) Comprised of members whose businesses and activities are similar or related; and

(F) Includes the phrase "Risk Retention Group" in its name.

PHYSICIANS NATIONAL RISK RETENTION GROUP, INC.

Physicians National Risk Retention Group, Inc. is a legal reserve insurance company. It issues policies, collects premiums, honors claims, and provides legal defense for its member policyholders. The cost of this sharing of risk is exactly what the losses are plus an expense factor. There are no profits incurred from the premiums. An administrative service company is paid a percentage of the premium for management services and legal counsel will be paid a percentage of all legal defense services.

This Group operates on the principle of pooled risk which is, simply, spreading the losses of a few among many, all sharing risk in common. Each member of the large group contributes to the fund from which claims against individual members of the group are paid. Premiums are calculated by evaluating the past experience of risks or losses for other similar groups.

The reserves will constitute the net premiums, (i.e., after any reinsurance premiums are paid) and will, together with interest earned, constitute policyholder equity. The investment of reserves is currently restricted to properly insured, interest bearing accounts, U.S. Government Bonds, Treasury bills and money market certificates. (See investment policy elsewhere in the group's memorandum.) As the Retention Group will offer member policies pursuant to Federal Law, no application will be made to your State's Insurance Commissioner for licensure. Therefore, policies obtained from the Retention Group may be ineligible for

participation in any State ılvency or guarantee fund. As we the Group is not subject to all of the insurance laws of your State.

RATES AND ASSESSMENTS

The calculation of rates for any insurer is based upon past loss experience. Our rates, which have been produced by independent actuaries, are calculated on a sound basis. If there is a shortfall in rates, our group will have to resort to assessing members to bring reserves up to a secure level. Any call for assessment may be without regard to monetary limitations. You may wish not to be liable for such assessments. Therefore, you may choose a non-assessable policy by paying 5% of your premium into our assessment pool.

Physicians National will reserve, in a separate escrow capital account, 5% of premium deposits above our standard rate for those members who wish to participate. This private "Assessment Fund" will offer, hopefully, those members who participate a source of money in which to meet any probable or likely assessment. All investment income will accrue to the benefit of the fund's contributors. Should the need for assessment arise, funds in this special account will be released to loss reserves. Members participating in this account will not be called upon for further assessment. Any call for assessment may be without regard to monetary limitations.

RISK MANAGEMENT AND CONTINUING EDUCATION

Since many doctors have not had even one lecture on risk management, it's no wonder, in this litigious society, that malpractice suits are becoming commonplace and that the immense value of an effective continuing education program, especially when combined with warnings about unavoidable risks of liability, would seem to be obvious. The past experience of one director in underwriting for a New York State insurer suggested a reduction of 66% in the number of lawsuits (after only three years) through risk management.

In addition, we will have a special educational and supervisory program for those doctors whose record indicates that they do not meet standard underwriting guidelines. Their insurance (and insurer) will be kept completely separate from that of the regular doctors so that the latter's ownership in the Physicians National Risk Retention Group (PNRRG) will not be violated. But we do want to give these doctors a chance to become rehabilitated.

MEMBERSHIP

Membership in the Physicians Reliance Association (PRA), Inc. is open to those physicians who have achieved experience in their field. The members must be insured by Physicians National.

Since insurance is required of all members, the Association will exercise extreme prudence and caution in accepting members. The directors have set high standards of professional qualification necessary for physicians to be eligible for the regular pool.

PHYSICIANS RELIANCE ASSOCIATION MEMBERSHIP DUES

Yearly Dues: $200.00

Dues in the Association are not refundable upon acceptance as a member of Physicians Reliance Association.

COVERAGE AVAILABLE

Physicians National offers first year claims-made through mature claims-made professional liability insurance coverage at policy limits of:

$ 100,000	$ 300,000
$ 200,000	$ 600,000
$ 250,000	$ 750,000
$ 500,000	$ 1,000,000
$ 500,000	$ 1,500,000
$ 1,000,000	$ 3,000,000

Partnership, professional corporation, ambulatory care center, and employee liability coverages are available.

