Approved April 3, 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 27, 89, 19__ in room 531-n of the Capitol.

All members were present except: Representative William Bryant, excused

Committee staff present: Chris Courtwright, Research Department
Bill Edds, Revisor of Statutes
Sharon Tucker, Secretary

Conferees appearing before the committee:
Others present: see attached list

The Chairman called the meeting to order at 3:30 p.m. and began hearings on SB 18.

SB 18 -- An Act concerning the health care provider insurance availability act; relating to private practice corporations or foundations and their full-time faculty employed by the University of Kansas medical center.

Bill Wolff, Legislative Research Department, gave the Committee an overview of the bill. Mr. Wolff stated that SB 18 as amended, would allow the private practice corporations or foundations and their full-time faculty, employed by the University of Kansas Medical Center, to self-insure for the basic $200,000/$600,000 medical malpractice insurance with the State General Fund reimbursing the Health Care Stabilization Fund for losses it pays out as those losses are incurred. Mr. Wolff also testified that the Senate Committee amendments would extend the self-insurance provision to all full-time faculty health care providers, not just physicians.

Marlin Rein, University of Kansas Medical Center, appeared before the Committee in favor of SB 18. Mr. Rein provided testimony (Attachments 1, 2, 3 and 4) explaining that the bill was a product of an interim study by the Special Committee on Ways and Means/Appropriations relative to Proposal No. 50, concerning the problem being experienced by the faculty of the School of Medicine as a result of increasing malpractice insurance costs. SB 18 would provide that the basic tier of coverage would be self-insured by the State, with the physicians continuing to be responsible for the surcharge to the Health Care Stabilization Fund.

Dr. James Price, University of Kansas Medical Center, gave testimony in support of SB 18 which addresses the serious and rapidly increasing threat to the financial viability of the Foundation in the cost of faculty malpractice insurance. Dr. Price explained that if the Foundations exhaust their resources in order to pay liability premiums, the Faculty will lose the incentive to teach, the ability to recruit, and the desire to remain a teaching institution. (Attachment 5)

Next appearing in favor of SB 18 was Chip Wheelan, Kansas Medical Society. Mr. Wheelan provided testimony (Attachment 6) endorsing the proposal to self insure the basic layer of professional liability insurance coverage for full-time physician faculty members.

There were no other conferees wishing to testify on SB 18 and the hearings were closed.

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N, Statehouse, at 3:30 ~~xx~~m./p.m. on March 27, 89.

The Committee began hearings on HB 2543.

HB 2543 -- Concerning professional liability insurance for health care providers; relating to the determination of rates therefor.

Chris Courtwright, Legislative Research Department, gave a brief overview of HB 2543 which would require professional liability insurance companies to establish experience rating programs.

Ron Smith, Kansas Bar Association, provided testimony in support of HB 2543. Mr. Smith explained that this legislation was a request of the Kansas Bar Association and would make some changes in premium structures for doctors that make sense, further reduce premiums for most, allow the rates to reflect current tort reforms that have been enacted, and to some extent put the doctor in control of his own premium destiny. (Attachment 7) Mr. Smith also suggest that the bill require experience be made on an individualized basis within a group of doctors.

Next appearing on behalf of the Medical Protective Company was Mike Mullen. Mr. Mullen provided testimony in opposition to HB 2543 which stated that experience rating hinders claim resolutions, that if an experience rating charge is based on dollars paid to a claimant, then the charge cannot be made until an average of five or six years after the incident(Attachments 8.) Mr. Mullen also provided a chart illustrating the frequency variations between doctors with prior claims and those without (Attachment 9.)

Chip Wheelan, Kansas Medical Society, appeared in opposition to HB 2543 and provided testimony (Attachment 10) which stated that a mandated experience rating plan will not accomplish its purported objective, but rather penalize physicians in high risk specialties by raising premiums which are already outrageously high. Mr. Wheelan stated that the Medical Society sees no benefit to be gained by this proposal.

Marlin L. Rein
KUMC

Testimony to House Insurance Committee
on Senate Bill 18
March 27, 1989

I appreciate very much the opportunity to appear before you today to discuss the provisions of Senate Bill 18. This bill is the product of an interim study by the Special Committee on Ways and Means/Appropriations relative to Proposal Number 50 concerning the problem being experienced by faculty of the School of Medicine as a result of increasing malpractice insurance costs. A similar bill was introduced a year ago and passed the Senate. However, because the bill passed the Senate late in the session, the House did not give consideration to the proposal. Because of the pressing nature of the problem, the 1988 Legislature authorized a one-time appropriation in the Omnibus Bill of $400,000 to moderate the impact of rising malpractice insurance costs.

The interim committee examined a variety of alternatives for addressing the problem confronting the institution. In the end, the committee came back to the same proposal introduced a year ago. Senate Bill 18 would provide that the basic tier of coverage would be self-insured by the State, with the physicians continuing to be responsible for the surcharge to the Health Care Stabilization Fund. The term "self-insured" is a bit of a misnomer since the State is not setting up reserves but merely assuring that it will fund costs for basic coverage. The procedure set out in the bill is identical to the

program established by the 1985 Legislature for house staff. The bill provides that the administrative responsibility for the program be vested with the Commissioner of Insurance. Any expenditures made by the Commissioner for legal services or payment of claims and settlements would initially be financed from the Health Care Stabilization Fund. In turn, those costs which represent expenditures for basic coverage would be reimbursed to the fund from the State General Fund. When Senate Bill 18 was considered in the Senate, the question was raised as to whether it was wise to establish a program utilizing the Health Care Stabilization Fund as the vehicle for its execution when legislation was under consideration to phase out that fund. We are not particularly concerned about tying the program to a fund that may be legislated out of existence since it is be our view that the Legislature should review this program after several years of experience.

The principal question which this committee and the Legislature has to address is why the State should assume this risk and financial obligation for its physician faculty at the University of Kansas School of Medicine. To make an informed judgment issue requires a general understanding of the typical model of organization found in medical schools across the country. The traditional mode of funding for clinical medical education is built upon a partnership between the School of Medicine and the physician faculty.

An explanation of this relationship is best provided by one who is personally involved, both as an educator and administrator, as well as a caregiver. I would like to have Dr. James Price, Professor and Chairman of the Department of Family Practice share with you his perspective on this issue. At the conclusion of his remarks, we will all stand for questions you may have.

Rein

Attachment 2

Attachment 2

FOUNDATION LOSS RUNS from 7/1/82 to 2/15/89

Foundation	Claims	Lawsuits	Total payments	Closed Suits Claims with no payout	Expenses
Anesthesiology	1	2	two payouts Total: $70,165	6	$17,105
Cardiovascular & Thoracic	0	0	0	0	-0-
Clinical Radiology	0	1	two payouts Total: $15,500	2	6,937
Family Medicine	0	1	four payouts Total: $135,000	3	unknown
Gyn/OB	1	7	six payouts Total: $351,899	20	151,265
Internal Medicine	1	1	seven payouts Total: $235,082	4	75,916
Neurology	0	2	two payouts Total: $212,500	1	41,629
Ophthalmology	0	2	0	0	-0-
Otorhinolaryhngology	0	1	0	1	unknown
Pathology	0	1	0	0	-0-
Pediatrics	0	0	one payout Total: $ 32,000	0	5,444
Psychiatry	0	1	0	3	29,273
Radiation Therapy	1	0	0	1	-0-

Rehabilitation Medicine	0	0	one payout Total: $150,000	0	11,466	
Surgery	1	6	five payouts Total: $41,800	13	226,032	
					$565,066	Total Expenses

Grand Total: $1,268,446.00
paid to plaintiffs

Rein

Professional Liability Insurance Costs
Clinical Foundations, KUMC

Department	1986	1987	1988	1989
Anesthesiology	$345,294	$313,650	$281,237	$341,371
CT Surgery	6,452	24,097	45,111	91,126
ENT	44,368	96,710	47,975	89,499
Family Practice	48,004	50,656	70,942	114,265
Medicine	192,493	226,873	231,225	587,250
Neurology	31,786	38,541	37,018	73,029
Ob/Gyn	232,081	243,590	381,148	625,166
Ophthalmology	12,151	20,052	31,191	61,629
Pathology	58,153	55,427	88,619	107,126
Pediatrics	115,877	97,823	126,100	244,946
Psychiatry	53,050	62,521	72,837	82,142
Radiation Oncology	34,455	50,091	49,443	78,874
Radiology	93,006	163,458	128,753	204,861
Rehab Medicine	18,090	15,946	20,435	38,002
Surgery	422,328	629,068	616,533	893,606
	$1,707,588	$2,088,503	$2,228,567	$3,632,892

NOTE: Some variation in costs may be attributable to vacant faculty positions.

Attachment 3

Rein

HOUSESTAFF MALPRACTICE
1985 SENATE BILL 362

FY 85 actual University expenditures were $814,079. Because funding was inadequate, the foundations paid additional costs. Recollection is that the total was approximately $1,050,000. Since the surcharge was 80 percent, the total was composed of approximately $580,000 for basic coverage and $470,000 surcharge. If one assumes annual increases in the basic premium of 25%, the following cost would nave occured had not the Legislature enacted SB 362.

	FY 86	FY 87	FY 88	FY 89	TOTAL 86-89
Basic	$ 725,000	$ 905,000	$1,130,000	$1,410,000	$4,170,000
Surcharge	797,500	814,500	1,017,000	1,762,500	4,391,500
TOTAL	$1,522,500	$1,719,500	$2,147,000	$3,172,500	$8,561,500

The following has been the cost of self-insuring residents to date.

