

ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672  
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**ADMINISTRATIVE SERVICES:**

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**MICA** Medical Indemnity  
Corporation of Alaska  
ALEUT PLAZA OFFICE BUILDING  
4000 OLD SEWARD HIGHWAY, SUITE 203  
ANCHORAGE, ALASKA 99503  
TELEPHONE (907) 563-3414

**1990**

**Physician's and Surgeon's  
Professional Liability Coverages and Premium Schedules**

## PROFESSIONAL LIABILITY COVERAGES

### Explanation of Policy:

The Claims-Made Policy extends professional liability protection to the physician, clinic or employee for claims reported in a single year, regardless of when service is rendered as long as the incident occurred while continuously insured under Claims-Made with MICA. Thus, claims reported this year are covered by this year's policy; claims reported next year by next year's policy and so on.

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19% of the total claims resulting from professional services are reported; the second 39%; the third 78%; the fourth 93%; the fifth and subsequent years, about 100%.

### Cost:

In keeping with the "stair step" development of claims, the rates charged for the Claims-Made policy mature at the fifth year. Subsequent renewal policies are charged at the mature rates. The specific cost of coverage is shown within our table entitled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

### Limits of Liability:

MICA's professional and optional comprehensive general liability coverages are available with policy limits of:

\$200,000 per occurrence/\$600,000  
aggregate per calendar year.  
\$500,000 per occurrence/\$1,000,000  
aggregate per calendar year.  
\$1,000,000 per occurrence/\$2,000,000  
aggregate per calendar year.  
\$1,000,000 per occurrence/\$3,000,000  
aggregate per calendar year.

### Reporting Endorsement (Tail Coverage) \*

Should you stop practicing or change to another insurance company, MICA guarantees availability of a limited or Unlimited Reporting Endorsement known as "tail" coverage to cover subsequently reported claims. Tail coverage must be purchased by the insured within 30 days of termination of coverage, (by cancellation or non-renewal) or by termination of employment or association with the physicians insured under a master group policy.

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplished by charging "tail" premium on a pro-rata basis as between the two specialty classes when the policy is ultimately terminated.

### Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

\* The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.

The tail premium is quoted as a one time cost but may be paid in installments. Refer to paragraph INSTALLMENTS.

#### Retirement Benefit:

An Unlimited Reporting Endorsement (tail coverage) will be issued at no extra cost to any physician who has attained the age and years in the MICA program (as per the schedule below) and having completed five consecutive years as a MICA insured just prior to retirement:\*\*

Age	Years as MICA Insured
60	5
59	6
58	7
57	8
56	9
55	10

\*\* Retirement is defined as totally ceasing the private practice of medicine. A limited or parttime practice is not considered retirement.

#### Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent total disability, i.e., unable to continue the practice of medicine in any limited or modified capacity.

#### New Doctor Rule:

For physicians entering private practice for the first time following completion of medical school, residency training, military or public health service, premiums will be discounted 25 % for the first year of coverage.

#### Claims Free Premium Discount:

A 20 % premium discount will be provided to our insured physicians for a five year claims free history. This policyholder benefit will be provided upon renewal following the completion of the fifth year in which a claims free record has been demonstrated.

#### Claims Experience Premium Surcharges:

Claims experience premium surcharges may be imposed upon insureds with two or more claims in

the last three years in which some elements of negligence or other contributing adverse factors are involved.

#### Employee Coverages:

Unlike many policies, most employees are provided coverage under the MICA policy.

Employee premium charges are limited to: (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician); (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

#### Locum Tenens:

MICA provides up to 60 days of coverage annually for a temporary substitute physician - locum tenens - for surgical and non-surgical specialties. Completion of application and prior approval of MICA is required.

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve the customary premium charges for short-term practice situations (see next paragraph)

A negative factor in considering the acceptability of a locum tenens physician is the lack of current or recent professional liability insurance coverage on the applicant. This lack precludes verification of prior claims experience and other elements of insurability.

#### Short Term Practice Situations:

Pro-rated amount of annual premium computed on short rate tables subject to \$250 minimum premium.

### Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

### Comprehensive General Liability Coverages:

This optional coverage is available at \$50 per physician covered, subject to the same limits of liability carried for professional liability. This coverage extends to bodily injury and property damage liability protection for those injuries accidentally sustained on the office premises by patients or the general public.

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

### Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide negligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

### Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability		
# Doctors on Policy	\$500,000	\$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

### Installments - Deferred Payments:

Initial policy issuance subject to deposit of \$1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

## PHYSICIAN'S RATE CLASSIFICATIONS

### Class 0

Psychiatry - Excluding ECT  
Pathology

### Class 1

Neurology  
Physicians - no surgery  
Applies to general practitioners and physician specialists who do not perform obstetrical procedures or major / minor surgery (other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or neonate circumcision) who do not ordinarily assist in major surgical procedures.

### Class 1-A

General Practitioners assisting at surgery (own patients only)  
Ophthalmology (excluding Radial Keratotomy)

### Class 2

Physicians - minor surgery or assisting in major surgery\*  
Applies to general practitioners and physician specialists who perform minor surgery or assist in major surgery.  
Neonatology  
Cardiology

### Class 2-A

Emergency Medicine  
Therapeutic Radiology

### Class 2-C

Urology

### Class 3

Physicians - major surgery \*  
Physicians who include obstetrical procedures as any part of their practice.  
Proctology  
Otorhinolaryngology  
Abdominal Surgery  
General Surgery  
Pediatric Surgery  
Thoracic Surgery

Traumatic Surgery

Plastic and Reconstructive Surgery (excluding cosmetic surgery)

Urology

Gynecology (No Obstetrics)

### Class 4

Anesthesiology

### Class 4-A

Physicians - major surgery \*

Obstetrics - Gynecology

Cardiovascular Surgery

Hand Surgery

Plastic and Reconstructive Surgery (including cosmetic surgery)

Vascular Surgery

Orthopedic Surgery (excluding total joint procedures spinal surgery and insertion of prosthetic devices)

### Class 5

Physicians - major surgery\*

Neurosurgery

Orthopedic Surgery (including total joint procedures, spinal surgery and insertion of prosthetic devices)

\*Major Surgery - involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

NOTE: IF A PORTION OF THE PHYSICIANS PRACTICE IS IN A SPECIALITY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE MAY BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

# CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

## LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	\$200,000/\$600,000	\$500,000/\$1,000,000	\$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000 *
<b>CLASS 0</b>				
1st year rates	Jan. 1, 1990	2,924	3,182	3,601
• 2nd year renewal rates	Jan. 1, 1989	3,467	4,026	4,857
• 3rd year renewal rates	Jan. 1, 1988	4,559	5,607	7,119
• 4th year renewal rates	Jan. 1, 1987	5,026	6,271	8,058
• 5th year renewal rates	Jan. 1, 1986	5,177	6,485	8,361
<b>CLASS 1</b>				
1st year rates	Jan. 1, 1990	3,798	4,305	5,067
• 2nd year renewal rates	Jan. 1, 1989	4,828	5,809	7,230
• 3rd year renewal rates	Jan. 1, 1988	6,724	8,497	11,031
• 4th year renewal rates	Jan. 1, 1987	7,517	9,612	12,599
• 5th year renewal rates	Jan. 1, 1986	7,772	9,970	13,103
<b>CLASS 1-A</b>				
1st year rates	Jan. 1, 1990	4,548	5,270	6,326
• 2nd year renewal rates	Jan. 1, 1989	5,997	7,341	9,268
• 3rd year renewal rates	Jan. 1, 1988	8,584	10,980	14,391
• 4th year renewal rates	Jan. 1, 1987	9,657	12,482	16,499
• 5th year renewal rates	Jan. 1, 1986	10,001	12,964	17,176
<b>CLASS 2</b>				
1st year rates	Jan. 1, 1990	5,338	6,286	7,651
• 2nd year renewal rates	Jan. 1, 1989	7,228	8,953	11,414
• 3rd year renewal rates	Jan. 1, 1988	10,542	13,593	17,928
• 4th year renewal rates	Jan. 1, 1987	11,909	15,503	20,605
• 5th year renewal rates	Jan. 1, 1986	12,348	16,116	21,464
<b>CLASS 2-A</b>				
1st year rates	Jan. 1, 1990	7,098	8,556	10,605
• 2nd year renewal rates	Jan. 1, 1989	9,971	12,547	16,196
• 3rd year renewal rates	Jan. 1, 1988	14,905	19,417	25,811
• 4th year renewal rates	Jan. 1, 1987	16,928	22,235	29,755
• 5th year renewal rates	Jan. 1, 1986	17,577	23,139	31,020
<b>CLASS 2-B</b>				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576

\* PREMIUM COST IS 4% ABOVE \$1,000,000/\$2,000,000 LIMITS.

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

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**Physician's and Surgeon's  
Professional Liability Coverages and Premium Schedules**

# **CORRECTION**

**THIS DOCUMENT  
HAS BEEN REPHOTOGRAPHED  
TO ASSURE LEGIBILITY**

# CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

## LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

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•Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

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# CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

## LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	\$200,000/\$600,000	\$500,000/\$1,000,000	\$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000 *
<b>CLASS 2-C</b>				
1st year rates	Jan. 1, 1990	8,294	10,089	12,613
• 2nd year renewal rates	Jan. 1, 1989	11,836	14,991	19,448
• 3rd year renewal rates	Jan. 1, 1988	17,872	23,377	31,171
• 4th year renewal rates	Jan. 1, 1987	20,342	26,813	35,976
• 5th year renewal rates	Jan. 1, 1986	21,133	27,915	37,518
<b>CLASS 3</b>				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,367	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576
<b>CLASS 4</b>				
1st year rates	Jan. 1, 1990	11,218	13,850	17,520
• 2nd year renewal rates	Jan. 1, 1989	16,392	20,960	27,392
• 3rd year renewal rates	Jan. 1, 1988	25,120	33,052	44,266
• 4th year renewal rates	Jan. 1, 1987	28,680	37,997	51,176
• 5th year renewal rates	Jan. 1, 1986	29,821	39,582	53,393
<b>CLASS 4-A</b>				
1st year rates	Jan. 1, 1990	14,140	17,608	22,422
• 2nd year renewal rates	Jan. 1, 1989	20,944	26,926	35,330
• 3rd year renewal rates	Jan. 1, 1988	32,362	42,720	57,351
• 4th year renewal rates	Jan. 1, 1987	37,012	49,172	66,365
• 5th year renewal rates	Jan. 1, 1986	38,502	51,241	69,255
<b>CLASS 5</b>				
1st year rates	Jan. 1, 1990	19,199	24,116	30,914
• 2nd year renewal rates	Jan. 1, 1989	28,829	37,257	49,079
• 3rd year renewal rates	Jan. 1, 1988	44,906	59,463	80,014
• 4th year renewal rates	Jan. 1, 1987	51,443	68,528	92,670
• 5th year renewal rates	Jan. 1, 1986	53,536	71,433	96,729

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### Cost:

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### Reporting Endorsement (Tail Coverage) \*

Should you stop practicing or change to another insurance company, MICA guarantees availability of a limited or Unlimited Reporting Endorsement known as "tail" coverage to cover subsequently reported claims. Tail coverage must be purchased by the insured within 30 days of termination of coverage, (by cancellation or non-renewal) or by termination of employment or association with the physicians insured under a master group policy.

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The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

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#### Retirement Benefit:

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<u>Age</u>	<u>Years as MICA Insured</u>
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#### New Doctor Rule:

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#### Claims Free Premium Discount:

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the last three years in which some elements of negligence or other contributing adverse factors are involved.

#### Employee Coverages:

Unlike many policies, most employees are provided coverage under the MICA policy.

Employee premium charges are limited to: (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician); (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

#### Locum Tenens:

MICA provides up to 60 days of coverage annually for a temporary substitute physician - locum tenens - for surgical and non-surgical specialties. Completion of application and prior approval of MICA is required.

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve the customary premium charges for short-term practice situations (see next paragraph)

A negative factor in considering the acceptability of a locum tenens physician is the lack of current or recent professional liability insurance coverage on the applicant. This lack precludes verification of prior claims experience and other elements of insurability.

#### Short Term Practice Situations:

Pro-rated amount of annual premium computed on short rate tables subject to \$250 minimum premium.

### Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

### Comprehensive General Liability Coverages:

This optional coverage is available at \$50 per physician covered, subject to the same limits of liability carried for professional liability. This coverage extends to bodily injury and property damage liability protection for those injuries accidentally sustained on the office premises by patients or the general public.

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

### Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide negligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

### Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

# Doctors on Policy	Discounts Per Limits of Liability	
	\$500,000	\$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

### Installments - Deferred Payments:

Initial policy issuance subject to deposit of \$1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25%, 25% and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

## PHYSICIAN'S RATE CLASSIFICATIONS

### Class 0

Psychiatry - Excluding ECT  
Pathology

### Class 1

Neurology  
Physicians - no surgery

Applies to general practitioners and physician specialists who do not perform obstetrical procedures or major / minor surgery (other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or neonate circumcision) who do not ordinarily assist in major surgical procedures.