GUARANTEE FUNDS

Many States have established guarantee funds to provide funding for the claims of an insolvent insurer. Risk retention groups do not participate in these funds and, therefore, do not provide any guarantee for the payment of claims by the various States.

It should be noted, however, that most States limit the guarantee to $100,000 which does not provide much comfort to the malpractice insured doctor. As well, each insurer is required to support the fund which results in a direct cost as part of each premium dollar.

BEYOND YOUR POLICY LIMITS

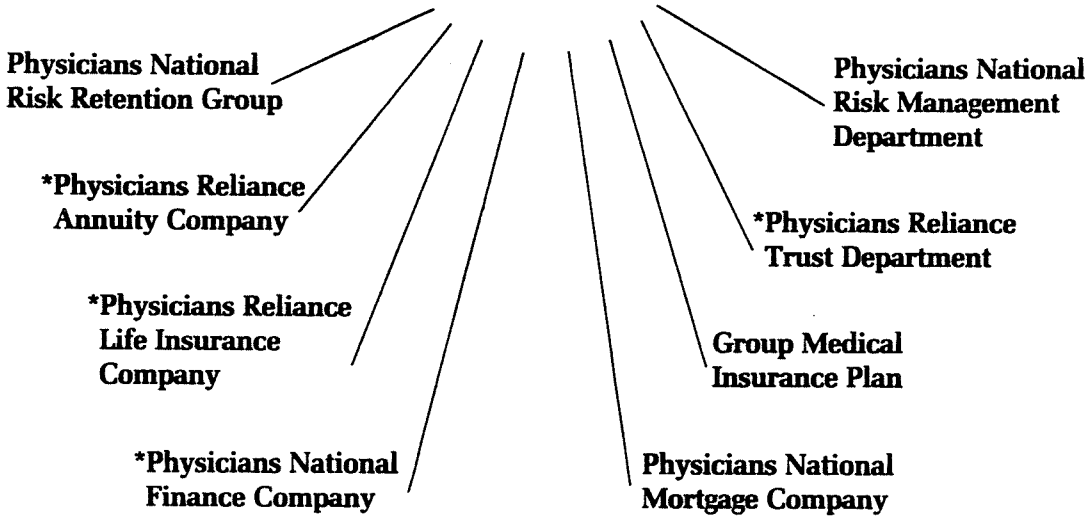
There is a limit as to how much liability insurance you can afford. In most States, however, there is no limit to the amount of money a jury can award. Therefore, each time you walk into that operating room, everything you've accumulated in life is on the line. It is interesting to note that our society demands this accountability from no one else. When the businessman errs in judgment, he bankrupts his corporation and looks for another job. No one comes to collect his art, furniture, home, and children's education fund. But, they'll come after yours. Due to a 1988 U.S. Supreme Court decision, even your pension may not be sheltered. The court held "Congress did not intend to pre-empt state law garnishment of an ERISA (Employee Retirement Income Security Act) welfare benefit plan, even where the purpose was to. collect judgment against plan participants."

The last surgery you perform could result in a suit years later when you're well into retirement and strip you to the bone, including your pension. But if you act now, before the crisis, there is much you can do to protect the assets you've accumulated in life. And we'll help you.

As a member of Physicians Reliance Association, our legal staff is available to assist you with the long range planning of your financial affairs. There is no charge for the first three hours per year of consultation to members. This consultation is intended to augment the services of your local attorney and not to replace them. Although both of you, the physician, and your local counsel may benefit from our research, thought, and menu of plans, it will be your local attorney who must perform the execution of any program designed. You may contact an attorney with our legal department by phoning the toll-free number listed in this brochure. While we do not provide investment advice, we will analyze your current affairs and assist you with a menu of alternatives so that you may achieve your future financial objectives without undue concern over the potentially disastrous effects of litigation.