Basic	$ -	$ -	$ -	$ -	$ -
Surcharge	660,000	$ 540,000	$ 540,000	$ 750,000	$2,490,000

Attachment 4

TESTIMONY TO
HOUSE INSURANCE COMMITTEE
27 MARCH 1989
BY

JAMES G. PRICE, M.D.
PROFESSOR AND CHAIRMAN
DEPARTMENT OF FAMILY PRACTICE
UNIVERSITY OF KANSAS MEDICAL CENTER
KANSAS CITY, KANSAS

I'd like to thank the committee for the opportunity of appearing here today and expressing some thoughts concerning the costs of malpractice insurance. Since I am most familiar with the Department of Family Practice, I'll focus my comments on it, while suggesting to you that the same forces exist in the other clinical departments.

As a Chairman of a Clinical Department, my job, in addition to overseeing the educational efforts, is to try to direct our business affairs is such a way that we make ends meet. This includes setting patient fees, watching the billing, hiring and firing, and keeping expenditures less than income. Paying the bill for faculty malpractice insurance is included in these duties, and this has been quite difficult. Since FY 83 the annual premium for each of our clinical faculty has gone from $1047 to $15,010--an increase of over 14 times ! This money has come out of those funds which were earned by our physicians by providing care. It's from this same pool that other expenses including faculty salaries must come, and it's obvious that if we spend too much for one type of expense, we'll likely have problems meeting the other expenses. Before going further, I think that some explanation of where faculty salaries come

from may help in explaining the relationship of the Foundations and state funding.

Traditionally, faculty salaries come from two sources-- from the state and from patient fees. The State pays for faculty educational efforts, and the corporate structures of each department bill the patients for physician services and supply the other portion of the faculty salaries These corporate structures, most of which are non-profit Foundations, exist in each clinical department and tend to the "business" side of physician medical practice. More about them in a minute..

A delicate balance must be maintained between these two sources of faculty salary. For example, if I am excessively dependent on patient fees for my income, I may slight my teaching responsibilities in favor of providing care to a greater volume of patients. There is no question but that excellence in teaching takes time that might otherwise be utilized for patient care. On the other hand, if I'm totally paid by the state, I am in danger of losing the incentive to build up the clinical practice volume needed for teaching and for hospital support. It's important that I be kept a little "hungry", but not so hungry that I forego the main reason that I'm in a University setting---and that's to teach.

Several years ago, the Legislature, cognizant of the need to maintain this balance, mandated that the State support of Faculty salary (with minor exceptions) should not exceed 38 percent, with the remainder of the physician income to arise from the departmental corporations which bill the patients for physician

services. The total of these two salary segments was then and is still annually set by the top Medical Center administrators.

At present, the State is supplying slightly over 31 percent of faculty salaries, with the remainder coming from the department foundations. In addition to 69 percent of the salaries, these foundations are responsible for a wide variety of other expenses involved in their outpatient clinic operations, such as support personnel salaries, computer expenses, business supply expenses, etc. and they are bearing an increasingly large portion of some educational costs such as faculty and resident recruitment, many housestaff training expenses, faculty educational travel, reference books, meeting registration, housestaff recruitment, etc. Recruitment of new faculty is made most difficult when the "going market rate" at any level has increased at a rate beyond that of state funds for recruitment purposes.

Compounding the problem of Foundation financial stability is the increasing volume of patients who simply cannot pay for health care, and who just miss being eligible for one or another type of governmental assistance. In one department, this exceeds 40 percent of the patient volume. Another factor is the widespread reduction of reimbursement levels for services, especially by governmental third party payors. The superficial answer might seem to be for us to work faster and longer and see more patients ; the other side of this coin would be for us to spend less time teaching and to produce fewer or less well trained physicians. Obviously this is unacceptable.

The most serious--and rapidly increasing--threat to the financial viability of the Foundations is the cost of faculty malpractice insurance. In the past, this expense has been borne by the Foundations, but the dollar costs of this insurance coverage have escalated to the level where the foundations simply can't afford them.

Let me give you an example that is painfully familiar to me. Most of you--like most of us--are deeply concerned about the availability of quality obstetrical care in the rural areas of Kansas. Our state University Medical Center is unique nationally, in that in addition to being a tertiary care center where the most sophisticated procedures can be done, it's also a center where Family Physicians can be trained. But continuing to provide this latter training is a problem. To teach fledgling family doctors to deliver babies, I have to have Family Physician faculty teaching them and they have to be insured. Today, the annual tab for each of our malpractice insurance policies is $15,010 with another premium increase expected in July. It is this same premium level which accounts for the doctors out in the state electing to quit delivering babies--they tell me there's no way to deliver enough babies to cover the premium.

Remember-the premium is the same if I deliver 1 or 100 babies a year--its doesn't change any if I spend half my time teaching medical students instead of being in the delivery room, and it doesn't decrease if I spend almost all my time in administrative activities. These costs have created an interesting change for older physicians. It used to be possible for a senior physician to wind down--to gradually phase out of full-time medical practice-but that's no longer

true. When you stop going full speed, you can't afford to continue to pay the premiums still being charged if you are functioning at half or quarter speed--so you have to stop completely, and the services of another .3,.4, or .5 FTE practicing physician are lost.

In summary, the departmental foundations and KUMC as a school, a hospital and an institution are totally interdependent. One can't be healthy while the others are ailing because of this mutual dependence. If the Foundations exhaust their resources in order to pay liability premiums, the Faculty will lose the impetus to teach, the ability to recruit to fill vacancies, the ability to spend needed time with students and very possibly the desire to remain in a teaching institution.

Senate Bill 18 is an attempt to address the financial problem of the foundations which are being financially ruined by liability premiums. The Bill recognizes that it isn't possible to conduct a full time medical practice and be a full time teacher of medical students.

A couple of figures which may interest you--In FY 86--the Foundations paid out 1.7 million dollars in premiums for liability insurance. In FY 89, they paid 3.7 million for this same purpose, although the faculty size had decreased in the interim. Some foundations are now unable to continue to support this expense, and the remainder are rapidly reaching that point. It is our hope that the legislature will address this issue by passage of Senate Bill 18. We will be pleased to answer any questions that you might have.

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612 • (913) 235-2383
Kansas WATS 800-332-0156 FAX 913-235-5114

March 27, 1989

TO: House Insurance Committee

FROM: Kansas Medical Society Chip Wheelen

SUBJECT: Senate Bill 18; Self Insurance of KUMC Faculty

Thank you for this opportunity to express our endorsement of the University of Kansas' proposal to self insure the basic layer of professional liability insurance coverage for full-time physician faculty members. Important features of the proposal include provisions to continue participation in the Health Care Stabilization Fund by paying the annual surcharge and basing the surcharge amount on the rates charged by the Health Care Providers Insurance Availability Plan.

The reason for this proposal is obvious - to improve the University's ability to recruit and retain faculty members. This is a difficult task when Kansas premiums for liability insurance exceed all of the states in the central plains region.

We believe that the quality of future health care in Kansas is affected by the University's ability to recruit and retain qualified faculty members. For this reason, we respectfully request that you recommend SB 18 for passage.

CW:lg

KANSAS BAR ASSOCIATION
A SECOND CENTURY OF SERVICE
1882

HB 2543
House Insurance Committee
March 27, 1989

Mr. Chairman, members of the committee. I am Ron Smith, Legislative Counsel for the Kansas Bar Association.

This legislation is part of the KBA's recently announced Kansas Plan. It creates new public policy that commercial insurance sold to health care providers in Kansas will be experience or "merit" rated. Basically, experience rating is simply that two doctors who otherwise are in the same set of circumstances but one has more paid claims than another, the first will probably pay higher rates. How much higher is up to the insurance companies involved.

I think if you talk to many Kansas physicians you will find that many of them believe they <u>are</u> experience rated. They are not experience rated in Kansas.

With HB 2543, we have an excellent opportunity to make some changes in premium structures for doctors that make sense, do not involve doctors and lawyers being at odds with each other, further reduce premiums for most of the doctors in Kansas, allow the rates to reflect current tort reforms that have been enacted, and to some extent put the doctor in control of his own premium destiny.

As this paper will show, experience rating of physicians <u>can</u> affect affordability of rates just as some tort changes will. Experience rating is a principle of good, sound, fundamental insurance.

<u>Why Experience Rate?</u>

Consider your experience as an insured automobile driver. If you and your neighbor were driving the same car, bought the same coverage, paid roughly the same premium with the same company, and when your neighbor had three accidents in a row and was caught speeding twice the premiums for both of you went up by identical amounts, you and your good driving neighbors would have a fit. Most Kansans understand experience rating and many of them <u>assume</u> doctors are experience rated.

Should the legislature experience rate physicians? I submit the answer to that question is found in the answer to this one: Do doctors want to pay a premium that reflects the risk they individually cause the Kansas medical malpractice system?

Attachment 7

1200 Harrison • P.O. Box 1037 • Topeka, Kansas 66601-1037 • FAX (913) 234-3813 • Telephone (913) 234-5696

If the answer is NO, then you will keep the current system. Doctors with good claims experience will continue to subsidize the others. Many will continue to pay higher rates than are necessary.

If the answer is YES, then this legislature must consider this type of legislation.

Historical Perspective

Historically, it is important to understand that the "tort" system did not set the standards of care and conduct for doctors independently of doctors, out of thin air. Doctors testifying as expert witnesses in medical malpractice cases set their own standards for deviation from the standard of care. Doctors may not agree on the legal meaning of negligence and they uniformly believe awards are too high, but they do understand what kind of physician activity in the treatment of disease or trauma is acceptable medical practice and what is not.

The tort system does two things with these doctor-created standards. It compensates some losses for those who have received substandard care and been damaged. And by imposing such economic loss on the negligent, it deters future negligence.

Richard Hite, a senior partner in the Wichita firm of Kahrs Nelson, Fanning Hite and Kellogg, told the House Judiciary Committee in February, 1986, the absence of merit rating in this state for medical malpractice insurance premiums has not allowed the distribution of the economic penalties to work in a manner contemplated by the tort system. Everybody is paying a lot. Some are not paying enough. Mr. Hite said that the KBA supports the adoption of a merit rating system so that "the economic penalties associated with deviating from accepted standards of conduct follow those doctors who have violated the code imposed upon them by their own profession."