### Class 1-A

General Practitioners assisting at surgery (own patients only)  
Ophthalmology (excluding Radial Keratotomy)

### Class 2

Physicians - minor surgery or assisting in major surgery\*  
Applies to general practitioners and physician specialists who perform minor surgery or assist in major surgery.  
Neonatology  
Cardiology

### Class 2-A

Emergency Medicine  
Therapeutic Radiology

### Class 2-C

Urology

### Class 3

Physicians - major surgery \*  
Physicians who include obstetrical procedures as any part of their practice.  
Proctology  
Otorhinolaryngology  
Abdominal Surgery  
General Surgery  
Pediatric Surgery  
Thoracic Surgery

Traumatic Surgery

Plastic and Reconstructive Surgery (excluding cosmetic surgery)

Urology

Gynecology (No Obstetrics)

### Class 4

Anesthesiology

### Class 4-A

Physicians - major surgery \*

Obstetrics - Gynecology

Cardiovascular Surgery

Hand Surgery

Plastic and Reconstructive Surgery (including cosmetic surgery)

Vascular Surgery

Orthopedic Surgery (excluding total joint procedures spinal surgery and insertion of prosthetic devices)

### Class 5

Physicians - major surgery\*

Neurosurgery

Orthopedic Surgery (including total joint procedures, spinal surgery and insertion of prosthetic devices)

\*Major Surgery - involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

NOTE: IF A PORTION OF THE PHYSICIANS PRACTICE IS IN A SPECIALITY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE MAY BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

# CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

## LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	\$200,000/\$600,000	\$500,000/\$1,000,000	\$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000 *
<b>CLASS 0</b>				
1st year rates	Jan. 1, 1990	2,924	3,182	3,601
• 2nd year renewal rates	Jan. 1, 1989	3,467	4,026	4,857
• 3rd year renewal rates	Jan. 1, 1988	4,559	5,607	7,119
• 4th year renewal rates	Jan. 1, 1987	5,026	6,271	8,058
• 5th year renewal rates	Jan. 1, 1986	5,177	6,485	8,361
<b>CLASS 1</b>				
1st year rates	Jan. 1, 1990	3,798	4,305	5,067
• 2nd year renewal rates	Jan. 1, 1989	4,828	5,809	7,230
• 3rd year renewal rates	Jan. 1, 1988	6,724	8,497	11,031
• 4th year renewal rates	Jan. 1, 1987	7,517	9,612	12,599
• 5th year renewal rates	Jan. 1, 1986	7,772	9,970	13,103
<b>CLASS 1-A</b>				
1st year rates	Jan. 1, 1990	4,548	5,270	6,326
• 2nd year renewal rates	Jan. 1, 1989	5,997	7,341	9,268
• 3rd year renewal rates	Jan. 1, 1988	8,584	10,980	14,391
• 4th year renewal rates	Jan. 1, 1987	9,657	12,482	16,499
• 5th year renewal rates	Jan. 1, 1986	10,001	12,964	17,176
<b>CLASS 2</b>				
1st year rates	Jan. 1, 1990	5,338	6,286	7,651
• 2nd year renewal rates	Jan. 1, 1989	7,228	8,953	11,414
• 3rd year renewal rates	Jan. 1, 1988	10,542	13,593	17,928
• 4th year renewal rates	Jan. 1, 1987	11,909	15,503	20,605
• 5th year renewal rates	Jan. 1, 1986	12,348	16,116	21,464
<b>CLASS 2-A</b>				
1st year rates	Jan. 1, 1990	7,098	8,550	10,605
• 2nd year renewal rates	Jan. 1, 1989	9,971	12,547	16,196
• 3rd year renewal rates	Jan. 1, 1988	14,905	19,417	25,811
• 4th year renewal rates	Jan. 1, 1987	16,928	22,235	29,755
• 5th year renewal rates	Jan. 1, 1986	17,577	23,139	31,020
<b>CLASS 2-B</b>				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576

\* PREMIUM COST IS 4% ABOVE \$1,000,000/\$2,000,000 LIMITS.

Claims made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

• Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

• All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy.

# CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

## LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	<u>1st - 5th Years</u>	<u>\$200,000/\$600,000</u>	<u>\$500,000/\$1,000,000</u>	<u>\$1,000,000/\$2,000,000</u> <u>\$1,000,000/\$3,000,000 *</u>
<b>CLASS 2-C</b>				
1st year rates	Jan. 1, 1990	8,294	10,089	12,613
• 2nd year renewal rates	Jan. 1, 1989	11,836	14,991	19,448
• 3rd year renewal rates	Jan. 1, 1988	17,872	23,377	31,171
• 4th year renewal rates	Jan. 1, 1987	20,342	27,813	35,976
• 5th year renewal rates	Jan. 1, 1986	21,133	27,915	37,518
<b>CLASS 3</b>				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576
<b>CLASS 4</b>				
1st year rates	Jan. 1, 1990	11,210	13,850	17,520
• 2nd year renewal rates	Jan. 1, 1989	16,392	20,960	27,392
• 3rd year renewal rates	Jan. 1, 1988	25,120	33,052	44,266
• 4th year renewal rates	Jan. 1, 1987	28,680	37,997	51,176
• 5th year renewal rates	Jan. 1, 1986	29,821	39,582	53,393
<b>CLASS 4-A</b>				
1st year rates	Jan. 1, 1990	14,140	17,608	22,422
• 2nd year renewal rates	Jan. 1, 1989	20,944	26,926	35,330
• 3rd year renewal rates	Jan. 1, 1988	32,362	42,720	57,351
• 4th year renewal rates	Jan. 1, 1987	37,012	49,172	66,365
• 5th year renewal rates	Jan. 1, 1986	38,502	51,241	69,255
<b>CLASS 5</b>				
1st year rates	Jan. 1, 1990	19,199	24,116	30,914
• 2nd year renewal rates	Jan. 1, 1989	28,829	37,257	49,079
• 3rd year renewal rates	Jan. 1, 1988	44,906	59,463	80,014
• 4th year renewal rates	Jan. 1, 1987	51,443	68,528	92,670
• 5th year renewal rates	Jan. 1, 1986	53,536	71,433	96,729

\* PREMIUM COST IS 4% ABOVE \$1,000,000/\$2,000,000 LIMITS.

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

• Retrospective dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

• All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy.

<u>RATE CHANGES</u>	<u>M.D.</u>	<u>HOSPITAL</u>
1981	+ 2.5%	- 6.0%
1982	+ 5.0%	+ 5.0%
1983	- 6.5%	+20.0%
1984	+ 7.5%	+ 7.5%
1985	+15.0% *	+15.0%
1986	+90.0% **	+107.0%
1987	+25.0%	+42.0%
1988	+23.0%	0%
1989	0%	0%
1990	- 8.0%	- 5.0%

\* Some specialties had class change providing larger increases:  
Examples:

Family Practice doing O.B. + 86% (Changed to Class 2B)  
Emergency Medicine + 66% (Changed to Class 2A)

\*\* Increase for IM/2M limits were greater (approximately 125%)

April 19, 1989

Mary Pierce, Executive Director  
Medical Indemnity Corporation of Alaska  
Aleut Plaza Office Building  
4000 Old Seward Highway, Suite 203  
Anchorage, Alaska 99503

Dear Ms. Pierce:

The State of Alaska Division of Public Health recently conducted a survey of the OB-GYN's and family practice physicians in Alaska in order to determine the effects of the current medical malpractice atmosphere on their decision whether to continue practicing obstetrics. In compiling a report on the survey results, I would very much like to include information from your organization concerning actual claims. I feel this information would contribute greatly to a balanced analysis of the medical malpractice situation in Alaska.

I have spoken with Jan Johnston, who gave me background information on MICA and helped me to refine my data request. My hope is that this information can be accessed relatively easily via computer. Please disregard any parts of this request that would require a major effort on the part of your staff. If a substantial amount of this information already exists in the form of an annual report or other prepared report, I will gladly accept a copy of these documents in lieu of a special computer run. Ideally, I'd like to complete my report by the end of April.

My questions are the following:

1. How many obstetrics-related claims has your agency processed each year from 1980 through 1988? Include both formal claims and filed suits in this total. I am interested in the year the incident was reported rather than the year of its occurrence, and would like to know what percentage of each year's claims resulted in a settlement with the claimant (do not include those which were successfully defended).
2. What is MICA's average settlement cost (as well as the median and the mode, if available) for obstetrics claims for each year from 1980 through 1988? If possible, I would like averages for both the amount paid to the claimant and the total expenses of the agency, including those cases in which the claimant receives nothing. If you normally categorize obstetrics claims in some way (such as by diagnostic categories), I am interested in knowing the average settlement amount for each type of claim.
3. How many physicians are insured by MICA for obstetrics practice in 1989, and how many of those currently insured have ever had a claim filed against them during the time they were insured by your agency?

4. For the years 1980 through 1988, what percentage of the physicians you insured each year had claims filed against them during that year?

Thank you very much for your assistance. If you have questions about this request or about the survey, please call me at 465-3100. I will be sure to send you a copy of the report on the medical malpractice survey as soon as it is completed.

Sincerely,

*MaryAnn VandeCastle*

MaryAnn VandeCastle  
Health Planner

State of Alaska Dept. of Health & Social Services  
Division of Public Health  
Section of Maternal, Child, and Family Health  
Box H-06B  
Juneau, AK 99811

FAX #: 586-1877

**MICA** Medical Indemnity  
Corporation of Alaska

ALEUT PLAZA  
4000 OLD SEWARD HWY., SUITE 203  
ANCHORAGE, ALASKA 99503  
(907) 563-3414

May 3, 1989

State of Alaska Department of  
Health & Social Services  
Division of Public Health  
Section of Maternal, Child, and Family Health  
Box H-06B  
Juneau, Alaska 99811

ATTN: Mary Ann VandeCastle  
Health Planner

RE: Survey of OB/GYN's and Family Practitioners doing O.B.

Dear Ms. VandeCastle:

This will serve as a response to your letter of 4/19/89.

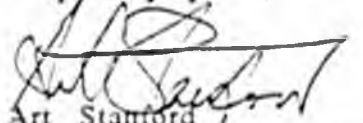
As I indicated in our telephone conversation MICA has only recently computerized its policyholder data and also as a result of changing specialty designations, it is virtually impossible to accurately pick up prior year figures on the number of insureds actually doing obstetrics except by manually going through each policy file.

However, in 1988 MICA insured 15 OB/GYN's and 53 Family Practitioners doing obstetrics but in 1989, about one third of the OB/GYN's dropped their insurance and are now going "bare".

I understand that our Claims Manager, Jan Johnston, has responded under separate cover to the remainder of your inquiry regarding obstetrically related claims or suits filed against these specialties.

Please let me know if MICA can be of further assistance.

Very truly yours,

  
Art Stamford  
Underwriting Manager

AS/tmb/SADHS.5/3

**MICA** Medical Indemnity  
Corporation of Alaska

ALBION PLAZA  
400 OLD SEWARD HWY., SUITE 203  
ANCHORAGE, ALASKA 99503  
(907) 563-1414

April 27, 1989

MaryAnn VandeCastle  
Health Planner  
State of Alaska Department of Health and Social Services  
Division of Public Health  
Section and Maternal, Child, and Family Health  
Box H-06B  
Juneau, AK. 99811

Dear Ms. VandeCastle:

Mary Pierce has asked me to respond to your letter of April 19th. I am the Claims Manager at MICA and am the individual you spoke with at some length prior to submitting your written request to Ms. Pierce.

Items number three and four are presently being addressed by our Underwriting Department. Underwriting Manager, Art Stanford will probably send you a separate letter. Alternatively he may give his information to me and I will send it to you in a follow-up letter. At any rate, I have some information pulled together for you and didn't want to delay in getting it off since I realize you're working under some deadlines.

Attached, you will find a computer summary of all obstetrical claims "processed" between 1/1/80 and 12/31/88. For purposes of this study I presumed that any file closed prior to 1/1/80 was something not processed in the time frame in which you expressed an interest.

The computer sort provided lists only closed obstetrical files.

Column One: Indicates whether the claim is against a physician or hospital insured by MICA.

Column Two: I have obliterated the claim numbers for our own security purposes and because I don't think that you need them for purposes of your analysis.

Medical Indemnity Corporation of Alaska

MaryAnn VandeCastle  
April 27, 1989  
Page 2 of 4

- Column Three: Severity Code. 5 = case in litigation 4 = formal claim against the insureds' policy.
- Column Four: C = closed files and P = pending files.
- Column Five: Date of occurrence is the date on which the care in question was rendered.
- Column Six: Date of report is the date our insured reported the situation to MICA.
- Column Seven: Date closed equals the date our file was closed in this office.
- Column Eight: Indicates the total reserve change for indemnity over the life of the file.
- Column Nine: Indicates the total reserve change for loss adjustment expense over the life of the file.
- Column Ten: Indicates the actual indemnity payment to the patient, if any.
- Column Eleven: Indicates the final LAE (Loss Adjustment Expense) over the life of the file.

As you can see, referencing formal suits only, seven of the seventeen closed files resulted in no payment to the patient. Ten of the seventeen did result in an indemnity payment to the patient. Since you did not ask me to separate out whether the indemnity payment was a result of a voluntary settlement or a court judgment, I have not done so. You did not ask, but I thought you might be interested in knowing, that out of those seventeen closed lawsuits three involved Board Certified OB/GYN specialists; nine involved family practitioners doing obstetrics; and five involved hospitals. In every instance where a hospital was a co-defendant in an obstetrical suit there was also a physician co-defendant. The physicians were not always insured by MICA and sometimes were not insured at all.

MaryAnn VandeCastle  
April 27, 1989  
Page 3 of 4

Turning to the formal claims (severity code four) you will note that six of the fourteen concluded with no payment to the patient while eight resulted in an indemnity payment to the patient. You can assume that every case of payment was a voluntary settlement since the case was not in suit. One case involved the hospital; the other thirteen involved physicians. The thirteen physician claims were broken down as follows. Five were against OB/GYN specialists. Six were against family practitioners doing obstetrics. One was against an emergency room physician. One was against an Anesthesiologist.

There are three formal claims pending involving obstetrical matters that are not on the printout. These are all physician directed claims and all involve OB/GYN specialists.