Why bother calling us, you may wonder? Why not simply rely upon your own counsel? Proper planning is not simply a matter of knowing the law. It's knowing how to use the law. Your attorney may not be a specialist in such matters. The scope of your lawyer's resources may be limited. If not currently, we intend to see that we become the best informed authority on this subject. In the years ahead, we believe that this program will be the single most valuable service to you as a member of the Physicians Reliance Association.

PROGRAM BENEFITS FOR THE MEMBERS OF THE PHYSICIANS RELIANCE ASSOCIATION



*Scheduled to begin operations in Spring, 1989

PHYSICIANS NATIONAL RISK RETENTION GROUP—A nonprofit, subsidiary of Physicians Reliance Association offering members equity in medical malpractice liability insurance.

PHYSICIANS RELIANCE ANNUITY COMPANY—A subsidiary of Physicians Reliance Association offering members NO LOAD annuity programs.

PHYSICIANS RELIANCE LIFE INSURANCE COMPANY—A subsidiary of Physicians Reliance Association offering members reduced rates.

PHYSICIANS NATIONAL FINANCE COMPANY—A subsidiary of Physicians Reliance Association offering members discounted consumer credit.

PHYSICIANS NATIONAL MORTGAGE COMPANY—To offer several attractive residential mortgage programs to the members of Physicians Reliance Association, Inc. with reduced closing costs and fees. A maximum loan of $1,000,000 will be available to its members. Interest rates, terms, and other costs associated with these mortgages will be below the market rate offered by traditional leading mortgages such as savings and loan associations. Interest earnings from your participation should benefit the loss reserves of Physicians National Risk Retention Group, Inc.

GROUP MEDICAL INSURANCE PLAN—The Association has contracted with private insurers for the purpose of providing group rates to our members and their staffs for major medical hospitalization and disability income insurance.

PHYSICIANS RELIANCE TRUST DEPARTMENT—Offers members confidential consultation on asset protection, trusts, family or business financial planning.

PHYSICIANS NATIONAL RISK MANAGEMENT DEPARTMENT—An ongoing program of video tapes, correspondence, advisory bulletins and seminars developed by our own medical/legal staff.

ANNUITY AND LIFE PROGRAMS—Physicians National is in the process of acquiring a life and annuity insurance company for the benefit of its members. As with Physicians National, this company will operate on a nonprofit basis. All earned income from capital and reserves will accrue to the direct benefit of members in the form of policyholder equity. Term life policies will be available by direct mail on a group basis. Annuity contracts are designed as "self-directed" programs in that the member annuitant may design the terms of his annuity contract.

LOCAL DEPARTMENT REGULATION—Physicians National is licensed and chartered pursuant to the provisions of the Liability Risk Retention Act of 1986, which minimizes much of the red tape inherent when filing in all of the individual States.

Our future direction will be determined by the desires of the members and the needs of our medical community as they relate to the malpractice and medico-legal issues of public interest. We appreciate your support.

Respectfully,

Charles P. Bailey

Charles P. Bailey, M.D., Sc.D., J.D.

LIST OF STATES IN WHICH PHYSICIANS NATIONAL IS REGISTERED TO DO BUSINESS

UPDATE FEBRUARY, 1989

Alabama
Arizona
California
Colorado
Connecticut
Delaware
District of Columbia (D.C.)
Florida
Georgia
Hawaii
Idaho
Indiana
Iowa
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
New Hampshire
New Jersey
New Mexico
North Dakota
Ohio
Oklahoma
Oregon
Rhode Island
South Dakota
Tennessee
Texas
Virginia
Washington
West Virginia
Wyoming

TESTIMONY BY

DICK BROCK
ADMINISTRATIVE ASSISTANT
KANSAS INSURANCE DEPARTMENT

BEFORE THE

HOUSE INSURANCE COMMITTEE

HOUSE BILL NO. 2458

MARCH 14, 1989

House Bill No. 2458 appears to be a rather simple bill and, from the perspective of its proponents, perhaps it is. At the outset, I want to make it clear that nothing in Kansas law prohibits risk retention groups from doing business in Kansas in accordance with the federal law that provides for their creation. However, in the case of medical malpractice insurance for health care providers as defined in K.S.A. 40-3401, the providers who purchase medical malpractice insurance from a risk retention group have not complied with the compulsory insurance requirement that is applicable to health care providers because under the current law such coverage must be "... issued by an insurer duly authorized to transact business in this state ..." An insurer can be "duly authorized" only by qualifying for and receiving a Kansas certificate of authority.