That is the most succinct statement I could find of the reasons we should required companies to experience rate physicians.

Previous Legislative Attempts

Experience rating ~~is not new.~~ The Kansas Joint Underwriting Authority, which writes 4% of the primary malpractice insurance coverage in Kansas, experience rates. At last count, New York and Florida have experience rating statutes. There may be other states.

The 1985 and 1986 interim committees on medical malpractice and general insurance reform both commented upon the lack of experience rating and offered suggestions for doing so. The 1985 interim report (APPENDIX "A") states "the unwillingness of insurers to experience rate health care providers also may be a factor in the affordability problem." The report also recommended equalizing surcharges between

the members of the same speciality who have different companies who charge different amounts when both have similar claims experience. Those recommendations were largely ignored.

The 1985 Citizens Committee Task Force on Medical Malpractice that the Insurance Commissioner put together recommended "an experience rating factor be added within classifications to reflect increased risk to the Fund." That is a form of experience rating of the Fund. This citizens committee included doctors, lawyers, business professionals and insurance company representatives, as well as the Commissioner's staff. The 1986 legislature passed such a law. The 1987 legislature repealed it.

Florida

I've also included part of a lengthy report from the Florida Academic Task Force for Review of the Insurance and Tort Systems. This 1987 study says that St. Paul's method of classifying risks basically, (1) divides physicians by medical specialty and surgical activity; and (2) imposes geographic differentials. There is no differential for number of surgical procedures performed per year, nor any adjustment for paid claims. As the report concluded,

> "the absence of experience rating leaves the Florida market without any price incentives in place for the person best able to control losses -- the physician."

Experience rating, in the words of this report, is a form of "external discipline placed on the doctor" by the tort and insurance systems.

Consequently, the Florida Tort Reform and Insurance Act of 1986 created a new statute, §627.6058 which requires that rates reflect the number of surgical procedures performed each year by individual health care providers as well as their claims experience. Three companies, the largest being CNA, write insurance in Florida. It is similar to HB 2543.

Opposition to Experience Rating

Insurance companies that insure doctors and work closely with doctors on loss and expense allocation are in a unique position to work closely with their insureds in creating an experience rating system. Many times we've been told that Kansas has more data on malpractice losses because of the presence of the Fund. Then we should put that data to work for our doctor's premiums.

The companies told past interim committees that they don't want to experience rate physicians because it is a breach of trust and good faith with the relationship with the doctor, makes communication difficult and encumbers the defense of the insured. Doctors opposed the merit rating because they might have a negative impact on the "unity" of the profession.

Well, the simple fact is Kansans can no longer afford such cozy relationships. Physicians and the business community, which includes the insurance industry, are wanting you to discard the Kansas Bill of Rights through a constitutional amendment in order to hopefully provide premium relief sometime before the turn of the century. Before we're asked to give up those kind of rights and when we know premium savings can be had for some by experience rating, this law should pass.

Second, allowing insurance companies to get chummy with their insureds is costing doctors with good claims experience higher premiums than they can afford.

Third, the minute there is a claim or two filed against a doctor, this relationship of trust between doctor and insurance company disappears. The doctor gets his pink slip. These doctors have to buy insurance from the JUA which, oddly, experience rates the 700 doctors insured by them.

Fourth, the idea that all doctors must sink or swim together in this sea of insurance is bogus.

As of July 1, 1989 if HB 2501 passes, doctors can choose different levels of coverage. The surgeon that chooses $300,000 of coverage is not going to be subsidizing the surgeon who chooses $1 million even if their claims experience is similar.

As of July 1, 1994, doctors no longer must buy insurance, so how can all doctors be in the same lifeboat, sinking or swimming together? How then will the specialists be subsidized by general practice doctors?

I hope physicians and rural Kansas understands that the sink or swim together philosophy works well for the high risk doctors living in metropolitan areas who have been sued numerous times. They're getting insurance they ordinarily could purchase at any price from the commercial system.

Medically-speaking there is a bond between general practice doctors and high risk specialists. But the idea of extending that bond to insurance systems has had a 13-year track record in Kansas, and it hasn't worked to hold down premiums. After the Fund is phased out, ~~that bonding~~ argument is no longer true -- from the insurance buying perspective.

What HB 2543 Does -- And Does Not -- Do

This bill is not an onerous burden. This requires as a matter of public policy that the commercial companies who write medical malpractice insurance experience rate their insureds. This means they charge more money for people who've had claims and indemnity paid than others without such claims or indemnity in the same rate class. How much more money is the company's discretion.

1. Each company establishes its own rating factors. The companies already use some form of what is called, generically, "risk classification." The actuaries know that a surgeon is more likely to get sued than general practice doctor doing no surgery. They assign a differential that will mean the surgeon pays a higher base premium. All the companies have to do is assign additional risk factors to these classifications based on paid claims and loss experience and they have complied with this bill.

2. The fact that St. Paul's merit rating system may be different than Medical Protective's plan is a consequence of free enterprise. The experience rating plans do not need to be identical to meet the requirements of HB 2543.

3. The company establishes its own trigger for the paid claims surcharge. For example, the multi-state captive legal malpractice insurance company that Kansas is part of, Attorney Liability Protection Society, is experience rated. Any two claims, or any single claim, where the aggregate indemnity paid is $10,000 or less, there is no higher surcharge for these claims. Defense costs in those claims do not count toward the $10,000, so they could be unlimited. ALPS' experience rating system is premised on the idea that everyone is human and is going to make a mistake, so they build in a claims surcharge into the rating structure. This company's rates are competitive with St. Paul in Kansas and helped stabilize our recent annual premium growth cycle.

4. Our insurance brokers who handle ALPS also handle medical malpractice brokering. They are insurance professionals. They tell us they have no doubt the large medical malpractice companies have the database, the expertise and the ability to experience rate physicians.

5. HB 2543 does not require actuarial work by the Commissioner's office. It maintains its role as the insurance regulator. The Insurance Department simply decides as part of the ordinary rate filing review process of these very small numbers of companies whether to approve the policy and whether the policy meets standards imposed by HB 2543. Further, the commissioner can rely on the actuaries of the company in terms of the mathematics of the rate filing. It doesn't necessarily require the Commissioner to hire his own independent actuary.

6. Medical Malpractice is not a field that mom and pop insurance companies get into. There will be very few rate filings for the commissioner to review in this arena. We're dealing with big companies: Medical Protective, CIGNA and St. Paul. They are large Fortune 1000 companies with a firm footing in the medical malpractice insurance industry, they have excellent Best averages which means they are solvent, and will be around for a long time.

Which Database?

Subsection (c) of this bill says if the commissioner of insurance deems Kansas claims experience is insufficient to make accurate rate adjustments based on Kansas actuarial information, the commissioner may approve using larger data bases of claims experience so long as the rating system carries out the intent of (a) and (b). Regional factors could be used, or nationwide data, at the commissioner's election. Nothing in HB 2543 requires the experience rating system be tied solely to Kansas data. This bill realizes that individual company books of business in Kansas might not be sufficient to make sound experience rating decisions solely on Kansas loss experience. Alternative data bases are certainly available.

Risk Exposure

Subsection (d) has the companies determine whether differences in premiums can be based on the number of surgeries and obstetrics services performed. Again, the risk exposure system is established by the company and approved by the commissioner. The bill makes no assumptions. In fact, this bill says if the company can convince the commissioner that a surgeon who does ten surgeries a year is more likely to be negligent than the surgeon who does two hundred surgeries a year, then the commissioner may approve higher rates for the low-frequency physician. The only thing this section does is prevent the company from making a presumption that low-frequency surgeons are more or equally risky than high-frequency surgeons without providing supportive data. Again, national data can be used.

Amendment for Group Practices

Under current law, in a group practice, one doctor with several paid claims artificially raises the rates paid by all doctors in the group. Most group practices have the same specialties in them. Without HB 2543, the group's sole recourse is to ask the offending physician in the group to leave the group practice.

KBA suggests that the bill require experience rating be made on an individualized basis within a group of doctors. Since the term "health care provider" also includes the professional corporation of a group of doctors, it would be unfair to allow the claims experience of one doctor in the group to artificially increase the entire group's individual premiums. It gives the insurer a free surcharge on doctors in the group with good claims experience. We suggest an amendment in line 33 after the period by inserting,

> "If a single company issues a policy or contract for each of the health care providers who practice as part of a group of health care providers, whether by use of a professional corporation, partnership or other group practice, such policy or contract shall experience rate such providers on the basis of

paid claims or losses experienced by each individual provider in the group practice."

Impact on Kansas Medical Society Mutual Company

There might be concern that the bill would adversely affect the new mutual company that Kansas physicians and hospitals are putting together. You authorized that company last year. The actuaries that help create the KMS/KHA mutual are the same situation as the actuaries that helped the Bar Association design ALPS. They must use existing databases and the rating structure of existing companies in the market. As a practical matter, it may elect to use the same experience rating and physician premium classes that St. Paul uses until it gets loss experience of its own. The impact of this bill on the new company is minimal.

Impact on the Fund

The beauty of having the commercial companies do the work is that commercial experience rating automatically experience rates the Fund's surcharge, thus providing more equity in surcharging of the Fund. The appendixes show that during 1985 and 1986, several legislative interim studies recommended experience rating in the Fund itself. HB 2543 automatically accomplishes that. Doctors who represent a higher risk of exceeding primary insurance coverage and "getting into" Fund coverage also would pay a higher surcharge.

Conclusion

HB 2543 is legislation whose time is come. It will provide lower premiums for some and higher premiums for others. It serves the fundamental principle of insurance: those who are the higher risks of liability pay more than those who are not. The Companies and the Commissioner can work out any inequities it might cause. KBA asks for your favorable approval of HB 2543.

ropolitan Life Ins. Co., App. 1 Dist., 454 So.2d 711 (1984).