After reviewing the information that you have requested in item one and two of your letter, I have decided it might be both easier and faster to provide you with the raw data and allow you to rearrange the numbers to suit your needs. I hope that meets with your approval.

You will note that I have not provided you with statistical data regarding the mean, mode, or average. The reason for this is twofold. First, the data base is not large enough to be creditable. Second, this information has to be compared with some separate parameters on long tail liability coverages like medical malpractice. You are free to extract those measurements from this raw data but I really don't think it has much statistical significance due to the small data base and the kind of business that we're talking about.

Another point of information. As I looked through our cases to extract obstetrically related ones, I made the decision to focus only on claims that really related to the later stages of pregnancy and labor and immediate post partum/neonatal period. There are a number of claims not included here against both obstetrical specialists and family practitioners doing obstetrics that derive from abortions, fertility care, ectopic pregnancies, etc. These are all situations that physicians who include obstetrics in their practice get into but I have not counted them as obstetrical claims. Likewise, on the other end of the conception-to-birth continuum I have excluded the number of claims against neonatologists and pediatricians who took care of babies who perhaps were born too early. No claim may have resulted for obstetrical management or, if a claim did involve the physician handling the obstetrical care, it is counted in the statistics I'm submitting to you. But some physician who ultimately took care of the baby may have been included in that claim and I have not included those files.

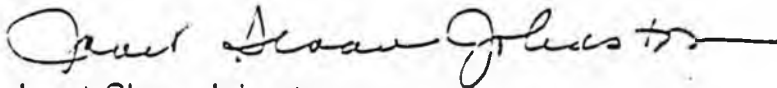
Medical Indemnity Corporation of Alaska

MaryAnn VandeCastle  
April 27, 1989  
Page 4 of 4

I guess the point I'm trying to make here is that the whole issue of reproduction is a very broad one and I have tried to limit my study to those case in which I thought you were most interested. But it doesn't really address the entire liability exposure that attends obstetrical and neonatal care.

I hope this information is of some help to you and invite you to contact me if I can clarify it in anyway.

Sincerely,



Janet Sican Johnston,  
Claims Manager

JSJ/nlb

Enclosure

P/ID/R	CLAIM #	SEV.	STAT	D/O	D/R	DATE CLOSED	TOTAL RESERVE CHANGE		TOTAL PAID	
							LOSS	CR	LOSS	CR
P.D.		A	C			22-Jun-80 07-Apr-81 30-Jun-82	0.00	0.00	0.00	0.00
P.D.		A	C			23-Mar-82 08-Sep-82 30-Sep-83	100,000.00	3,925.75	100,000.00	3,925.75
P.D.		A	C			23-Mar-82 08-Sep-82 30-Sep-83	25,000.00	2,273.75	25,000.00	2,273.75
P.D.		A	C			07-Oct-81 01-Feb-84 23-Aug-84	7,803.18	1,110.00	7,803.18	1,110.00
P.D.		A	C			28-Nov-84 31-Jan-85 30-Jun-86	2,529.20	0.00	2,529.20	0.00
P.D.		A	C			08-Jun-84 05-Aug-84 30-Jun-86	831.00	0.00	831.00	0.00
P.L.		A	C			01-Sep-85 05-Dec-85 31-Mar-86	20,000.00	0.00	20,000.00	0.00
P.D.		A	C			31-Jul-85 25-Nov-85 16-Sep-87	0.00	0.00	0.00	0.00
P.L.		A	C			30-Jul-85 25-Nov-85 16-Sep-87	0.00	0.00	0.00	0.00
P.D.		A	C			05-Jun-86 01-Jul-86 16-Dec-88	112,582.00	17,525.19	112,582.00	17,525.19
P.D.		A	C			17-Jul-86 05-Aug-86 10-Oct-86	5,925.00	0.00	5,925.00	0.00
P.L.		A	C			06-Nov-87 29-Dec-87 19-Dec-88	0.00	0.00	0.00	0.00
P.D.		A	C			21-Sep-84 14-Dec-87 19-Dec-88	0.00	0.00	0.00	0.00
							274,662.15	24,801.61	274,662.15	24,801.61

14 closed 6 w/out payment to pt.  
 8 with payment to pt.

Hosp = 1  
 OB/gyn 5  
 FP/OB 6  
 other - ER = 1  
 other 1

3 pending - not on printout  
 OB.

all MDs - all OB/gyns.

REPORT 4/26/89  
 CURRENT AS OF 3/31/89

M/D	CLAIM #	SEV.	STAT	D/O	D/R	DATE CLOSED	TOTAL RESERVE CHARGE		TOTAL PAID	
							PER YEARS	PER	PER YEARS	PER
M.D.		S	C	25-Jul-78	11-Feb-80	01-Aug-85	43,750.00	19,231.27	43,750.00	19,231.27
M.D.		S	C	03-Jul-79	26-Feb-80	30-Jun-81	75,000.00	4,076.74	75,000.00	4,076.74
M.D.		S	C	01-Jun-79	23-Feb-81	31-Mar-82	142,500.00	35,000.00	142,500.00	35,000.00
107P		S	C	16-Apr-82	16-Apr-82	20-May-87	150,000.00	24,913.87	150,000.00	24,913.87
107P		S	C	01-Sep-81	14-Apr-82	31-Dec-84	0.00	4,340.48	0.00	4,340.48
M.D.		S	C	16-Apr-82	16-Apr-82	20-May-87	150,000.00	21,713.11	150,000.00	21,713.11
107P		S	C	19-Oct-81	23-Nov-83	31-Dec-84	0.00	6,393.41	0.00	6,393.41
M.D.		S	C	17-Dec-83	01-Mar-84	31-Dec-86	170,000.00	14,702.86	170,000.00	14,702.86
107P		S	C	17-Dec-83	01-Mar-84	31-Dec-86	30,000.00	3,675.53	30,000.00	3,675.53
M.D.		S	C	03-Jul-83	01-Apr-84	12-Nov-86	0.00	7,676.01	0.00	7,676.01
M.D.		S	C	15-Feb-83	18-Feb-85	31-Mar-87	0.00	2,316.75	0.00	2,316.75
107P		S	C	01-Sep-84	18-Mar-85	03-Jun-89	0.00	6,544.74	0.00	6,544.74
M.D.		S	C	01-Sep-84	18-Mar-85	30-Jul-88	0.00	10,300.11	0.00	10,300.11
M.D.		S	C	19-Oct-84	31-Jul-85	30-Jun-88	2,200,000.00	13,046.84	2,200,000.00	13,046.84
M.D.		S	C	16-Jan-86	05-Feb-86	24-Mar-88	0.00	17,671.85	0.00	17,671.85
M.D.		S	C	27-Dec-82	02-Mar-87	20-Oct-89	47,357.50	2,437.00	47,357.50	2,437.00
M.D.		S	C	28-Feb-85	02-Mar-87	20-Oct-88	47,357.50	2,177.07	47,357.50	2,177.07
							3,059,965.50	197,511.86	3,059,965.50	197,511.86

17 Closed      7 w/out payment to pt.  
 10 with payment to pt

Wasp = 5  
 OB-94n = 3  
 FP/05 = 9

5 OB files pending - not on printout

Wasp = 2  
 FP/05 = 2  
 Gen Denq = 1

**BOARD OF GOVERNORS:**

William G. Brock, Chairman  
David J. Frazier, 1st Vice-Chairman  
Ronald W. Keller, M.D., 2nd Vice-Chairman  
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4000 OLD SEWARD HIGHWAY, SUITE 203  
ANCHORAGE, ALASKA 99503  
TELEPHONE (907) 563-3414

**1990**

**Physician's and Surgeon's  
Professional Liability Coverages and Premium Schedules**

December 29, 1989

Representative Dave Donley, Chairman  
House Labor and Commerce Committee  
House of Representatives  
P.O. Box V  
Juneau, AK 99811

Dear Representative Donley:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

MICA's 1990 Premium Schedule is enclosed for your information. The committee had asked me questions at the hearings specifically relating to the cost of insurance to physicians delivering babies. I mentioned that the majority of our physician policyholders have limits \$500,000 per claim, \$1,000,000 aggregate. Physicians delivering babies are Class 3 on the schedule. Assuming a physician had policy limits of \$500,000/1,000,000 and had been insured with MICA for five or more years his premium for 1990 would be \$30,162. (This is about \$20,000 less than I quoted to you.)

Another question is the difference in premium between a Family Practitioner doing obstetrics and those who were not. Assuming the same scenario as above and that the Family Practitioner not doing obstetrics was doing minor surgery the difference would be \$14,046. In other words, the Family Practitioner who delivers babies pay \$14,046 to do so (or about 1/2 of the total premium is for obstetrical coverage).

I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce  
Executive Director

MAP/blb

Enclosure


### LIABILITY INSURANCE SURVEY

1. Do you now carry medical liability insurance?     Yes     No  
     If yes, how long? \_\_\_\_\_  
     With what carrier? \_\_\_\_\_  
     If no, when did you cancel? \_\_\_\_\_  
     Do you contemplate not carrying it in the near future, i.e. within the year?     Yes     No  
     If you don't carry insurance: Is this a philosophical choice (i.e., you don't believe in it; if you don't have it you won't get sued, etc.)     Yes     No  
     Is this economic, or because of other factors that have forced your choice?     Yes     No

2. What proportion, i.e. percent, of your net income is the medical liability premium?

3. What is your opinion as to a "fair" liability premium, as either an absolute dollar figure, or percent of gross, or percent of net?

4. Is there a level of premium that you would pay, i.e. what do you think you could afford?

5. Do you deliver babies?     Yes     No  
     If yes, how many per year? \_\_\_\_\_

What premium do you pay simply for obstetrics, in excess of your liability premium without obstetrics?  
 \_\_\_\_\_

If no, was the cost of malpractice liability a major factor?     Yes     No

6. If there was an affordable insurance as described above, would you then change to doing obstetrics?

Please verify the code in the top right hand corner of this survey (as noted in the accompanying letter) and return the survey in the enclosed envelope. Thank you.

# Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

December 29, 1989

Dear Colleague:

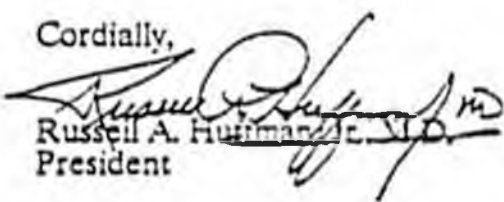
Enclosed is a survey intended to derive some needed information from Alaska physicians. As most of you know, the state medical association is taking a leadership role in trying to help the state legislature with the complicated issues surrounding tort reform and/or liability insurance. Before we can confront the legislature, we need factual data. This survey will help us gather the data regarding Alaska and match it with the larger picture of the nation and other nations of the world.

The information will be kept confidential. It is important that you realize that your name or even the coding will only be known to two or three members of the ASMA staff. Secondly, the information you provide should be flexible. You may add more data than is questioned. We want this information to be interactive so that you feel you have a part in deriving this survey. Make it as specific as you want to: give us your thoughts.

The code in the right hand corner is in three parts. The first part: G = Group, S = Solo (single practitioner). The second part is the speciality code as designated by the American Medical Association. A copy of the list with codes is on the back of the survey form. The third part is location and that is: N = North, W = West, A = Anchorage, F = Fairbanks, SE = Southeast, and P = Kenai Peninsula. Please check the code to be sure that it does apply to you and to your practice.

I wish I could offer a prize or an incentive for completing this survey. The best I have to offer is our thanks and to tell you that you are taking part in some of the most important issues that we, as organized medicine, face today. Thank you for helping.

Cordially,

  
Russell A. Huimantle, M.D.  
President

RAH/jlw

**Obstetricians**

	Fewer than					
	10	10-20	21-40	41-100	101-200	over 200
Anchorage			1***	2	11	3
Kenai Peninsula				1		
Fairbanks					4	

\*\*\* This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

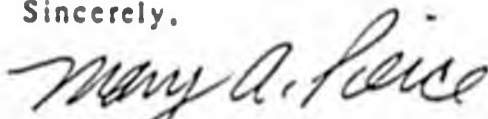
Total: 321                      Uninsured: 48 or 15%  
187 of total doctors reside in Anchorage

	<u>Delivering or Had Been Delivering Babies</u>	<u>Not Doing Deliveries</u>
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage 7 - Kenai Peninsula 2 - Fairbanks 2 - North 2 - Southeast	14 - Anchorage 4 - Kenai Peninsula 3 - Southeast
Stopped Coverage before 1987	6	9
<b>% of Gross Income willing to Pay</b>		
Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%
No Longer Delivering Babies	42 • or 32%	

- - 33 doctors in the insured group were no longer delivering babies all due to cost.
- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,



Mary A. Pierce  
Executive Director, MICA

**MICA** Medical Indemnity Corporation of Alaska

ALEUT PLAZA  
4000 OLD SEWARD HWY., SUITE 203  
ANCHORAGE, ALASKA 99503  
(907)563-3414

February 23, 1990

Representative David Donley, Chairman  
House Labor and Commerce Committee  
State of Alaska  
P.O. Box V  
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

	Fewer than					
	10	10-20	21-40	41-100	101-200	over 200
Anchorage *		1	3	6		
Fairbanks		1	1			
Kenai Peninsula		2	1	3	1	
South East	1	3	6	3	1	
North				1 **		

\* - Anchorage includes Mat-Su Valley

\*\* - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than					
	10	10-20	21-40	41-100	101-200	over 200
Southeast			1	1		

**MICA** Medical Indemnity  
Corporation of Alaska

ALEUT PLAZA  
4000 OLD SEWARD HWY., SUITE 203  
ANCHORAGE, ALASKA 99503  
(907) 563-3414

April 2, 1990

Representative Peter Goll, Co-Chairman  
House Judiciary Committee  
House of Representatives  
P.O. Box V  
Juneau, AK 99811

Dear Representative Goll:

There were several questions from members of the Judiciary Committee regarding my testimony on March 29th. I felt that it might be helpful if, as a member of this committee, you received information answering all the questions.