House Bill No. 2458 is a suggested solution to this situation because it simply exempts health care providers who purchase coverage from a risk retention group from the compulsory insurance requirements. It also does more than that, however, because under the provisions of the bill, risk retention groups would not be required to comply with the other statutory requirements relating to the collection and remission of surcharges and other portions of the Health Care Provider Insurance Availability Act relating to the Health Care Stabilization Fund. Furthermore, the bill cannot be amended to make these provisions applicable because the federal law that provides for the creation of risk retention groups preempts the application of state laws that are not specifically permitted by the federal act. Article 41 of Chapter 40 of the Kansas statutes contains the permissible state laws. Needless to say, those relating to the Health Care Stabilization Fund are not among them. As a result, the federal law that shields risk retention groups from general application of state insurance laws is not an impediment.

The only reasonable way for a risk retention group to meet the requirements of the Health Care Provider Insurance Availability Act as far as health care providers it insures are concerned, is to qualify for

a Kansas certificate of authority the same as other insurers and some risk retention groups have already done.

The alternative, of course, is to do precisely what House Bill No. 2458 provides. That is, simply except health care providers who purchase medical malpractice from a risk retention group from the compulsory insurance requirements and other provisions of the Health Care Provider Insurance Availability Act. This course of action might have some appeal but it obviously flies in the face of the historic purpose of the compulsory requirement and is not compatible with the decision to phase out the fund over a five year period of time. In addition, the excess and tail coverage available through the Health Care Stabilization Fund would be available only to the extent the risk retention group or groups provided it. Finally, risk retention groups are not subject to the same financial regulatory requirements as admitted insurers and is specifically prohibited from participation in insurance guaranty funds. Therefore, enactment of House Bill No. 2458 would have some extremely significant ramifications which should be very carefully considered and very cautiously approached.

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

March 14, 1989

TO: House Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: HB 2458; Concerning Risk Retention Groups

The Kansas Medical Society appreciates the opportunity to appear in opposition to HB 2458, which seems to us to be a backdoor attempt to allow certain risk retention groups to sell policies in Kansas. Currently, risk retention groups organized under federal law, must meet certain minimum requirements before they may provide insurance to Kansas health care providers. Apparently there are some risk retention groups who find these regulations which are intended to demonstrate financial stability somewhat oppressive, and would like to be exempted from them. The Legislature passed 1987 HB 2129 in order to protect insureds as well as injured parties from possible harm that could occur if an undercapitalized risk retention group were to sell coverage in Kansas and then become insolvent.

Aside from the issue of whether or not as public policy you want to encourage the sale of insurance in a very volatile market by organizations who don't meet minimum financial requirements, there exists another consideration. This committee has just completed work on a major overhaul of the Health Care Stabilization Fund, which must defend all claims in excess of the primary coverage which the risk retention groups would propose to insure in this legislation. With the demonstrative concern on the part of the Legislature that the Health Care Stabilization Fund be actuarially sound, we believe the state has a legitimate interest in seeing that the companies which provide primary coverage limits meet certain minimal standards so that they are able to pay claims should they arise, and not leave the Fund holding the bag, as it were.

Especially now, as we enter the first year of a five-year phase-out of the Fund, it would seem imprudent to make any significant changes in insurance policy without first assessing the impact it will have on the Fund's total liabilities and exposure during the phase-out period. We respectfully request that HB 2458 be reported adversely. Thank you.

JS:nb