627.6057. Medical malpractice insurers; required offer of coverage limits

An insurer issuing policies of professional liability coverage for claims arising out of the rendering of, or the failure to render, medical care or services shall make available to physicians licensed under chapter 458 and to osteopathic physicians licensed under chapter 459 coverage with the following limits, subject to usual underwriting standards:

(1) One hundred thousand dollars per claim, $300,000 annual aggregate; and

(2) Two hundred fifty thousand dollars per claim, $750,000 annual aggregate.

Added by Laws 1986, c. 86–160, § 46, eff. July 1, 1986.

Repeal

Laws 1987, c. 87–50, § 2, provides that this section and § 627.6058, relating to medical malpractice insurance, are repealed on October 1, 1992, and shall be reviewed by the Legislature prior thereto pursuant to § 11.61, the Regulatory Sunset Act.

627.6058. Rating classifications for medical malpractice insurance

(1) Any rates, rating schedules, or rating manuals filed with the department for liability coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall provide rating classifications for policyholders based on the following factors:

(a) For an individual physician or osteopath, the number of surgical procedures performed annually; and

(b) For an individual health care provider or health care facility, the number and severity of indemnities resulting from claims of medical malpractice against such health care provider or facility.

(2) This section shall not preclude the use of other rating classifications approved by the department pursuant to the other requirements of this part.

Laws 1986, c. 86–160, § 45, eff. July 1, 1986.

Repeal

For repeal of this section, see the italicized note following § 627.6057.

627.616. Legal actions

Notes of Decisions

In general ½

½. In general

Arbitration clause of life policy applicable to claim for disability benefits did not violate §§ 627.616 and 627.659 granting disability insureds the right of access to the courts, in view of exclusion under § 627.601 for supplemental coverages incidental to life policy. Hall v. Metropolitan Life Ins. Co., App. 1 Dist., 454 So.2d 711 (1984).

627.6375. Contracts for alternative rates of payment

(1) An insurer or group of insurers may negotiate and enter into contracts for alternative rates of payment with licensed health care providers. An insurer may, by agreement with insureds, limit payments under policies to such alternative rates, regardless of the providers chosen by the insureds, and offer the benefit of such alternative rates to insureds who select such providers.

(2) The insurer or group of insurers shall provide each policyholder with a current roster of health care providers under contract to provide services at alternative rates

care providers from 1976 when the Fund was created to January 31, 1985.

TABLE I

NUMBER OF CLAIMS AGAINST PROVIDERS

Number of Providers	Number of Claims
1,444	1
152	2
56	3 (8 hospitals, 5 P.A.s, 2 D.O.s, 41 M.D.s)
16	4 (7 hospitals, 3 P.A.s, 1 D.O., 1 D.P.M., 4 M.D.s)
7	5 (1 hospital, 2 P.A.s., 4 M.D.s)
3	6 (1 hospital, 1 P.A., 1 M.D.)
1	7 (1 D.O)
12	More than 7 (10 hospitals, 1 P.A., 1 M.D.)
1,691	TOTAL CLAIMS

(These figures include claims against defined "inactives" who are no longer rendering professional care in Kansas.)

Note: Professional Associations (P.A.s), Doctors of Osteopathic Medicine (D.O.s), Medical Doctors (M.D.s), and Doctor of Podiatry Medicine (D.P.M.).

Source: Kansas Insurance Department

advocated tying the post judgment interest rate to the treasury bill rate.

Other Reforms Discussed. A representative of the Western Insurance Companies and several others supported legislation to "tighten up" jury instructions regarding the standard of care through statutory provisions. An argument made is that the current Pattern Instructions for Kansas (PIK) are too broad, lead to confusion, and facilitate a finding of negligence. Representatives of the Kansas Bar Association and several district judges pointed out that PIK instructions can be and often are supplemented by jury instructions tailored for a particular case, that the PIK instructions are based on case law and that this area is properly the province of the judiciary and not the Legislature.

The Kansas Medical Society advocated the sunset provision of Sub. for S.B. 110 be repealed.

Various other reforms were also discussed before the Committee.

Insurance Issues

The following reflects the testimony and discussion of various insurance issues raised before the Committee.

Insurance Experience Rating by Primary Carriers. Representatives of the Kansas Bar and some Committee members suggested that the claims and loss experience of individual practitioners should be taken into account in setting their premium rates, especially since this is the practice in the case of other professions, including attorneys. Currently, the Joint Underwriting Association (JUA) uses individual provider claim and loss experience as a factor in its determination of physician insurance costs. New York recently mandated insurance experience rating of physicians.

Advocates said that 1 percent of the physicians in Kansas account for a much larger percent of the paid claims and that without experience rating, health care providers with

good records unduly subsidize the rest. Advocates noted under the current system a type of experience rating occurs since rates of the Medical Protective Company, which writes insurance on a selective basis and is one of the major malpractice insurers, are significantly lower than rates of St. Paul Fire and Marine, another of the major insurers, and that the JUA Plan base rates are generally 20 percent higher than St. Paul's rates. The JUA does experience rate providers as noted above.

Several insurers testified that merit rating of physicians would create a breach of trust and good faith in the insurer-insured relationship, making communication difficult and encumbering the defense of the insured. The medical community opposed merit rating because it was feared this would have a negative effect on the sense of unity and solidarity of the medical profession. It was also argued that number of claims may not correlate directly with competence since certain high risk specialties are more subject to lawsuits.

Experience Rating by the Health Care Stabilization Fund. Both the Kansas Trial Lawyers Association and the Citizens Committee recommended that level rate classifications for health care provider specialties be implemented and that an experience rating factor be added within classifications to reflect increased risk to the Fund. The level rate classification concept was proposed due to the fact that Fund surcharges now are based on a percent of the primary carrier's premium amount. Doctors of the same specialty, however, pay different insurance rates. For example, a doctor practicing obstetrics and gynecology under 1985 rates will pay $11,970 for base coverage if insured by Medical Protective but $20,052 if insured by St. Paul and $24,062 if insured by the JUA Plan. When the 110 percent premium surcharge is added, the total premium costs will vary from $25,137 for Medical Protective insureds to $50,530 for JUA Plan insureds. In this example, it is possible that none of the doctors have ever had a claim filed against them.

Reduction in Amount of Fund or Excess Coverage. Both the Kansas Bar Association and the Kansas Trial Lawyers Association advocated reducing the liability of the Health

nsurers nationally and internationally have had an impact on all types of liability insurance.

The Committee believes that the unwillingness of insurers to experience rate health care providers also may be a factor in the affordability problem. In addition, the current method of funding the Health Care Stabilization Fund on the basis of a percentage of the insured's primary coverage premium has had the effect of increasing costs to certain high risk specialties.

The Committee believes that medical negligence does exist and that the powers of the Board of Healing Arts are not adequate to insure timely removal or limitation of negligent practitioners of the healing arts. Additionally, the Committee believes that health care institutions should accept responsibility for reducing the risk of negligence in patient care through the development of risk management programs. The members believe that all health care provider regulatory agencies should receive information relating to actions filed against those providers whose practice they regulate.

The Committee believes that the current method of imposing surcharges for the Health Care Stabilization Fund is inequitable and should be changed to impose these surcharges at the same rate, with provision for a higher rate when loss experience justifies such treatment.

The Committee notes that licensees in medicine and surgery are now required to pay medical malpractice premiums and surcharges as individuals and, additionally, must pay these costs for professional associations they may belong to (albeit at a reduced rate). The Committee believes this dual coverage requirement is not necessary to protect the public welfare and is aggravating a problem that already exists with high insurance costs.

For these reasons the Committee is making a number of recommendations with the following broad objectives in mind: stabilize medical malpractice premium costs; deter negligent practice and improve the quality of health care; assure consumer access to needed care; control health care costs;

Expert witnesses are required to have devoted at least 50 percent of their professional time to clinical practice in the past two years in order to qualify as expert witnesses.

Attorney fees for either party must be approved at an evidentiary hearing at which the judge must determine the reasonableness of the fees based upon eight factors, which now appear in the lawyer canon of ethics regarding fees.

Health Care Stabilization Fund. The excess coverage exposure for the Fund would be reduced to $1 million per claim with an annual aggregate of $3 million per health care provider.

The method for computing Fund surcharges is amended to require health care providers within the same rate classification to pay the same surcharge; however, health care providers with poor loss experience will be required to pay higher rates.

The Fund coverage for inactive health care providers is amended. After July 1, 1986, inactive health care providers must have paid surcharges for at least three consecutive years in order to qualify for continued coverage. If they do not qualify for coverage they must show proof of equivalent insurance.

Other Insurance Changes. The bill requires partnerships of persons who are health care providers to obtain the mandatory insurance coverages so that vicarious liability of one health care provider for another may be abolished if both are covered by the Fund. Further, insurers may exclude from coverage liability for those health care providers already required to maintain professional liability insurance.

Health Care Providers — Reporting. Insurers providing professional liability insurance would be required to report within 30 days any written or oral claims for medical malpractice to the appropriate state licensing agency and the State Department of Insurance. The reports shall be confidential and not admissible in civil or criminal trials nor in administrative proceedings, except in administrative licensure

of data about the size and frequency of awards for pain and suffering; and a lack of information about other nonpecuniary damage items.

Another conclusion of the Committee is that insurers typically do not rely only on Kansas experience to determine their rates for property and casualty lines. As a result, whatever changes Kansas chooses to make in its own tort system will not have a direct or immediate impact on rates paid by Kansans. Further, the Committee notes that Kansas has already adopted many of the most significant tort reform measures advocated by insurers and others at the national level. For example, Kansas has a comparative fault law, a law regulating frivolous lawsuits, and a tort claims act capping state and local government liability at $500,000 and prohibiting punitive damage awards against governmental entities. In spite of these laws, Kansas professionals, businesses, and municipalities are faced with an insurance crisis.

No conferee could document what beneficial effect these changes have already had on insurance premiums nor would any conferee assure the Committee additional changes in the tort system would have a direct effect of lowering or stabilizing liability insurance rates paid by Kansans. In particular, the Committee notes that the Insurance Services Office, Inc. will not consider tort reform measures in any of its new rate filings.