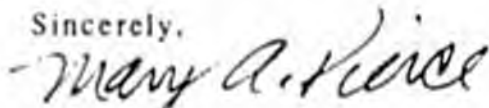
First of all, I appreciate your interest in both MICA and your concern for the healthcare delivery system in the state. I have included information that might prove useful in understanding specific questions on how MICA does business and also, general information on physician demographics, specifically on those delivering babies.

**Informational Items**

- 1.) A letter to the House Labor and Commerce Committee. This provides information on where physicians practice, how many deliveries they do, and if they are insured. Included is a copy of the questionnaire that was distributed to the 614 private practice physicians in the state that we used to develop these statistics.
- 2.) Another letter to Representative Donley, a 1990 MICA premium schedule is enclosed.
- 3.) A schedule of rate changes since 1981.
- 4.) Response to questions about obstetrical claims to Department of Health and Social Services. This should answer all questions regarding loss experience.

Please let me know if I can provide you with other information that would prove useful.

Sincerely,



Mary A. Pierce  
Executive Director

### Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

### Comprehensive General Liability Coverages:

This optional coverage is available at \$50 per physician covered, subject to the same limits of liability carried for professional liability. This coverage extends to bodily injury and property damage liability protection for those injuries accidentally sustained on the office premises by patients or the general public.

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

### Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide negligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

### Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability		
# Doctors on Policy	\$500,000	\$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

### Installments - Deferred Payments:

Initial policy issuance subject to deposit of \$1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25%, 25% and 15% quarterly or 60% and 40% semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

## PROFESSIONAL LIABILITY COVERAGES

### Explanation of Policy:

The Claims-Made Policy extends professional liability protection to the physician, clinic or employee for claims reported in a single year, regardless of when service is rendered as long as the incident occurred while continuously insured under Claims-Made with MICA. Thus, claims reported this year are covered by this year's policy; claims reported next year by next year's policy and so on.

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19% of the total claims resulting from professional services are reported; the second 39%; the third 78%; the fourth 93%; the fifth and subsequent years, about 100%.

### Cost:

In keeping with the "stair step" development of claims, the rates charged for the Claims-Made policy mature at the fifth year. Subsequent renewal policies are charged at the mature rates. The specific cost of coverage is shown within our table entitled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

### Limits of Liability:

MICA's professional and optional comprehensive general liability coverages are available with policy limits of:

\$200,000 per occurrence/\$600,000  
aggregate per calendar year.  
\$500,000 per occurrence/\$1,000,000  
aggregate per calendar year.  
\$1,000,000 per occurrence/\$2,000,000  
aggregate per calendar year.  
\$1,000,000 per occurrence/\$3,000,000  
aggregate per calendar year.

### Reporting Endorsement (Tail Coverage) \*

Should you stop practicing or change to another insurance company, MICA guarantees availability of a limited or Unlimited Reporting Endorsement known as "tail" coverage to cover subsequently reported claims. Tail coverage must be purchased by the insured within 30 days of termination of coverage, (by cancellation or non-renewal) or by termination of employment or association with the physicians insured under a master group policy.

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplished by charging "tail" premium on a pro-rata basis as between the two specialty classes when the policy is ultimately terminated.

### Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

\* The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.

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**1990**

**Physician's and Surgeon's  
Professional Liability Coverages and Premium Schedules**

December 29, 1989

Representative Dave Donley, Chairman  
House Labor and Commerce Committee  
House of Representatives  
P.O. Box V  
Juneau, AK 99811

Dear Representative Donley:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

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I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce  
Executive Director

MAP/blb

Enclosure


## LIABILITY INSURANCE SURVEY

1. Do you now carry medical liability insurance?     Yes     No  
     If yes, how long? \_\_\_\_\_  
     With what carrier? \_\_\_\_\_  
     If no, when did you cancel? \_\_\_\_\_  
     Do you contemplate not carrying it in the near future, i.e. within the year?     Yes     No  
     If you don't carry insurance: Is this a philosophical choice (i.e., you don't believe in it; if you don't have it you won't get sued, etc.)     Yes     No  
     Is this economic, or because of other factors that have forced your choice?     Yes     No
  
2. What proportion, i.e. percent, of your net income is the medical liability premium?
  
3. What is your opinion as to a "fair" liability premium, as either an absolute dollar figure, or percent of gross, or percent of net?
  
4. Is there a level of premium that you would pay, i.e. what do you think you could afford?
  
5. Do you deliver babies?     Yes     No  
     If yes, how many per year? \_\_\_\_\_  
     What premium do you pay simply for obstetrics, in excess of your liability premium without obstetrics?  
     \_\_\_\_\_
  
- If no, was the cost of malpractice liability a major factor?     Yes     No
  
6. If there was an affordable insurance as described above, would you then change to doing obstetrics?

Please verify the code in the top right hand corner of this survey (as noted in the accompanying letter) and return the survey in the enclosed envelope. Thank you.

# Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2562 (Fax) 561-2063

December 29, 1989

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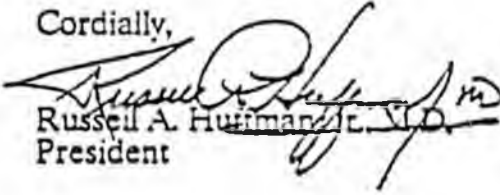
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Cordially,

  
Russell A. Huiman, M.D.  
President

RAH:jlw

Obstetricians

	Fewer than					
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Kenai Peninsula				1		
Fairbanks					4	

\*\*\* This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

Total: 321                      Uninsured: 48 or 15%  
187 of total doctors reside in Anchorage

	<u>Delivering or Had Been Delivering Babies</u>	<u>Not Doing Deliveries</u>
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage 7 - Kenai Peninsula 2 - Fairbanks 2 - North 2 - Southeast	14 - Anchorage 1 - Kenai Peninsula 3 - Southeast
Stopped Coverage before 1987	6	9
% of Gross Income willing to Pay		
Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%

No Longer Delivering Babies                      42 \* or 32%

\* - 33 doctors in the insured group were no longer delivering babies all due to cost.

- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,



Mary A. Pierce  
Executive Director, MICA

**MICA** Medical Indemnity Corporation of Alaska

ALECT PLAZA  
4000 OLD SEWARD HWY., SUITE 203  
ANCHORAGE, ALASKA 99503  
(907) 563-3414

February 23, 1990

Representative David Donley, Chairman  
House Labor and Commerce Committee  
State of Alaska  
P.O. Box V  
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

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Anchorage *		1	3	6		
Fairbanks		4	1			
Kenai Peninsula		2	1	3	1	
South East	1	3	6	3	1	
North				1**		

\* - Anchorage includes Mat-Su Valley

\*\* - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than					
	10	10-20	21-40	41-100	101-200	over 200
Southeast			1	1		

**MICA** Medical Indemnity  
Corporation of Alaska

ALEUT PLAZA  
4000 OLD SEWARD HWY., SUITE 203  
ANCHORAGE, ALASKA 99503  
(907) 563-3414

April 2, 1990

Representative Peter Goll, Co-Chairman  
House Judiciary Committee  
House of Representatives  
P.O. Box V  
Juneau, AK 99811

Dear Representative Goll:

There were several questions from members of the Judiciary Committee regarding my testimony on March 29th. I felt that it might be helpful if, as a member of this committee, you received information answering all the questions.

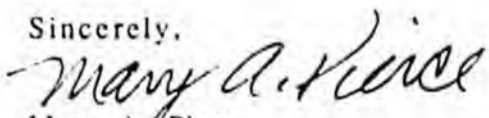
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**Informational Items**

- 1.) A letter to the House Labor and Commerce Committee. This provides information on where physicians practice, how many deliveries they do, and if they are insured. Included is a copy of the questionnaire that was distributed to the 614 private practice physicians in the state that we used to develop these statistics.
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Please let me know if I can provide you with other information that would prove useful.

Sincerely,

  
Mary A. Pierce  
Executive Director



# Alaska Action Trust

P.O. Box 102323 • Anchorage, Alaska 99510  
Office: 540 L Street, Suite 102 • Anchorage  
(907) 258-4040

November 3, 1989

Representative Peter Goll  
P. O. Box V  
Juneau, Alaska 99811

Dear Representative Goll:

I would first like to introduce myself. I am Debra Gravo, the new executive director for the Alaska Academy of Trial Lawyers. I look forward to working with you during the upcoming legislative session.

Enclosed is a copy of the subsidy for rural obstetricians bill which Arizona Governor Mofford signed into law June 28, 1989. The bill has a rather interesting legislative history. The bill was introduced by an anti-tort reform legislator who lives in a rural country. While he strongly supported anti-reform, he felt that he had to do something to help the doctors in his district.

Sincerely,

Debra C. Gravo  
Executive Director  
dch/encl.

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STATE OF MINNESOTA  
DEPARTMENT OF COMMERCE  
ST. PAUL 55101

OFFICE OF THE COMMISSIONER

500 METRO SQUARE BUILDING  
ST. PAUL, MN 55101

February 8, 1989

Mr. Paul Roller  
Director of Insurance  
PO Box D  
Juneau, Alaska 99811

FEB 16 1989

Dear Director Roller:

I enclose a copy of a report recently issued by this Department regarding medical malpractice. The report reviews all claims filed with two insurers in Minnesota, North Dakota and South Dakota against physicians from January 1, 1982 until December 31, 1987. These two insurers composed the entire physician malpractice market in Minnesota. The report states as follows:

1. The frequency of physician malpractice claims has not measurably changed over the last six years.
2. The claims have not measurably changed in terms of the average claim payment.
3. Approximately 75% of all claims are closed without payment.
4. Insurers overestimate exposure of pending claims by at least two to three times the amount eventually paid.
5. Claims determined by insurer personnel to be frivolous did not increase.
6. The cost of investigation and defense of claims has not increased.
7. There were only 20 jury verdicts over the six-year period which were entered against a physician.
8. No punitive damages were found to be awarded against a physician.

The report concludes that in specialty markets insurers are able to raise premiums in a non-competitive manner primarily because:

1. Physicians are sold policies which do not insure claims made after the expiration of the policy year. As a result, if a physician attempts to switch insurers, they must purchase a second policy to cover future claims that occurred during the policy year. The second policy, a "tail endorsement," is expensive and creates a negative environment for competitive pricing.
2. Data concerning the frequency of claims or the severity of claims is not available to competitors. As a result, it is difficult for other insurers to price a policy.
3. The number of purchasers of speciality lines of insurance such as medical malpractice is not sufficient to generate substantial numbers of competing vendors. Insurers must insure large numbers of policyholders to spread risk, and that the limited number of policyholders in a niche makes it clear that new competitors would likely not survive market entry.

The report recommends that government agencies periodically examine and collect loss data in niche markets so that competing insurers will have credible data to use in determining whether competitive pricing exists.

The report has been examined by actuaries who verify its credibility. While the insurers acknowledge the accuracy of the raw data, the St. Paul Companies nonetheless has issued a critique of the report charging that it has flawed methodology.

If you have any questions on the report, please give me a call.

Very truly yours,



MICHAEL A. HATCH  
Commissioner of Commerce

MAH:n1  
Encl.

MEDICAL MALPRACTICE  
CLAIM STUDY

1982 - 1987

MICHAEL A. HATCH, COMMISSIONER  
MINNESOTA DEPARTMENT OF COMMERCE

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## I. INTRODUCTION

Raising the issue of "malpractice" in a room crowded with doctors, lawyers, consumer advocates, and insurance executives results in greater commotion than yelling "fire" in a crowded theater.

Unfortunately, the answers given to the many questions asked are different and conflicting. And everyone has their own statistical study to substantiate their answer. The only sure conclusion is a barrage of accusations and counter accusations that find the public and lawmakers caught in the crossfire. Tort reform? Insurance reform? Physician reform?

This report briefly reviews the history of medical malpractice claims in this country and the various proposals regarding malpractice coverage. The report further analyzes data collected during the Commerce Department's six month study of the two insurers who sell virtually 100 percent of the physician professional liability coverage in the State of Minnesota, the exception being self-insured groups. The two insurers are St. Paul Companies and Minnesota Medical Insurance Exchange (MMIE). During this time, the Department reviewed every individual claim filed with these two insurers over the last six years in the states of Minnesota, South Dakota and North Dakota - over 4,700 files.

It should be noted that, after reviewing this report, both the St. Paul Companies and MMIE asked that the Department clarify that the positions attributed to the insurance industry in this report do not necessarily reflect the individual views of St. Paul Companies or MMIE. Specifically, both companies stated, and the Department acknowledges, that they should not be identified as proponents of "tort reform." Further, MMIE stated that they know of no crisis in physicians and surgeons liability in Minnesota.

It should be emphasized that this report should not be construed as a critique of either insurer. The report is a critique or survey of the medical malpractice insurance market, and these insurers happen to comprise the market in Minnesota.

## II. HISTORY

### A. Medical Malpractice in the Seventies

Medical malpractice claims first appeared in significant numbers in the 1930's but did not attract much public attention until the late sixties and early seventies. In 1971, President Nixon created a Commission on Medical Malpractice to study the problem of increasing claim frequency. Its report was issued in 1973, about the same time that the medical malpractice insurance market began to experience its first crisis. The commission's findings concluded that the increase in medical malpractice litigation was due to a combination of more affordable and therefore widespread medical care and more complex medical procedures.

During the malpractice crisis of the mid seventies, many insurers raised their rates dramatically. Sky rocketing premiums became commonplace--50 percent, 100 percent, even 300 percent increases occurred in a single year. In addition, several large insurers withdrew from the medical malpractice market entirely, leading to a gap in availability of coverage. As a result, the problem escalated and became one of both affordability and availability.

In response to the crisis, legislatures around the country enacted measures aimed at curbing the effects of the crisis. Since insurers asserted that increased lawsuits caused unforeseen losses, legislation was primarily aimed at limiting the liability of health care providers. The various legislative attempts often included one or more of the following: 1) limits on attorney's contingency fees; 2) limits on non-economic damage awards, i.e. punitive damages; 3) revision of the statute of limitations; 4) creation of pretrial panels to screen cases to establish merit; 5) changes to collateral source rules; and 6) institution of periodic payment of judgments.

#### B. Joint Underwriting Associations:

In addition to these changes, two other significant changes resulted from the mid seventies crisis. The first was the creation of alternative markets - specifically joint underwriting associations (JUAs) and physician and hospital-sponsored nonprofit insurers or mutuals. A number of states enacted laws giving the insurance commissioner the power to establish a JUA at his or her discretion when warranted by market conditions. JUA's generally are comprised of all companies writing insurance in a particular state or all companies writing property/casualty insurance in a state and are controlled by a group of public and private sector representatives. The purpose of a JUA is to write liability insurance for health care providers who are unable to obtain coverage in the private market. In 1987, 13 medical malpractice JUA's were offering coverage to health care providers, including the Minnesota JUA. The market shares for the active JUA's ranged from 3 percent to 85 percent according to the National Coordinating Committee on Medical Malpractice JUAs.

The committee issued a report in 1987, the 1986 Financial Condition of Medical Malpractice JUAs, which found that five JUAs had insufficient funds to pay all existing claims liabilities. The greatest deficiency, reported in Massachusetts, was estimated to be \$365.3 million. The report also found that the JUA market share had not changed significantly overall between 1985 and 1986, although the Florida, New York, and Wisconsin JUAs nearly doubled their respective market shares. It is apparent that those JUAs which incurred large deficits did so because of artificially low rates.

#### C. Physician Mutuals:

Physician/hospital mutuals, the second form of alternative malpractice market, first appeared in New York, Maryland and California in 1975. The creation of mutuals was based on two

premises: First, that a major influx of new insurers would alleviate the availability crisis and, secondly, that doctor-controlled nonprofit companies could issue affordable coverage to physicians in need. Nationwide in 1987, such mutuals represented more than half the premium volume in the medical malpractice market. In Minnesota, the Minnesota Medical Insurance Exchange (MMIE) began selling coverage in October of 1980. Today, MMIE is the largest insurer of physicians and surgeons in the state.

D. Claims-made Insurance:

The final significant change resulting from the seventies crisis was the change from an occurrence-based policy form to a claims-made form. In medical malpractice cases, there is often a significant time lag between the date an incident occurs and the date the claim is paid. This long "tail" has contributed to the insurers' difficulties in making accurate actuarial evaluations of malpractice loss experience. The claims-made policy form alleviates some of those difficulties by covering only those claims that are reported while the policy is in effect.

Under the traditional occurrence form, the transfer of risk from the health care provider to the insurance carrier took place when the incident occurred. Under the claims-made form, the transfer of risk takes place only when the claim or incident is reported to the insurance carrier. As a result, the health care provider maintains a risk at any given point in time for incidents that are unreported.

It is estimated that 70-80 percent of the medical malpractice market nationwide is now written on a claims-made basis. In Minnesota, St. Paul Companies shifted to the claims-made form in 1975 and MMIE has written coverage on a claims-made basis since the company's inception in 1980.

E. Malpractice Crisis in the Eighties:

The crisis of the eighties is evidence that the response to the crisis of the seventies did not resolve the problems in the malpractice insurance market. Rate increases in recent years have exceeded those experienced in the 1974-75 crisis and, although virtually everyone agrees a problem exists, there is little agreement on just what or who the "problem" is.

Doctors contend the problem is lawyers and their lawsuit-prone clients, a view shared by many insurers. They believe that many patients have unrealistic expectations of their physicians and the medical profession in general.

The trial lawyers place the blame on medical malpractice insurers and physicians saying they've created a "litigation crisis" as a public relations maneuver. They contend that the problems in the insurance marketplace are caused by the industry's inability and/or unwillingness to avoid the investment and "cash flow" cycles that cause the market disequilibrium.

And in the middle lies the public, who simply do not have independent data available from which to make a conclusion

Not surprisingly, since there is little agreement on the source of the problem, there is less agreement on a solution. Representing many physicians, the American Medical Association (AMA) recently proposed a virtual abandonment of the existing tort liability system. The AMA proposal calls for replacing the current court and jury system with an administrative claims facility. Under the plan, medical malpractice complaints would be reviewed by an expert administrative agency to try to reach a settlement between parties and/or make a determination as to the merits of the case. The agency would also have the power to discipline physicians who demonstrate a pattern of substandard conduct. In addition, the AMA plan would redefine the legal basis for determination of medical liability. Currently, medical liability is based on the standard of care a reasonably prudent physician in a given locality would dispense. Under the AMA proposal, the liability would be based on the standard of care a "prudent and competent practitioner in the same or similar circumstances" would provide, thereby eliminating the locality standard.

The insurance industry asserts that "the only truly viable long range solution lies in comprehensive and substantial tort reform." (Medical Malpractice: A Second Opinion. National Association of Independent Insurers (1986) p.15.) Insurers argue that, when enacted on a comprehensive basis, reforms discussed earlier effectively reduce the costs associated with medical malpractice litigation without restricting the right or ability of individuals to recover just compensation for their injuries. They blame ineffectiveness of reforms in many states on lack of a total commitment to comprehensive reform and implementation of reforms in a piecemeal fashion.

Lawyers and consumer advocates are proponents of increased regulation aimed at stabilizing the insurance market. Their proposals include more state regulatory power over rates; federal anti-trust regulation to eliminate price fixing; the creation of more federal insurance pools including reinsurance pools; mandatory reduction of the number of rating classes used to improve the spread of risk; and use of experience rating rather than class rating alone so that physicians with bad claim records would be penalized.

### III. THE STUDY

The impetus for this study was not only the magnitude and far reaching impact of the malpractice crisis but the bewildering array of conflicting statistics and reports on the subject. Rather than reviewing statistical samples presented by hired consultants representing a particular viewpoint, the Department sought to review every claim filed in the State since 1981. It is believed that this study is the only study in the country where independent examiners reviewed each claim filed in a specific line of insurance.

The review included all medical malpractice claims, open and closed, filed against physicians and surgeons in Minnesota, North Dakota, and South Dakota from 1982 to 1987 at Minnesota Medical Insurance Exchange and St. Paul Fire and Marine Insurance Company.

A. St. Paul Companies:

The St. Paul Companies, Inc. was organized in 1853 in St. Paul, Minnesota under the title of St. Paul Fire & Marine Insurance Company. The medical professional liability is underwritten by a wholly-owned subsidiary of The St. Paul Companies incorporated in 1925 under the title "Mercury Insurance Company." The subsidiary changed its name to St. Paul Fire & Marine Insurance Company when the former St. Paul Fire & Marine changed its status to that of a management company in 1967 and took the title "The St. Paul Companies, Inc." The St. Paul is a large diversified financial company specializing in insurance. In 1988 they acquired a large wholesale and retail insurance broker based in the United Kingdom making St. Paul the seventh largest insurance broker in the world. St. Paul Companies currently writes medical malpractice insurance in 43 states. The Medical Services Division is the largest of the company's underwriting units with the malpractice business accounting for 35 percent of the company's premiums in 1987. The St. Paul Companies has written malpractice insurance since the 1930's and presently writes coverage for doctors, hospitals and other health care specialties. In 1987, they had net malpractice premiums nationwide of \$722 million which was about 18 percent of the total market, a market share equal to three times that of their nearest competitor.

B. Minnesota Medical Insurance Exchange:

In Minnesota, the Minnesota Medical Insurance Exchange (MMIE) now insures more than 50 percent of the state's physicians. MMIE began business in October of 1980 in Minneapolis as a reciprocal insurance exchange. It is governed by a board composed of twenty-two physicians appointed by the Minnesota Medical Association. Recently, it reorganized as a stock company to raise more funds and sell more coverage and has subsequently changed its name to Midwest Medical Insurance Company. (At the time this report was compiled, the company was operating as MMIE and is referred to as such throughout the report.) MMIE is managed by Minnesota Medical Management, Inc. and currently has over 3,200 policyholders in three states.

The two companies underwrite their malpractice coverage on similar policy forms (see Appendix A) and at similar policy limits. The policy limits range from \$100,000 per occurrence/\$300,000 aggregate to \$10,000,000 per occurrence/\$10,000,000 aggregate. The majority of policies are written either at \$1,000,000/\$3,000,000 (63.3%) or \$2,000,000/\$4,000,000 (20.4%) limits.

C. Methodology:

Department examiners reviewed a total of 4,747 medical malpractice files from Minnesota, North Dakota and South Dakota: 2251 files

from MMIE and 2496 files from St. Paul Fire and Marine. The study included all incident reports as well as claim files. Incident reports differ from claim reports in that they are made by physicians and do not necessarily result in a claim. Incident files were included because reserves were usually established for these files. It should be noted, however, that MMIE suspended the practice of setting reserves on incident files in 1985 after determining that these reserves "had not proven helpful in evaluating the total liabilities for MMIE ...". The study did not include claims made against hospitals, clinics or other institutions, nor claims against nurses or other health care providers. A four-page survey form was completed for each file.

The first draft of the questionnaire was developed by the Department's property casualty actuary, general counsel and examination supervisor. The malpractice study conducted by the National Association of Insurance Commissioners (NAIC) in 1976 was used as a reference source and St. Paul Companies also provided information with regard to loss coding procedures. Possible survey questions were considered with an eye toward current issues in the medical malpractice insurance market while taking into account which information examiners could reasonably expect to extract from the files based on their prior experience reviewing claims.

The first draft survey was tested by Department Counsel and the examination supervisor in a review of 40 St. Paul claim files pulled at random by the company. Some modifications were made based on the sample review and a copy of the revised questionnaire was then sent to the St. Paul Companies for comment. The St. Paul expressed concern over the issue of confidentiality with respect to the identity of physicians and claimants and other specifics of individual files, particularly open files where the defense of their insured was at risk. Assurances were given by the Department that the identity of any individuals or specific details relating to an individual file would not be released.

The St. Paul Companies also requested that the wording of question #25 be revised. The original wording read: "Based on the insurer's evaluation of this claim and using your own judgment, do you believe a claim was justified under these circumstances?" St. Paul asked that the judgment of the examiner be eliminated so that the question was based entirely on the judgment of the claims adjustor and/or the defense counsel. The Department made the change. In March, prior to beginning the examination of files at MMIE, the survey form was sent to the company and a similar assurance of confidentiality was given. MMIE did not request any changes be made to the questionnaire.

D. Survey Format:

A copy of the survey form is found on pages eight through eleven of this text. Survey questions one through three record basic identifying information for each file. The loss date and report date recorded in four and five allow for computation of the time lag between the incident giving rise to a claim and the report

of the claim to the insurer, an issue which prompted many insurers to switch to a claims-made policy form.

Question six identifies the specific medical procedure or incident which gave rise to the claim. In addition to being an integral piece of the total malpractice picture, a compilation of the loss cause information was thought to be particularly useful for insurers and health care providers in their loss control efforts. The following question identifying the location where the incident took place was included for similar reasons.

Questions eight and nine record personal characteristics of the claimant. The characteristics of age and sex help answer the question, "Who are the claimants?" This information also enables a comparison of claim frequency and severity for different ages and sexes, information which should be useful to insurers in their reserving practices. For example, the same injury may result in a consistently greater or smaller loss depending on the age and sex of the claimant.

Item ten completes the information about the type of loss along with questions six and seven. Here, the actual injury that resulted from the cause identified in question six is described.

Question 11 was included because of assertions that claimants' lawsuits unjustly include everyone remotely connected to a case. Items 12a-c record information about the physician defendant including specialty and the physician's professional relationship to the claimant. The physician's specialty was included to determine which specialties present the greatest risk and whether the rating classes used by insurers appear to be an accurate reflection of actual risk. Question 12c was an attempt to quantify the physician-patient relationship in order to test the theory that the nature of this relationship can be a contributing factor in decreasing or increasing a physician's exposure in a given situation. Although the claim files may not reveal the finer points of this issue, they often told us whether there had been an ongoing doctor-patient relationship and therefore, presumably increased loyalty or concern for the physician's reputation on the part of the patient.

Questions 13 through 16 are essentially recordkeeping items to decrease the potential for duplicate entries when several defendants were involved in the same claim.

In question 17, the policy limits and deductible were recorded. This information was included in order to identify any correlation between the loss amount and the potential compensation available to a claimant through an insurer. The deductible was noted in order to verify that the loss payment recorded reflected the deductible, if any.

For purposes of data analysis, it was necessary to separate closed from open claims and therefore the status of the file was noted in number 18.