The Committee does recognize the difficulty insurers may have in calculating the direct and immediate effect on premiums that legislative changes to the tort system may have because the impact of the laws would be subject to time delays due to court challenges and court interpretations of legislative intent.

The Committee does believe changes are needed in both our tort system and in our insurance regulatory scheme. The recommendations the Committee is making are based on the realization that they likely will not have any direct impact on rates. The Committee feels, however, the changes it is suggesting are justified and advisable, based on their own merits.

ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS

PRELIMINARY FACT-FINDING

REPORT ON MEDICAL MALPRACTICE

August 14, 1987

D. Risk Classification System

A problem which contributes to the rate of premium increase is the risk classification system used in medical malpractice liability insurance. The existing classification system has served a purpose up to this point, but the level of loss payments in certain specialties may have become too large in relation to the number of physicians available to pay for the losses. Stated differently, there may be insufficient spreading of the risk of loss among certain high-risk specialties.

In addition to the risk classes being too small in certain cases, the risk classification system does not appear to provide adequate market based incentives to avoid losses nor does it seem to measure accurately individual exposures to loss. Consequently, physicians with widely differing loss experience and exposure are placed in the same risk pool and charged the same price, even though their expected loss payments are significantly different.

1. Description of Risk Classification

Medical malpractice liability insurance is a financing mechanism by which the cost of administering, determining liability, measuring loss and paying the claim is spread over a group of individuals or organizations. Risk classification is the process by which actuaries analyze this cost and, in conjunction with senior management of the company, determine how to allocate claims costs to groups of risks - in this case physicians. On the basis of some factor or factors, premium

addition, the risk classification system did not allocate specifically a portion of the claims costs to the group that generated them.

Task Force shows that increases in both factors have been responsible for the increase in medical malpractice insurance rates. However, the rate of increase in average cost per paid claim substantially exceeds the growth in frequency. Stated differently, more generous verdicts and higher insurance company settlements have contributed more to Florida's increased medical malpractice loss payments than has increased litigiousness or increased claims consciousness on the part of Florida's population.

3. Physicians with Multiple Claims

At the Task Force's public hearing in Miami on February 6, 1987 the question was raised whether a few doctors generated a disproportionate amount of claims and thereby became a major cause of the malpractice problem. It was suggested that there would be no medical malpractice crisis if there were no "bad" doctors but the latter term was left undefined by the witnesses. There are a number of reasons why a physician with multiple claims should not be considered a "bad" doctor. Multiple claims could occur because a physician is practicing in a high risk specialty or a high risk area of the state. In addition, some physicians may be more willing to treat high risk patients for which unfavorable results are to be expected more frequently.

The Task Force has analyzed the number of physicians with two or more claims and, without characterizing such physicians as "bad" doctors, found that of the approximately one-half billion dollars paid to claimants and their attorneys during the period

1975 to 1986, almost one-half was accounted for by physicians with two or more paid claims.

These facts have important implications for controlling the frequency of claims. If a substantial amount of paid claims is due to physicians with multiple paid claims, then it raises the question of what means were in place to review or regulate the quality of medical care practiced by such physicians. Two types of external discipline are possible. One is a market based type of discipline such as experience rating which would surcharge physicians who generate excessive amounts of claims. The other is non-market based regulation or peer review such as would be conducted by the Department of Professional Regulation, the Florida Medical Society or a county medical society.

Until the state recently imposed a requirement for experience rating, no market based incentives existed for physicians insured in the standard market (ie. physicians that were not in the Florida Medical Malpractice Joint Underwriting Association). The Department of Professional Regulation has disciplined a number of physicians, but it is unknown what proportion of them were disciplined because they incurred one or more malpractice insurance claims. We have no evidence as to discipline of physicians with multiple claims by the Florida Medical Association and local medical societies.

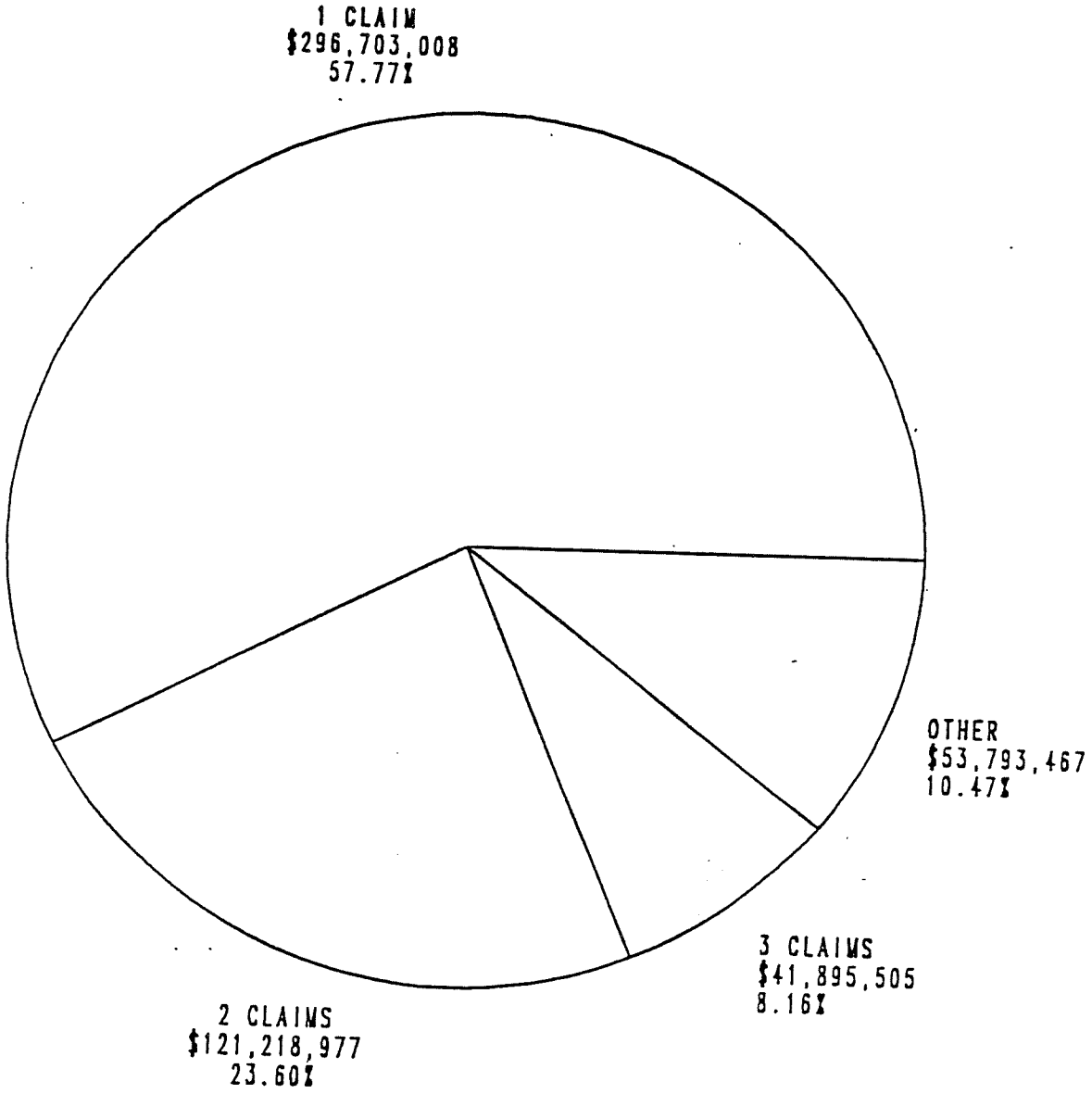
TABLE 35
MULTILPLE CLAIM ANALYSIS OF
MEDICAL MALPRACTICE CLOSED CLAIMS IN FLORIDA
1975 - 1986

NUMBER OF NON-ZERO CLAIMS PER PHYSICIAN/SURGEON FREQUENCY	NUMBER OF PHYSICIANS	NUMBER OF CLAIMS	PERCENT OF CLAIMS	CUMULATIVE PERCENT OF CLAIMS	TOTAL INDEMNITY AMOUNT	PERCENT OF INDEMNITY	CUMULATIVE PERCENT OF INDEMNITY
1	3,229	3,229	78.8330	78.8330	$296,703,008	57.7680	57.7680
2	588	1,176	14.3555	93.1885	$121,218,977	23.6013	81.3694
3	164	492	4.0039	97.1924	$41,895,505	8.1571	89.5264
4	53	212	1.2939	98.4863	$19,009,391	3.7011	93.2275
5	38	190	0.9277	99.4141	$17,519,203	3.4110	96.6385
6	12	72	0.2930	99.7070	$5,333,256	1.0384	97.6769
7	3	21	0.0732	99.7803	$5,147,520	1.0022	98.6791
8	2	16	0.0488	99.8291	$1,517,650	0.2955	98.9746
9	3	27	0.0732	99.9023	$3,328,868	0.6481	99.6228
10	1	10	0.0244	99.9268	$175,000	0.0341	99.6568
11	1	11	0.0244	99.9512	$315,761	0.0615	99.7183
13	1	13	0.0244	99.9756	$379,835	0.0740	99.7923
34	1	34	0.0244	100.0000	$1,066,983	0.2077	100.0000
TOTALS	4,096	5,503	.	.	$513,610,957	.	.

SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET

FIGURE 8

MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA ACCORDING TO THE NUMBER OF PAID CLAIMS PER PHYSICIAN 1975 - 1986



FIGURES ARE NOT ADJUSTED FOR INFLATION
SOURCE: TABLE 35

differentials between the groups will then be determined. Once this has been accomplished, the insurer will request approval to use the risk classification plan and its indicated premiums from the Florida Department of Insurance.