Medical Malpractice  
Claim Survey

St. Paul Companies

Initial when completed \_\_\_\_\_  
Date: \_\_\_\_\_

1. File No. 1. \_\_\_\_\_
2. Policy No. 2. \_\_\_\_\_
3. State where loss occurred 3. \_\_\_\_\_
4. Date of Loss 4. \_\_\_\_\_
5. Date reported to insurer 5. \_\_\_\_\_
6. Cause of loss 6. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Location where injury occurred 7. \_\_\_\_\_
  1. Office
  2. Clinic
  3. Hospital E.R.
  4. Hospital-Surgery
  5. Hospital-Labor/Delivery/Nursery
  6. Hospital-Patient Care Area
  7. Hospital-Outpatient Surgery
  8. Hospital-Other
  9. Surgi-Center
8. Age of injured person 8. \_\_\_\_\_
  1. 0-30 days
  2. 30 days - 2 yrs
  3. Over 2 yrs - 12 yrs
  4. Over 12 yrs - 18 yrs
  5. Over 18 yrs - 35 yrs
  6. Over 35 yrs - 55 yrs
  7. Over 55 yrs - 70 yrs
  8. Over 70 yrs
9. Sex of injured person 9. \_\_\_\_\_
  1. male
  2. female
10. Briefly describe principal injury giving a rise to the claim. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Total number of defendants 11. \_\_\_\_\_

12. Name of defendant for this file.

\_\_\_\_\_

a. Profession \_\_\_\_\_

12a. \_\_\_\_\_

b. Specialty \_\_\_\_\_

12b. \_\_\_\_\_

c. Relationship to injured party:

12c. \_\_\_\_\_

- 1. Family/personal physician
- 2. No relationship prior to this injury
- 3. Other \_\_\_\_\_

13. Named insured on policy covering above defendant.

\_\_\_\_\_

- a. Named insured is an
- 1. Institution
  - 2. Individual
  - 3. Group

13a. \_\_\_\_\_

14. List any other defendants in this case covered by the same policy given in #11.

14. \_\_\_\_\_

Name	Claim File # (if known)
------	----------------------------

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. List any other defendants also covered by this insurer but under a different policy.

15. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. List ~~other~~ defendants not covered by this insurer.

16. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

17. Policy limits.

a. \_\_\_\_\_ occurrence

17a. \_\_\_\_\_

b. \_\_\_\_\_ aggregate

17b. \_\_\_\_\_

18. Status of claim. 18. \_\_\_\_\_
1. open
2. closed on \_\_\_/\_\_\_/\_\_\_
19. If claim is open, indicate:
- a. beginning loss reserve 19a. \_\_\_\_\_
- b. current loss reserve 19b. \_\_\_\_\_
- c. current LAE reserve 19c. \_\_\_\_\_
- d. settlement demand 19d. \_\_\_\_\_

ANSWER QUESTIONS 20 - 24 ONLY IF CLAIM IS CLOSED.

20. If claim is closed, indicate:
- a. beginning loss reserve 20a. \_\_\_\_\_
- b. ending loss reserve 20b. \_\_\_\_\_
21. Method of disposition 21. \_\_\_\_\_
1. settled
2. tried
3. arbitration
22. Indicate amount of settlement or verdict broken down as follows:
- a. medical expenses 22a. \_\_\_\_\_
- b. future medical expenses 22b. \_\_\_\_\_
- c. pain and suffering 22c. \_\_\_\_\_
- d. lost wages incurred 22d. \_\_\_\_\_
- e. lost wages anticipated 22e. \_\_\_\_\_
- f. punitive damages 22f. \_\_\_\_\_
- g. other 22g. \_\_\_\_\_
- h. total 22h. \_\_\_\_\_
23. Indicate amount paid to claimant:
- a. total amount paid to claimant 23a. \_\_\_\_\_
- b. by this insurer 23b. \_\_\_\_\_
- c. deductible paid by insured over limits 23c. \_\_\_\_\_
- d. amount paid by insurer over limits of policy 23d. \_\_\_\_\_
- e. amount paid by excess coverage insurer 23e. \_\_\_\_\_
- f. amount paid by other defendants/ contributors 23f. \_\_\_\_\_

24. Amount of allocated loss adjustment expenses:

- a. total LAE 24a. \_\_\_\_\_
- b. claim investigation 24b. \_\_\_\_\_
- c. court costs 24c. \_\_\_\_\_
- d. internal defense counsel 24d. \_\_\_\_\_
- e. external defense counsel 24e. \_\_\_\_\_
- f. other 24f. \_\_\_\_\_

25. Based on the adjuster/defense counsel's evaluation of this claim, does it appear a claim was justified under the circumstances of this injury? 25. \_\_\_\_\_

- 1. definitely
- 2. probably
- 3. doubtful
- 4. definitely not
- 5. uncertain

26. Additional Comments/Observations:

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Because different information could be obtained depending on the status of the file, a separate set of questions was developed for open and closed files. Obviously, if a file remains open, information regarding the disposition of the claim and the loss payment are not available. Therefore, in question 19 we recorded loss and loss expense reserves and the settlement demand if one had been made. The reserve amounts are necessary to the calculation of loss ratios. Reserving practices have consistently been an issue in the malpractice debate as lawyers and consumer groups have blamed overly conservative reserves for what they claim are inflated loss ratios published by insurers. In order to address the reserving issue, we recorded both the beginning loss reserve (the reserve set when the file was opened) and the ending reserve (the last reserve recorded prior to the closing of the file.) This was done to trace the progress of the reserve (in a limited way) and also to compare the ending reserves to the actual loss payment to gauge the accuracy of reserving.

Question 21 identified the method of disposition of a closed claim. Much of the media coverage of malpractice issues focuses public attention on jury verdicts and tried cases. Therefore, by separating the claims according to method of disposition, the various expense levels and final outcomes of tried claims as opposed to settled claims could be compared, for example.

Question 22 was directed toward some of the issues in the tort reform controversy. Insurers have pushed for caps on noneconomic damages as part of the solution to the rising costs of malpractice insurance. In order to determine the effect of noneconomic damages on overall loss experience, in question #22 the settlement or verdict was broken down into its various components.

Claimants may receive compensation through more than one source. Question 23 identified the various sources of compensation so that an accurate reading of the losses actually paid by the insurer as opposed to the total compensation awarded a victim could be obtained.

Insurers have pointed to the rising cost of claims management, regardless of whether any loss payment is ever made, as another factor in the rising cost of insurance. Question 24 broke down the allocated loss adjustment expense (LAE) costs according to investigation, court, and legal expenses.

Another argument evoked by insurers when explaining the rising cost of insurance is the large number of frivolous claims and their impact on insurance costs. Question 25 was included to determine the volume of frivolous claims and their cost to insurers.

Finally, space was included for additional comments and observations. Examiners used this section to record observations such as "new file - little information available" or other pieces of information that were not captured in the more quantitative survey questions but which could shed light on the claim.

E. Field Review:

The examiners began their review at St. Paul's Upper Midwest Service Center in Bloomington, Minnesota on January 19, 1988. The number of examiners reviewing files at any one time ranged from one to four. However, three examiners worked for seven weeks of the nine week examination at St. Paul. Department staff were provided a conference room in which to work and a photocopy machine was available for their use. Company employees were cooperative and available to answer examiners' questions. Over 250 of the files given to the examiners were incorrectly identified by the company as being within the survey's parameters. These files were rejected for a number of reasons including files where: The policyholder was not in one of the survey states (for example, frequently, Montana files were found); the claim was made against a health care professional other than a physician; or the claim was made against a clinic or hospital - although examiners did include claims against physicians where the named insured on the policy was a hospital or clinic.

Examiners encountered some difficulties in extracting information from St. Paul's files. Documents within each file were kept in approximate chronological order, however, examiners found a significant number of duplicate documents such as memos, depositions and medical records, which increased their time spent reviewing. In addition, medical records which were detailed and voluminous were often not separated from other file documents making it more difficult to sift through files for the survey information.

Examiners also had difficulty determining the date when the insurer was notified of the claim because frequently several different dates were listed as the report date or notice date in various parts of the file. Since it is the notice date that determines in which year's loss experience a claim is placed, determining the date accurately was an important concern. When examiners raised this issue with the service center staff, they were directed to use the report date listed on the computer printout label found on the cover of each file.

The initial examination at St. Paul was completed on March 23, 1988. Following the completion of the file review at St. Paul, field examiners and the examination supervisor developed data codes for survey questions where an appropriate code system could not be identified prior to the review. The St. Paul data was then entered on a Department computer using a DBASE program. Data entry and coding were performed by the same examiners who reviewed the files for maximum accuracy and consistency. Entry of St. Paul data was completed in approximately two and one-half weeks. Examiners returned to review some additional files retrieved by St. Paul on April 15 for three days.

On April 20, examiners began to review files at MMIE. The same three examiners who reviewed most of St. Paul's files also reviewed MMIE's. Department staff were accommodated in a conference room and had a photocopy machine at their disposal. As with St. Paul,

MMIE's staff was cooperative and available to answer questions. MMIE's files were organized chronologically, however, they did separate the medical records from the other documents within each file. MMIE's files contained fewer duplicate documents than St. Paul's which also decreased examiners' review time. After the first day at MMIE, examiners revised the order of the survey questions to accommodate more efficiently the MMIE file arrangement. The review at MMIE was completed on July 8, 1988 and data was again entered using the same format and procedures as were used for the St. Paul data.

F. Data Reconciliation

Following completion of the data entry process, a variety of data reports were run and staff began checking for data entry errors and organizing data in an appropriate format for use in this report. In late August, examiners noticed a significant discrepancy between the number of claim files listed on loss experience data sheets supplied by St. Paul Companies prior to the file review and the number of files actually reviewed. The Department's first inquiries regarding the discrepancy were met with assurances from St. Paul that the Department had in fact reviewed all their claims against physicians and surgeons. However, after the magnitude of the discrepancy, over 400 files were verified, St. Paul officials informed the Department they believed some files had inadvertently been omitted from the review. Company officials explained that the problem resulted from a communication breakdown between their actuarial department and their claims department as to the "definition of a physician and surgeon claim." For the next four weeks, St. Paul officials sought to determine which files the Department had reviewed and which it had not. During this period, the Department supplied a computer run list of file numbers that had been reviewed. St. Paul then used the list to cross check against their own. Both the Department's list and St. Paul's list were organized by report date. Apparently due to the conflicting information in the files, the two lists did not coincide with regard to report year thereby making files more difficult to cross reference. Consequently, if St. Paul located a file the Department had reviewed but had listed it in a different report year, the Department changed its data base to reflect the date in St. Paul's data base. A total of 197 report dates were changed.

Examiners returned to St. Paul's Upper Midwest Service Center on October 5, 1988 to review the files St. Paul had identified as the remainder of the survey group. Over the course of the next week, examiners reviewed 249 additional St. Paul files. The remaining discrepancy between the original St. Paul figures and the number of files reviewed was explained by the fact that when more than one claimant is involved in a lawsuit, the company counts one claim for each claimant, even when there is only one claim file. In addition, the service center staff was unable to locate the hard files for 50 claims listed in the actuarial division's data base. They did provide the Department with a computer run summary of 45 of the missing files. The Department accepted the 45 claims listed on the computer reports for both the claims center

and the actuarial division even though no claim file was found. This data is included in the study. With regard to the five claims found on the actuarial computer but not the claims center computer, the Department stated it would include such files if they could be found. No such files were found.

#### G. Company Verification of Data

Following St. Paul Companies' review of this report, they noted that the report differed from their own data in the areas of loss payments and loss expenses on closed files. The Department agreed to review again all individual files where a discrepancy was found. Accordingly, St. Paul Companies and Department personnel reviewed all files where there was a discrepancy of over \$100. In files with lesser discrepancies, St. Paul's figures were accepted. Corrections were agreed on between both parties and were then made in the Department's database. These corrections did not result in any notable increase or decrease in the aggregate figures. Approximately the same number and amount of upward and downward dollar figure adjustments resulted from the review.

### IV. FINDINGS

#### A. General

Seventy-eight percent (3689) of the claim files reviewed were closed and twenty-two percent (1058) were open. The following section also refers to a subgroup of closed files identified as "loss files" which includes only those closed claims where a loss payment was made by the insurer. Twenty-seven percent (982) of the closed files were loss files. The remaining seventy-three percent involved no compensation to the claimant by the insurer.

It should be noted that the data in this report is organized according to the year each claim was reported. Accordingly, unless otherwise stated, all references in text and the tables to "year" is a reference to the report (or notice) year of the claim.

The data in the report does not take reinsurance into account in calculating losses. Some of the larger losses in the study were paid in part by reinsurance therefore reducing the amount actually paid by the primary insurer. However, reinsurance also is an expense for insurers and is a factor in setting the target loss ratios discussed below. Reinsurance is a greater relative expense for MMIE than St. Paul Companies because of the company's smaller size and the fact that MMIE has been in business for a shorter length of time.

The loss payments ranged from \$0 to \$1,296,090. The average loss payment for all closed claims was \$14,542 and the median was zero. The average loss payment on loss files only was \$54,629 and the median was \$15,000.

There were three files (0.1 percent of closed claims) where a company paid one million dollars or more, 15 files (0.4% of closed claims)

where the payment was equal to or greater than \$500,000, and 145 claim files (four percent of closed claims) where the loss payment was equal to or greater than \$100,000. One of the three payments that met or exceeded \$1.0 million was the result of a jury verdict, the other two resulted from negotiated settlements.

#### B. Loss Ratios

A loss ratio is derived by dividing the sum of the loss payments, loss adjustment expense (LAE), loss reserve, and allocated LAE reserve by earned premium. Allocated LAE represents expenses that insurance companies pay to outside entities such as expert witnesses and attorneys during the course of investigating and litigating a claim. Both MMIE and St. Paul Companies have a targeted loss ratio of 82-85 percent.

It was the Department's intention not to include reporting endorsement premium and losses in this report. Reporting endorsement coverage, commonly known as "tail" coverage, essentially converts a claims made policy to an occurrence policy.