2. Purpose of Risk Classification

In making these cost allocations, an attempt is made to group together individuals of similar loss propensity so as to produce a system which is fair and equitable as well as cost effective. In other words, the insurer must try to choose risk classification variables which measure as accurately as possible the likelihood of loss but which also are cost effective to collect and are not subject to manipulation by actual or potential insured's. For example, carrying out a surgical procedure is more likely to produce a claim than is a routine annual physical examination.

3. Risk Classification Variables

The class plan used by the St. Paul Fire and Marine Insurance Company was reviewed by the Task Force and it shows a division of physicians according to medical specialty and surgical activity. Also included are classifications for active military personnel, full-time federal government employees, and retired physicians. The state is also divided into two territories for rate-making purposes. Dade and Broward counties are one territory and the rest of the State is the other territory. No specific factors are included for the physician's level of activity, i.e. number of patients seen per year or the

number of surgical procedures performed per year, nor is there any price adjustment based upon the number and amount of claims incurred by the physician.[1]

4. Number of Practicing Physicians

A total of 25,566 Florida non-federal physicians (i.e., not employed in the military, V.A. hospitals, or in any other capacity by the federal government) were registered with the American Medical Association in 1985 (1986 data was not available at the time of writing). Of this total, 4,271 physicians were classified as inactive, 1,472 were in medical teaching, administration, research or other professional activity and 821 were not classified. Consequently, the AMA reported that in 1985 a total of 20,002 physicians were involved in patient care in Florida as their major professional activity and this figure is presented in Table 21. Comparable figures for previous years are also reported.

Number of Physicians By Specialty. The number of physicians whose major professional activity is patient care is reported for a number of specialties in Table 21. As noted above, medical malpractice liability insurance is rated by specialty so the figures shown in Table 21 represent the financing base for paid and reserved claims and expenses in the state. In some cases, e.g., surgery, the base is even smaller because the risk classes are further subdivided according to the riskiness of the surgical procedures performed.

TABLE 21
NUMBER OF PRACTICING PHYSICIANS IN FLORIDA

SPECIALTY	CALENDAR YEAR OF CLOSING											
	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	N	N	N	N	N	N	N	N	N	N	N	N
ANESTHESIOLOGY	437	469	579	590	642	705	726	818	897	.	1,005	.
GENERAL PRACTICE	1,767	1,986	2,167	2,239	2,414	2,641	2,497	2,800	2,696	.	3,009	.
GENERAL SURGERY	1,057	1,068	1,162	1,154	1,218	1,267	1,276	1,361	1,422	.	1,516	.
INTERNAL MEDICINE	1,478	1,618	1,868	1,830	2,050	2,138	2,231	2,438	2,534	.	2,921	.
NEUROLOGY & NEUROSURGERY	231	246	283	298	331	357	370	419	446	.	488	.
OBSTETRICS & GYNECOLOGY	791	816	915	934	995	1,060	1,101	1,182	1,249	.	1,354	.
ORTHOPEDICS	479	501	560	574	624	662	673	722	758	.	821	.
OTORHINOLARYNGOLOGY	216	217	259	265	277	290	274	296	315	.	325	.
ALL SPECIALTIES	10,930	11,600	13,163	13,584	14,498	15,486	15,979	17,105	18,101	.	20,002	.

1984 AND 1986 DATA ARE NOT AVAILABLE
SOURCE: AMERICAN MEDICAL ASSOCIATION

Losses Have Increased Faster Than The Number Of Physicians. In certain areas claims paid have grown much faster than the number of physicians available to finance the losses. For example, in the earlier years of 1975, 1976 and 1977 total paid claims in the OB/GYN category amounted to $595,266, $900,335 and $1,497,881 respectively. In comparison, for the later years 1984, 1985 and 1986, paid claims were $17,423,465, $18,394,761 and $14,677,155 respectively. The average total paid has gone from about $1 million in the mid-seventies to $16.8 million in the mid-eighties (this represents a compound growth rate of 32.7 percent per year). During this same time period, the number of OB/GYN physicians in the state has increased from an average of 840 in 1975-1977 to 1354 in 1985, which is a growth rate of 4.9 percent per year.[2]

5. Rate Relativity by Specialty

The difference in rates between certain specialties within a rating territory will be examined in this part of the report. The analysis will show that, for the sample risk classes examined, the relativities for the three major medical malpractice insurance carriers in the State are quite similar. Second, all three organizations, the spread in rates between the high and low risk classes has increased.

Table 22 shows the relationship between the premiums for three high risk groups and the premium for a low risk category. The first entry in the table (6.33 for 1983) means that the rate for an orthopedic physician in Dade/Broward was 6.33 times

TABLE 22.
Selected Medical Malpractice Rate Relatives: Florida

	Dade/Broward				
Orthopedics to: Family Physicians-No Surgery	1983	1984	1985	1986	1987
Florida Physicians Insurance Co.	6.33	6.33	6.72	6.72	7.03
Physicians Protective Trust	6.15	6.33	6.72	6.72	7.03
St. Paul Fire and Marine	6.37	6.55	6.65	6.67	6.69
Obstetrics to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	7.28	7.28	8.40	8.40	8.79
Physicians Protective Trust	6.13	5.78	6.68	6.83	7.34
St. Paul Fire and Marine	7.41	7.63	8.29	8.33	8.34
General Surgery to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	5.08	5.08	5.04	5.04	5.27
Physicians Protective Trust	6.13	5.78	6.68	6.83	7.34
St. Paul Fire and Marine	5.32	5.46	4.99	5.01	5.02
	Rest of State				
Orthopedics to: Family Physicians-No Surgery	1983	1984	1985	1986	1987
Florida Physicians Insurance Co.	6.15	6.33	6.72	6.72	7.03
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	6.32	6.48	6.59	6.62	6.65
Obstetrics to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	7.08	7.28	8.40	8.40	8.79
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	7.36	7.55	8.22	8.26	8.31
General Surgery to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	4.94	5.08	5.04	5.04	5.27
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	5.28	5.41	4.95	4.97	5.00

Note: The rates used by St.Paul Fire and Marine are as follows: 10/1-/83, 9/1/84, 7/1/85, 12/31/85, 7/1/87. The effective dates for rates by Florida Physicians Insurance Company and Physicians Protective Trust Fund are January 1 of the respective year.
Calculations use rates for mature claims - made coverage for $1,000,000 limit of liability per occurance and $3,000,000 annual aggregate. FPIC has rates 50 percent higher in Palm Beach county than in the rest of the state.

Source: Bureau of Rates.

greater than the rate for a family physician performing no surgery in Dade/Broward. The second entry in the same column shows that the Physicians Protective Trust Fund (PPTF) was charging orthopedists a rate which was 6.15 times higher while St. Paul's rate was 6.37 times higher, i.e., there was very little difference in the relationships between the rates. This does not necessarily mean the actual premiums were almost the same, since the base price for each of the three companies could be, and usually was, different.

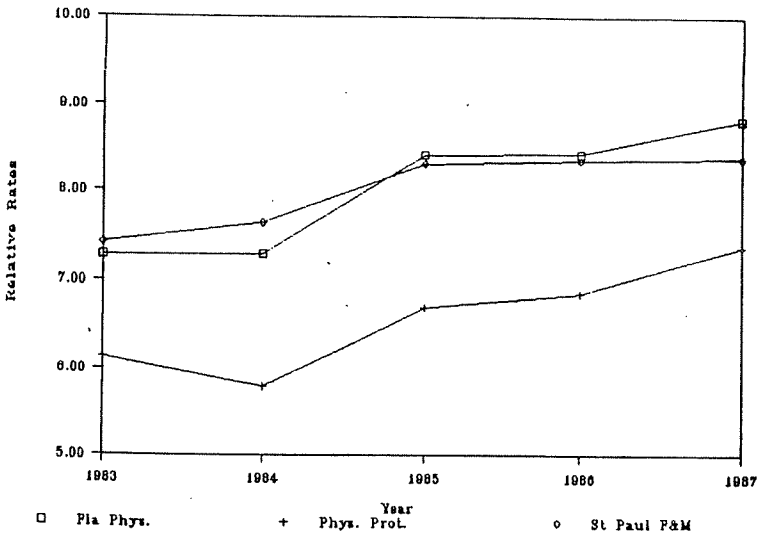
Figure 3 shows how the relationship between obstetrics rates and family physicians rates has changed, i.e., the spread between the rates has increased from 1983 to 1987. Florida Physicians Insurance Company (FPIC) was charging 8.79 times more (as of 1/1/87) compared to 7.28 times more in 1983. The important point here is that the multiple has increased for all companies. This may by relevant, because some proposed reforms would involve changing the differential between high and low risk classes. For example, one Department of Insurance proposal called for a maximum rate which was no more than 5 times greater than the lowest rate. While the data here show that such a proposal could produce rate reductions for high risk specialties, the Task Force has not assessed potential offsetting costs and disadvantages of such a proposal.

6. Rate Relativities Within Florida

This section concerns premium variations among different parts of the state and shows that the rate spread for physicians in Dade/Broward has increased relative to the rest of the State.

FIGURE 3.

Obstetrics Premium Divided by Family Physician-No Surgery Premium for Dade/Broward Counties



Source: Table 22

The first entry in Table 23 means that FPIC charged family physicians in Dade/Broward 41 percent more than they charged family physicians in the rest of the state. By July 1, 1987 they were charging twice as much in Dade/Broward as in the rest of the state. PPTF increased its differential by 25 percentage points during the same time period, while St. Paul held off making a change until July 1, 1987 when it increased the differential by 50 percentage points. These changes are graphed in Figure 4.

7. Summary

This section has been concerned with the factors used to categorize physicians into risk classes and also with the size of the resulting risk classes. It was found that paid losses have increased substantially faster than the number of physicians available to pay them, leading to an inexorable rise in premiums. In addition, it was found that the extra amount charged high risk specialties compared to low risk groups has increased as has the surcharge for Dade/Broward physicians compared to the rest of the State. While the closed claim data indicate that the surcharges are justified, they have contributed to the premium increases for the affected groups.