After the report was complete, however, MMIE advised the Department that reporting endorsement premium and loss files had been included in the review at the company. Because reporting endorsements are written on an occurrence basis, MMIE reserves for claims "incurred but not reported" (IBNR reserves) were added to the loss reserve data in the loss ratio calculation. This resulted in an upward adjustment of overall loss ratio by .5 percent.

The overall loss ratio (as determined by the value of the claims on the day the Department reviewed the files) for the six-year period of the study was 71.8 percent. That is, the 4,747 claim files had losses and reserves totalling \$182,742,647 which is divided by earned premiums of \$254,597,909. Table 1 below gives the loss ratio and its various components for each year of the study. The loss experience for each of the three states individually is found in Appendix B.

It should be noted that reserves are, by definition, estimates. In addition, medical malpractice is a line of insurance that, by its very nature, requires long periods for claim settlement. There is a good probability that claims from the most recent report years, especially 1986 and 1987, will see a number of reserve changes **before** they are finally paid. As a result, the 1986 and 1987 loss **ratios** should be viewed as less stable than earlier years. The **degree** to which reserves are accurate obviously affects fluctuations in loss ratios over time. Reserving accuracy is discussed in section D below.

TABLE 1:  
PHYSICIAN MALPRACTICE LOSS EXPERIENCE  
COMBINED STATES BY YEAR

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	721	\$23,369,849	\$16,034,369	\$3,833,712	\$2,555,000	\$ 290,005	\$22,713,086	97.2%
1983	776	26,940,428	7,729,884	2,513,698	3,040,501	548,524	13,839,607	51.3
1984	768	32,489,891	12,009,664	3,546,127	8,780,000	1,431,037	25,816,828	79.3
1985	937	43,451,439	10,648,054	3,877,240	19,674,353	2,706,981	37,036,628	85.4
1986	758	57,001,803	5,230,846	2,071,814	27,119,856	5,637,437	40,409,953	70.9
1987	787	71,344,499	1,993,071	761,053	32,655,891	6,916,530	42,926,545	60.2
TOTALS	4,747	\$254,597,909	\$53,645,888	\$16,603,644	\$93,825,601	\$17,530,514	\$182,742,647	71.8%

C. Claim Frequency and Severity

Claim frequency and severity are indicators commonly used in analyzing loss data. Claim frequency is the number of claims made per policyholder. Claim severity is the average size of a claim measured in dollars paid and reserved. Frequency and average severity are important to examine because increases in both have been blamed for the shortage in insurance coverage. If a "litigation explosion" has occurred, it should be reflected in the frequency and severity numbers.

It would appear, however, that the data does not substantiate the litigation explosion assertions. Claim frequency has not changed measurably in the last six years. The 1987 frequency rate is actually less than the 1983 rate. Table 2 illustrates this trend.

TABLE 2: CLAIM FREQUENCY 1982 - 1987

YEAR	NUMBER OF INSURED	QUANTITY CLAIMS	CLAIMS PER 100 INSURED
1982	6,912	721	10.4
1983	6,605	776	11.7
1984	6,599	768	11.6
1985	6,942	937	13.5
1986	7,072	758	10.7
1987	6,836	787	11.5
TOTAL/AVG.	40,966	4,747	11.6

Claims severity trends also do not evidence a litigation explosion. Both averages and medians may indicate trends in claim severity. The median loss payment for each year was \$0. Table 3A compares average loss payments on all closed files and on loss files only. Average payments actually appeared to be decreasing over the period of the study.

It should be noted that the 1986 and 1987 averages do not have substantial credibility due to the large percentage of claims still open.

TABLE 3A: CLAIM SEVERITY 1982 - 1987

YEAR	NUMBER OF CLOSED CLAIMS	PERCENT OF TOTAL CLAIMS	AVERAGE LOSS PAYMENT	PERCENT OF CLOSED CLAIMS WITH LOSSES	NUMBER OF OPEN CLAIMS	AVERAGE OPEN RESERVES	AVERAGE TOTAL
1982	700	97.1%	\$22,906	31.0%	21	\$121,667	\$25,783
1983	741	95.5	10,432	30.6	35	86,871	13,880
1984	685	89.2	17,532	27.6	83	105,783	27,070
1985	783	83.6	13,599	23.6	154	127,756	32,361
1986	516	68.1	10,137	21.3	242	112,066	42,679
1987	264	33.5	7,550	20.5	523	62,440	44,027
TOTAL	3,689	77.7%	\$14,542	26.6%	1,058	\$ 88,682	\$31,066

The "average total" column includes both paid losses and unpaid reserves. Although this column would seem to indicate an upward trend in severity, the discussion below suggests that inflated reserves distort these figures. The more claims that are open, the greater the upward distortion.

After reviewing this report, St. Paul Companies and MMIE objected to the Department's presentation of claim severity in Table 3A arguing that severity must be measured by comparing claims at the same point in their development. Accordingly, Table 3B compares average loss payments for closed claims at the same year of development. For example, a claim reported in 1982 and closed in 1982 would be directly comparable to a claim reported in 1984 and closed in 1984. Both were closed in "year 1" of their development. If claims are becoming more severe, an upward trend would be reflected in these comparisons.

TABLE 3B: CLAIM SEVERITY FOR POLICY YEARS 1982-1987  
MEASURED AT EQUAL POINTS OF LOSS DEVELOPMENT

NOTICE YEAR	CLAIMS CLOSED YEAR 1	AVERAGE	LOSS	PAYMENTS	CLAIMS CLOSED YEAR 5
		CLAIMS CLOSED YEAR 2	CLAIMS CLOSED YEAR 3	CLAIMS CLOSED YEAR 4	
1982	\$5,391	\$11,567	\$21,857	\$49,668	\$41,963
1983	1,801	4,885	13,665	17,602	36,549
1984	6,690	14,303	10,592	52,712	
1985	8,309	6,987	25,697		
1986	3,040	7,504			
1987	4,604				
TOTAL NUMBER OF CLOSED CLAIMS (by development year)	726	1,527	724	263	109

If average loss payments were becoming increasingly severe, each column of figures in Table 3B should show an upward trend. However,

Table 38 clearly indicates there has been no upward trend in claim severity based on a comparison of loss payments at equal points in loss development.

Attached as Appendix D is a graph of the figures set forth in Table 38.

D. Accuracy of Loss Reserves

Table 4 compares the reserve established when the file was opened (beginning reserve), the last reserve recorded before the file was closed (ending reserve) and the average loss payment, for all closed files. Although the beginning reserve has, on average, been less than the eventual loss payment, the beginning reserve is significantly closer to the average loss than is the ending reserve. The average loss payment for the six year period is 117 percent of the average beginning reserve but only 36 percent of the average ending reserve. A random sample of 150 claims indicated that the ending reserve is set an average of three months after the beginning reserve is first set. Therefore, at any given time, most of the open reserves are "ending reserves" rather than "beginning reserves."

TABLE 4: LOSS RESERVE ACCURACY CLOSED FILES

YEAR	I AVERAGE BEGINNING RESERVE	II AVERAGE ENDING RESERVE	III AVERAGE LOSS PAYMENT	IV AVERAGE DOLLAR DIFFERENCE (II - III)	V LOSS PAYMENT AS A PERCENT OF THE FINAL RESERVE (III + II)
1982	\$16,433	\$40,532	\$22,906	\$17,626	56.5%
1983	10,752	34,922	10,432	24,490	29.9
1984	12,136	47,519	17,532	29,987	36.9
1985	12,418	46,165	13,599	32,566	29.5
1986	10,694	41,755	10,137	31,618	24.3
1987	10,368	23,226	7,551	15,676	32.5
	\$12,405	\$40,831	\$14,542	\$26,289	35.6%

It is apparent from the data that the insurers have consistently and significantly over-reserved. Ending reserves have been three times higher than actual loss payments for the last five years. A further comparison of loss payments and open reserves is found in Appendix C.

The insurers have accurately pointed out that over reserving does not necessarily lead to artificially high rates if actuaries reduce the reserve levels appropriately during the rate making process. However, rate filings published by these insurers indicate their actuaries have not compensated adequately for the companies' conservative reserving when developing rates. Both companies apply a loss and loss expense reserve development factor in their ratemaking formula. This factor averaged for the period of the study was .69

for MMIE and .79 for St. Paul Companies. Thus, although MMIE is closer, both companies fall short of an accurate development factor.

E. Allocated Loss Adjustment Expense (LAE)

The allocated LAE for closed claims ranged from 0 to \$177,628. The average allocated LAE for all closed claims was \$3,244 while the median was \$144. For loss files only, the average allocated LAE was \$6,573 while the median was \$989.

There were seven claims (0.2% of closed claims) where allocated LAE reached or exceeded \$100,000.00, 96 claims (2.6% of closed claims) where it was equal or greater than \$25,000, and 300 claims (8.1% of closed claims) where the allocated LAE was greater than or equal to \$10,000. Table 5A shows the average allocated LAE for closed claims, the average reserve for open claims and the combined average for open and closed files. Insurance companies spent an average of \$330 on files where the claim was not pursued by the claimant. A typical example of such a claim is where the physician filed an incident report and no claim was ever filed by the patient.

Insurers argue that the rising costs of defending claims is one cause of the malpractice crisis. Table 5A indicates that the highest defense cost year was 1982, and that costs have actually decreased since that time. Once again, the percentage of claims still open in 1986 and 1987 make a direct comparison with other years less credible. Nevertheless, the figures do not seem to reverse the overall trend of decreasing costs.

TABLE 5A: AVERAGE ALLOCATED LAE

YEAR	NUMBER OF CLAIMS	AVERAGE INCURRED LAE (CLOSED CLAIMS)	NUMBER OF OPEN CLAIMS	AVERAGE LAE RESERVE (OPEN CLAIMS)	AVERAGE LAE INCURRED & RESERVED (CLOSED & OPEN FILES)
1982	721	\$5,090	21	\$13,810	\$5,719
1983	776	2,995	35	16,133	3,967
1984	768	3,781	83	17,241	6,481
1985	937	3,072	154	17,578	7,027
1986	758	1,738	242	23,295	10,170
1987	787	1,111	523	13,225	9,756
TOTAL	4,747	\$3,244	1,058	\$16,585	\$7,194

The same argument the insurers made regarding Table 3A and claim severity trends (see p. 18) could also be made with regard to the LAE severity trends reflected in Table 5A. Accordingly, Table 5B is a comparison of average allocated LAE according to the loss development year.

TABLE 5B: AVERAGE ALLOCATED LAE  
BY EQUIVALENT DEVELOPMENT YEAR

POLICY YEAR	CLAIMS CLOSED YEAR 1	CLAIMS CLOSED YEAR 2	CLAIMS CLOSED YEAR 3	CLAIMS CLOSED YEAR 4	CLAIMS CLOSED YEAR 5
1982	\$ 522	\$1,438	\$4,586	\$8,902	\$13,879
1983	316	625	3,249	6,604	13,934
1984	185	1,350	2,670	17,065	
1985	479	1,200	6,300		
1986	382	1,300			
1987	562				
TOTAL NUMBER OF CLAIMS CLOSED	726	1,527	724	263	109

Once again, if loss adjustment expenses were increasing, each column in Table 5B should show an upward trend. However, this table clearly indicates no discernable upward trend in loss adjustment expenses when comparing claims at equal points in their development.

F. Disposition of Closed Claims

The claims were resolved through numerous methods which are categorized in Table 6. Files where there was no loss payment account for 73.4 percent of all closed files. Over one-third of the files were closed due to a lack of activity or pursuit by the claimants.

TABLE 6: DISPOSITION OF CLOSED FILES

DISPOSITION	TOTAL FILES	PERCENT OF TOTAL	AVERAGE LOSS PAYMENT	AVERAGE LAE	AVERAGE TOTAL COST
No Activity/Not pursued	1,325	35.9%	N/A	\$ 330	\$ 330
Settled	1,073	29.1	\$45,364	5,449	50,813
Dismissed	457	12.4	N/A	2,604	2,604
Dismissed with Prejudice	260	7.1	N/A	3,423	3,423
Statute of Limitations Expired	240	6.5	N/A	478	478
Tried	110	3.0	40,042	27,907	67,949
Summary Judgment	82	2.2	N/A	3,112	3,112
Claim Denied	59	1.6	N/A	306	306
Unknown	52	1.4	10,527	1,780	12,307
Conciliation Court	26	0.7	78	1,094	1,172
Arbitration	5	0.1	3,250	5,001	8,251
TOTAL	3,689	100.0%	\$14,542	\$ 3,244	\$17,786

Three percent (110) of the closed claims were decided by a jury. The defense prevailed in 81 percent (90 of 110) of the tried cases. Claims that were tried cost the insurance companies over five times as much, on average, in allocated LAE than settled claims. However,

the average loss payment was considerably less on the tried claims than those that were settled. Thus, the cost for litigated cases exceeded the cost of negotiated cases by 33.7 percent. There is no evidence that the percentage of claims being tried is increasing. For the years 1982-85 where most files have been closed, the percentage of cases tried has remained remarkably constant: 1982, 6.7 percent; 1983, 3.2 percent; 1984, 2.9 percent; 1985, 2.2 percent.