It was also noted that the risk classification plans in use during the time period studied made no specific provision for experience rating, i.e., there were no specific surcharges for those physicians who had paid claims. Thus, during the time period studied, there were no market price incentives in place for the person best able to control losses (the physician). In

Table 23.
Territorial Rate Differences in Florida
For Selected Medical Specialties*
Dade/Broward Compared to Rest of State

	1983	1984	1985	1986	1987
Family Physicians-No Surgery					
Florida Physicians Insurance Co.	1.41	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.47	1.50	1.50	1.50
St. Paul Fire and Marine	1.49	1.48	1.48	1.49	1.97
General Surgery					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99
Orthopedics					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99
Obstetrics					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99

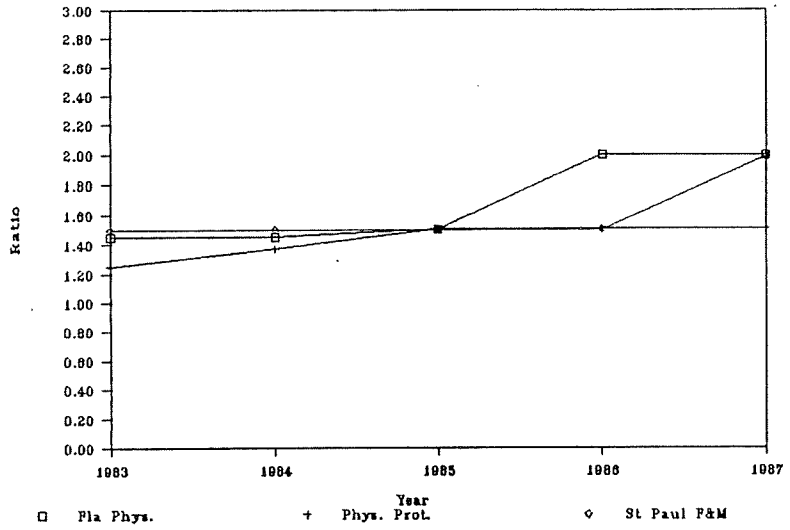
* Note: The rates used by St.Paul Fire and Marine are as follows: 10/1-/83, 9/1/84, 7/1/85, 12/31/85, 7/1/87. The effective dates for rates by Florida Physicians Insurance Company and Physicians Protective Trust Fund are January 1 of the respective year.

Calculations use rates for mature claims - made coverage for $1,000,000 limit of liability per occurance and $3,000,000 annual aggregate. FPIC has rates 50 percent higher in Palm Beach county than in the rest of the state.

Source: Bureau of Rates.

FIGURE 4.

Obstetrics Premiums in Dade/Broward Compared to
Obstetrics Premiums in the Rest of the State



Source: Table 23

Mike Miller

Attachment 8

EXPERIENCE RATING

1. If an experience rating charge is based on dollars paid to a claimant, then the charge cannot be made until an average of five or six years after the incident.

   a. The lawsuit will have been on file an average of two years before resolution.

   b. The suit will not be filed until two or three years after the incident, on the average, and may possibly not be known for more than ten years after the incident.

2. Even if the experience rating charge is based on a loss reserve at a particular amount, several years will still elapse until the surcharge could be assessed, on the average. This assumes that a substantive evaluation can be made by one year after the filing of the claim.

3. Another alternative is to impose an experience surcharge at the time a lawsuit is filed. The rationale in this instance is not the seriousness or validity of the claim, but the mere fact that a suit was filed. A number of years ago, The Medical Protective Company investigated the prospective insurance risks of those who had recently had lawsuits filed against them as against those who had not. It appeared that doctors with one or more claims in their immediate past were more apt to have a claim filed against them. Thus, the frequency risk differential indicated the appropriateness of such a surcharge. This is a matter of rating the insurance exposure and experience, not the level of malpractice involved nor the validity of the legal claim.

4. Experience rating hinders claim resolution.

   a. Since professional reputations, as well as dollars, are at stake in a professional liability lawsuit, attention must be paid to the desires of the policyholder, even if the policyholder's consent is not required under state statutes.

   b. If a settlement triggers an experience surcharge, the doctor will not be anxious to have the claim resolved to the doctor's financial detriment.

c. If the trigger of the surcharge is the filing of the lawsuit, doctors may be loathe to report claims, and this can be detrimental to the interests of all parties, and would likely cause an eventual increase in cost.

5. Individuals rated up for experience:

   a. May have retired, died, moved, changed insurers before the claim was filed, or before it is resolved.

   b. May opt to shift to another insurance carrier if faced by a surcharge from the first.

   c. May decide this is the time to go completely bare.

6. Effective claim defense requires close cooperation between insureds and insurers. The threat of experience rating surcharges places these parties into adversarial positions which translate into aid to claimants and increased premiums.

7. Experience rating tends to be counter-selective. "Good" risks with a chargeable claim will take a walk. "Bad" risks won't risk going elsewhere.

Mike Mullen.

EXPERIENCE RATING

A review of elements which impact on the concept of merit rating or experience rating for professional liability insurance for physicians.

1. Payment based experience rating surcharge not timely made related to incident.
   a. delay in resolution
   b. delay in filing

2. Reserve based experience rating surcharge also delayed by rime required to evaluate.

3. Basing surcharge on fact of suit filing does not address merits of cases.

4. Experience rating can hinder claim resolution.

5. Surcharging may be fruitless.

6. Experience rating impedes cooperation between doctor and insurer.

7. Expensive rating can result in adverse risk selection.

The enclosed charts illustrate the **frequency** variation—thereby prospective insurance risk—between doctors with prior claims and those without prior claims.

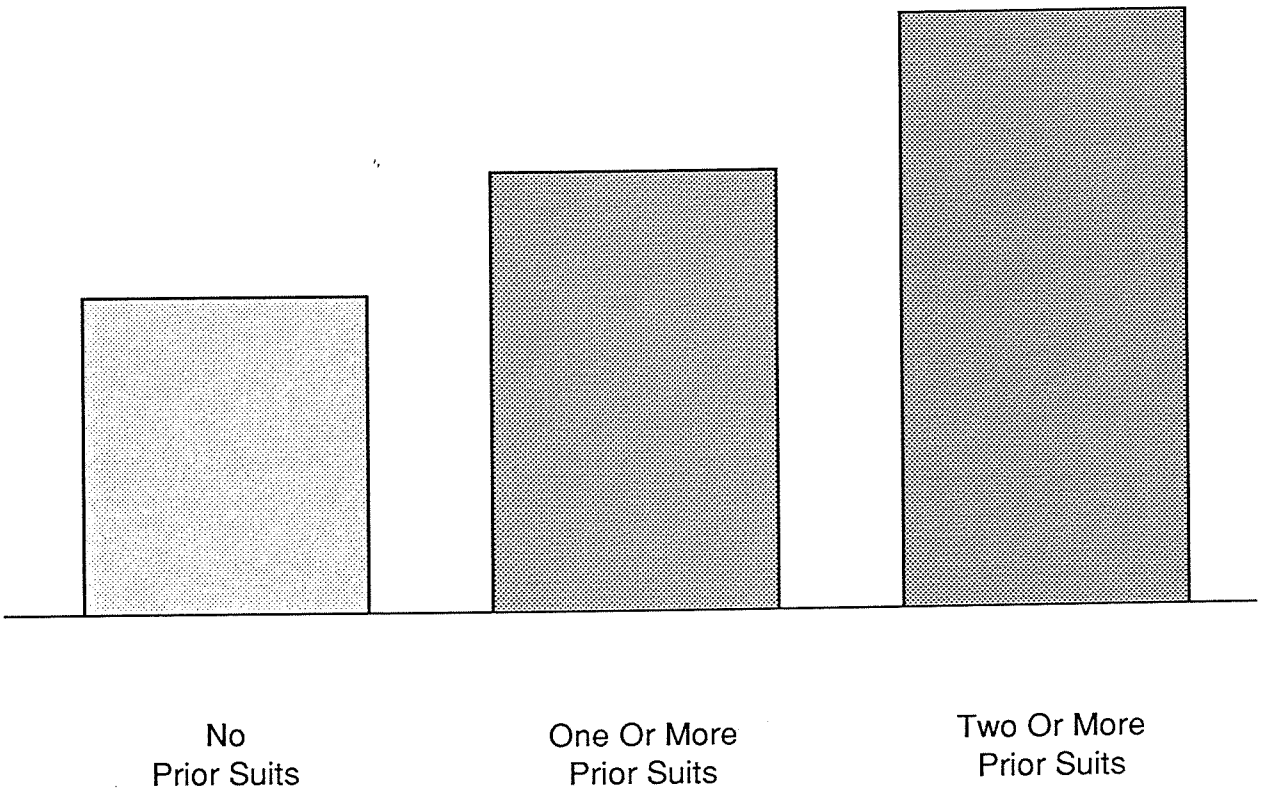
CLAIMS EXPERIENCE COMPARISON

MICHIGAN

BASE PERIOD OF FIVE YEARS

Frequency :

No prior suits:	.1001
One or more prior suits:	.1352
Two or more prior suits:	.1711



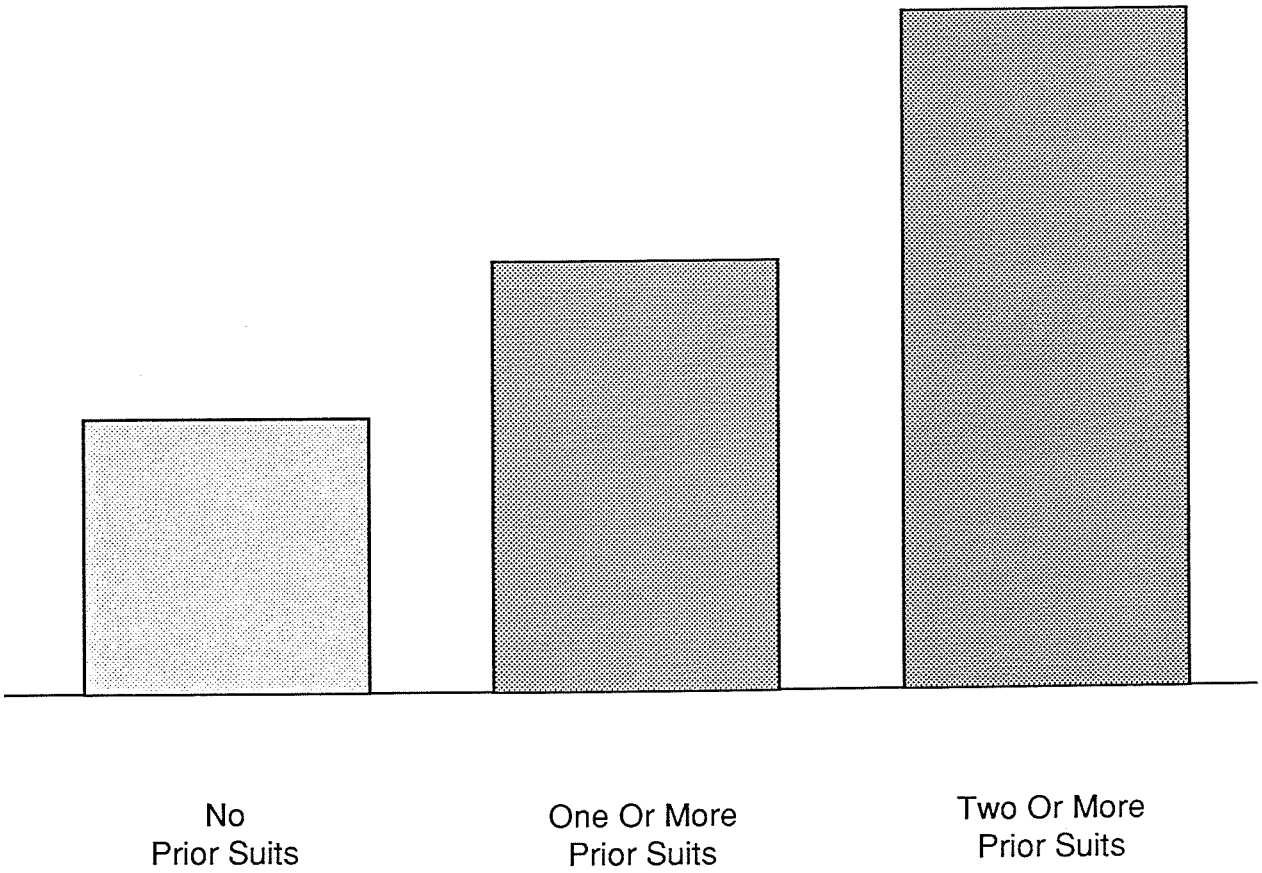
CLAIMS EXPERIENCE COMPARISON

OHIO

BASE PERIOD OF FIVE YEARS

Frequency :

No prior suits:	.0870
One or more prior suits:	.1316
Two or more prior suits:	.2143



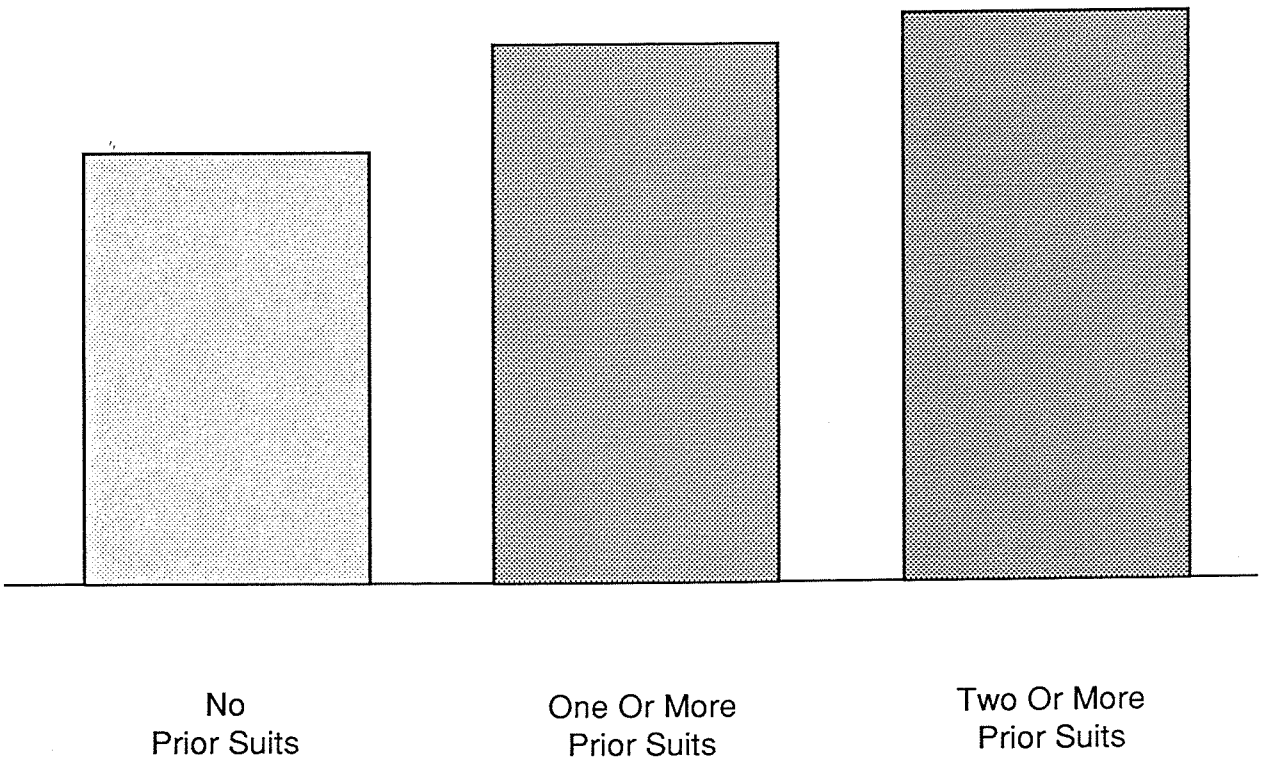
CLAIMS EXPERIENCE COMPARISON

TEXAS

BASE PERIOD OF FIVE YEARS

Frequency :

No prior suits:	.1345
One or more prior suits:	.1806
Two or more prior suits:	.1951



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March 27, 1989

TO: House Insurance Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: HB 2543; Concerning Experience Rating Professional Liability Insurance

The Kansas Medical Society appreciates the opportunity to offer the following comments about HB 2543, a bill which would require professional liability insurance companies to establish experience rating programs for insuring health care providers. KMS opposes HB 2543, for the reasons set forth in this testimony.

On the surface, the concept of experience rating sounds good: make physicians who generate more claims and losses than their colleagues pay higher insurance costs, ostensibly to encourage them to alter their behavior. Experience rating is a concept borrowed principally from automobile insurance which is intended to adjust the costs of insurance to the frequency and severity of claims. It is an attempt at equitable apportionment of the overall costs of insuring a group, whether they be automobile drivers or others.

However, does this concept work for medicine? The proponents of this concept, principally lawyers groups, have been telling the Legislature for years that "the trouble with malpractice is malpractice" and "get rid of the bad doctors and the problem will go away." This notion that the malpractice problem is rooted in "bad" physicians, is simply not supported by the data and experience. Our own 13 year experiment with a state-administered insurance company, the Health Care Stabilization Fund, shows that malpractice claim repeaters represent just a small fraction of all insured physicians.

Malpractice claims against particular physicians cannot be predicted with any certainty. They are more accurately characterized as random events, than as the predictable results of an individual physician's capability. Malpractice claims happen to conscientious, careful physicians in all specialties, but tend to happen more frequently to physicians in the highest risk specialties. In fact, an experience rating system based on claim payouts and numbers of procedures performed will merely punish those in the highest risk practices, the very physicians who already pay higher premiums in the first place. For example, about two-thirds of the obstetricians in our state have been sued, and almost half of those have been sued more than once. That doesn't mean that those physicians are "substandard" at all, nor does it mean they are not careful and com-

petent specialists. It means that they practice in a specialty, which because of its high risk, generates lots of claims. To punish these people simply on the basis of the number of claims filed against them would be grossly unfair, and would drive these physicians out of our state, at a time when we can sorely afford to lose them.

An additional problem with experience rating is that it will probably increase overall insurance costs as more physicians insist on trying claims to a verdict in an effort to keep their record from being marred by a paid claim. Currently, insurance companies settle claims of nuisance value, because it is more economical to pay a small claim, than incur defense costs which may run into tens of thousands of dollars to prove a physician was not negligent in the care he or she rendered.

Despite what lawyers believe, experience rating would provide little useful incentive to change physician behavior. In our state, a claimant has four years after the alleged incident of medical malpractice to file a claim, and then it usually takes two to three more years before the claim is resolved. Any experience rating plan would be based on claims which occurred many years earlier. As is often the case, physicians who have substantial numbers of claims against them usually leave practice or the state by the time the claims start showing up. The experience rating plan would be of no benefit in those instances.

The screening of outcomes and occurrences in hospitals pursuant to existing quality assurance and risk management programs offers the best way to correct any perceived quality of care problems. Kansas was among the first states to implement a comprehensive peer review and quality assurance network.

Finally, the number of physicians with multiple claims is too small to allow meaningful and reasonable experience rating. For this reason, medical malpractice insurance can be distinguished from other lines of insurance, such as automobile, where a substantial volume of claims makes experience rating more appropriate.

A mandated experience rating plan will not accomplish its purported objective. It will, however, penalize physicians in high risk specialties by raising premiums which are already outrageously high. We can see no benefit to be gained from this proposal, and urge that you report HB 2543 adversely. Thank you for the opportunity to offer these comments.

JS:nb