TABLE 7: COMPARISON OF COSTS  
SETTLED VERSUS TRIED CLAIMS

	NUMBER OF CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE	TOTAL COST
CLOSED SETTLED CLAIMS	1073	\$45,364	\$ 5,449	\$50,813
CLOSED TRIED CLAIMS	110	\$40,042	\$27,907	\$67,949

G. Non-economic Damages

Non-economic damages have been a central issue in the malpractice debate. Insurers have asserted, "The huge amounts awarded (by juries) for punitive damages, pain and suffering, and other non-economic loss provide a windfall for the plaintiff while resulting in substantial costs to all other patients in the aggregate." (Medical Malpractice: A Second Opinion. National Association of Independent Insurers (1986) p.10) There were no punitive damages awarded in any of the 110 cases that were tried in the three survey states during the last six years. Further, both companies exclude punitive damages under the terms of their policy. There also were no pain and suffering awards specified in any of the jury verdicts in the study. It should also be noted that the entire issue of non-economic damages is minimized by the fact that there were only 20 cases where any compensation was awarded a plaintiff by a jury verdict due to physician malpractice. Thus, there is no data upon which the insurer can argue that damages for non-economic loss have increased.

H. Physician Specialty

The physicians who were the object of claims have been classified by specialty using the thirty categories listed in Table 8. The table shows the relative market presence of each specialty as a percentage of the total number of insureds and the corresponding percent of total claims and dollar losses for the six years of the study.

TABLE 8: EXPERIENCE COMPARISON  
BY PHYSICIAN SPECIALTY

SPECIALTY	PERCENT OF INSURED	PERCENT OF CLAIMS	PERCENT OF DOLLAR LOSSES
General/Family Practice	35.6%	22.3%	35.3
Internal Medicine	11.1	6.6	4.6
Pediatrician	5.2	2.4	1.4

Table 8 cont.

SPECIALTY	PERCENT OF INSUREDS	PERCENT OF CLAIMS	PERCENT OF DOLLAR LOSSES
General Surgeon	5.1	10.3	16.6
Obstetrician/Gynecologist	4.9	10.1	8.2
Anesthesiologist	4.0	4.0	1.6
Orthopedic Surgeon	3.8	7.6	7.0
Emergency Medicine	3.5	1.5	1.0
Ophthalmologist	3.4	2.2	1.1
Pathologist	3.0	0.7	0.7
Radiologist	2.9	3.5	2.7
Psychiatrist	2.7	1.6	0.7
Unknown/Other	2.6	15.5	9.5
Neurologist	2.3	2.9	1.6
Urologist	1.7	1.8	1.1
Cardiologist	1.4	1.4	1.6
Dermatologist	1.1	0.5	1.2
Ear/Nose/Throat	1.1	1.5	0.3
Plastic Surgeon	1.0	1.1	0.6
Allergist	0.6	0.3	0.0
Oncologist	0.5	0.4	0.8
Thoracic	0.5	0.6	0.3
Gastroenterologist	0.4	0.3	0.1
Occupational Medicine	0.4	0.2	0.3
Endocrinologist	0.3	0.1	0.0
Pulmonary Specialist	0.3	0.1	0.3
Colon & Rectal	0.2	0.3	1.5
Geriatrics	0.2	0.0	0.0
Rheumatologist	0.2	0.1	0.0
Neonatalogist	0.1	0.1	0.0

General surgeons, orthopedic surgeons, and obstetricians/gynecologists have a claim rate that is approximately double their presence in the marketplace. General/family practice physicians, as well as internal medicine specialists, pathologists, ophthalmologists, psychiatrists, dermatologists, allergists, emergency medicine specialties, and pediatricians all have significantly fewer claims than one would expect based on their relative numbers.

Tables 9-11 below show the average loss payment and average allocated LAE for specialties where there was a minimum of ten closed claims. For comparison purposes, the overall average loss payment for all closed claims was \$14,542, and the average allocated LAE was \$3,244.

TABLE 9: SPECIALTIES WITH HIGHER THAN AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Dermatologist	20	\$32,279	\$3,273
Oncologist	15	28,049	3,429
General/Family Practice	635	22,706	4,388
General Surgeon	401	22,049	3,580

TABLE 10: SPECIALTIES WITH  
NEAR AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Cardiologist	54	\$15,399	\$4,892
Pathologist	28	14,185	4,669
Orthopedic Surgeon	283	13,208	2,866
Radiologist	123	11,883	1,981
Ob/Gyn	386	11,364	3,105

TABLE 11: SPECIALTIES WITH  
BELOW AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Emergency Physician	52	\$10,081	\$1,682
Internal Medicine	244	10,031	2,253
Unknown	520	9,329	3,023
Urologist	64	9,392	3,604
Neurologist	94	9,124	2,604
Pediatrician	88	8,580	1,495
Plastic Surgeon	41	7,405	2,741
Psychiatrist	53	7,383	4,509
Ophthalmologist	84	6,966	3,022
Thoracic	27	6,791	2,890
Anesthesiologist	161	5,473	2,043
Ear/Nose/Throat	45	3,275	2,359

The obstetrician/gynecology specialty has been a primary focus in the malpractice debate. The tables indicate that while their frequency rate is higher than average, the average loss payments for obstetricians is \$3,000 below the average for all physicians. General surgeons are an example of a specialty with higher than average frequency and severity while emergency physicians are below average in both categories.

It should be noted that, when broken down by specialty, the size of the sample is not large enough to draw any definite conclusions relative to the experience of any one specialty.

#### I. Location of Injury Occurrence

The location where the injuries occurred were separated into seven areas. The distribution of claims by location are shown in the table below.

TABLE 12: LOCATION OF INJURY OCCURRENCE

LOCATION	PERCENT TOTAL	AVERAGE PAYMENT CLOSED FILES	AVERAGE PAYMENT LOSS FILES
Surgery	34.3%	\$13,000	\$45,571
Clinic	23.1	12,173	45,327
Patient Care Area	10.5	14,326	58,876
Labor/Delivery/Nurs.	9.4	32,505	117,654
Emergency Room	9.0	20,334	67,985
Office	7.6	9,324	36,674
Hospital-Other	4.6	4,601	31,826
Other/Unknown	1.5	3,543	29,357
TOTAL/AVERAGE	100.0%	\$14,542	\$54,629

The most expensive injuries are those that occur during labor and delivery. The largest percentage of claims results from events occurring in the operating room, accounting for over one-third of all claims made.

#### J. Cause of Loss

The causes of the injuries resulting in claims were identified by using the 107 different categories developed and used by St. Paul Companies (see Appendix D). Eighteen of these causes contributed more than one percent of the total claims (open and closed) and they are listed in Table 13 below. The table also gives the average loss payment for closed claims and average payment on loss files only.

TABLE 13: COMPARISON OF LOSS CAUSES

CAUSE OF LOSS	QUANTITY OF CLAIMS	PERCENT OF ALL CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE PAYMENT LOSS FILES
Post Operative Complications	774	16.3%	\$11,382	\$44,859
Other	657	13.8	5,932	32,406
Birth Related Problems	394	8.3	31,891	142,514
Failure to Diagnose Cancer	250	5.3	21,483	89,202
Surgery, Inadvertant Act	234	4.9	15,802	49,347
Failure to Diagnose FX/Dislocation	198	4.2	4,933	20,381
Improper Treatment FX/Dislocation	172	3.6	11,391	42,565
Drug, Side Effect	121	2.5	10,007	41,394
Failure to Diagnose Infection	112	2.4	55,597	166,790
Surgery, Inappropriate Procedure	105	2.2	15,972	53,025
Pregnancy Related Problems	103	2.2	21,923	68,204
Failure to Diagnose Heart Attack	84	1.8	31,949	118,669
Lack of Supervision/Control	74	1.6	3,462	15,981
Incorrect Drug	74	1.6	28,689	67,419
Unnecessary Surgery	67	1.4	5,779	10,422
Post Operative, Death	64	1.3	14,250	51,061
Lack of Informed Consent	60	1.3	13,628	43,439
Surgery, Sponge Left	52	1.1	4,203	6,693
TOTAL/AVERAGE	3,595	75.7%	\$14,542	\$54,629

The highest average payments were made on claims arising out of birth related injuries and failure to diagnose an infection. These were the only two types of causes where the average payment on loss files only exceeded \$100,000. The category "other" is not "unknown", but rather is a cause that is not included on our list. The relatively large size of this category is due to the many claims that result from unusual and unique events which are difficult to categorize.

Table 14 illustrates a more general breakdown of the loss causes through a combination of related types of injuries. These ten categories account for nearly eighty percent of all claims.

TABLE 14: LOSS CAUSE COMPOSITE

CAUSE OF LOSS	PERCENT OF ALL FILES
Surgical Related Problems	29.5%
Other	13.8
Pregnancy/Birth Related	10.7
Fracture/Dislocation Related	7.8
Failure to Diagnose Cancer	5.3
Drug Related	5.3
Failure to Diagnose Infections	2.4
Failure to Diagnose Heart Attack	1.8
Lack of Supervision/Control	1.6
Lack of Informed Consent	1.3
TOTAL	79.3%

K. Characterization of Claimants

The ages of the claimants were grouped according to the breakdowns listed in Table 15. The average loss payment was the highest for the youngest of all claimants. It then declined to a low in the teen years and began rising during the wage earning years reaching a second (lower) crest during the peak wage earning years of 35-55. It then dropped continuously as age increased.

TABLE 15: COMPARISON OF LOSSES BY AGE OF CLAIMANT

	PERCENT ALL CLAIMS	AVERAGE PAYMENT CLOSED FILES	AVERAGE PAYMENT LOSS FILES
Birth - 30 Days	5.8%	\$35,273	\$133,175
Over 30 Days - 2 Years	3.7	20,188	80,750
Over 2 Years - 12 Years	3.2	12,405	51,528
Over 12 Years - 18 Years	4.0	8,319	26,849
Over 18 Years - 35 Years	30.6	13,505	48,591
Over 35 Years - 55 Years	22.1	19,180	68,283
Over 55 Years - 70 Years	15.1	13,361	51,537
Over 70 Years	6.7	8,385	31,321
Unknown	8.9	4,991	24,125
TOTAL/AVERAGE	100.0%	\$14,542	\$54,629

Female claimants accounted for 56.3 percent of all the claimants while 42.7 percent of the claimants were male. In 1.0 percent of the files there was too little information to determine the sex of the claimant. The average loss payment for males was \$18,107 compared with \$12,119 for females, making the average loss payment for males nearly 55 percent more than the average for females.

L. Relationship of Claimant and Physician

In reviewing files, the examiners sought to determine whether the claim was the result of a visit to the claimant's regular physician or the result of a first or second time visit to a physician not seen regularly. In the case of specialists, they determined whether or not the claimant had been seeing this specialist for a problem over a period of time. An example would be a woman who had a family practice physician but who saw an obstetrician during her pregnancies. Both physicians, in this case, would be considered her regular doctor.

Claims made against physicians who were believed to have seen the claimant no more than a couple of times accounted for 62.8 percent of all claims compared with 26.7 percent which were filed against the claimants' regular physicians. In 10.5 percent of the claims this relationship could not be determined. The average loss payment made on behalf of a claimant's regular physician was \$18,122 while an average of \$13,337 was paid on behalf of physicians who were not seen by the claimant on a regular basis.

While this data may indicate that patients are less likely to file a claim against a physician with whom they have had an on-going relationship, it may also be an indication of the increased risk associated with the work of specialists who frequently would not be categorized as a "regular physician."

M. Frivolous Claims

As stated earlier, question #25 of the survey form was included to determine the volume of frivolous claims. It should be noted that the results of the question as phrased reflect the companies' evaluation of the physician's liability rather than the examiner's evaluation. The files indicate that 8.6 percent of all claims reported definitely involve liability and 16.8 percent probably do, according to the insurers. The files also indicate that liability was doubtful in 28.3 percent of all claims and that physicians liability was virtually ruled out by the company in 10.5 percent of the cases. Liability was uncertain in 34.4 percent of the files reviewed.

If the frivolous claims are defined as those identified by the company as cases of definite absence of liability on the part of the physician, then frivolous claims cost an average total of \$112,940 per company annually in loss and loss adjustment expenses. If the definition of a frivolous claim is broadened to include those claims the companies identified as doubtful liability cases, the annual cost per company increases to \$615,532.

Comparing these frivolous claim costs to earned premium, the data indicates that such claims cost insurers between .5 percent and 3 percent of earned premium each year, depending on whether the narrower or wider definition of a "frivolous claim" is used. The assertion that frivolous claims are to blame for rapidly rising insurance rates or that an explosion of frivolous suits has occurred is not substantiated by the data.

The data does not indicate any increase in frivolous claims over the last six years. Table 16 shows the percentage of all claims where liability was judged improbable or ruled out by the company.

TABLE 16: FRIVOLOUS CLAIM TRENDS

REPORT YEAR	TOTAL CLAIMS REPORTED	"NO LIABILITY" CLAIMS	"DOUBTFUL LIABILITY" CLAIMS
1982	721	7.8%	30.9%
1983	776	12.1	27.4
1984	768	10.2	29.4
1985	937	12.8	29.5
1986	758	12.1	28.6
1987	787	7.2	23.8
TOTAL/AVG.	4,747	10.5%	28.3%

The data does indicate that there are ways in which the cost of frivolous claims may be controlled. St. Paul Companies spent, on average, nearly twice as much per claim on losses and loss adjustment expenses resulting from frivolous claims than did MMIE. MMIE's average loss payment per claim where their evaluation indicated "no liability" was \$72 while St. Paul's was \$575, almost eight times MMIE's figure. The average allocated LAE cost on the same group of claims was \$1,555 at MMIE and \$2,559 at St. Paul. The total cost of the average frivolous claim at MMIE then was \$1,627 and the comparable cost at the St. Paul was \$3,134. The difference between companies was greater when comparing the "doubtful liability" category where St. Paul's total loss and loss adjustment expense costs were 2.4 times those of MMIE.

N. Company Comparison

A comparison of the experience of the two companies examined is pertinent because of their differing management structures and organizations. Physician-run companies such as MMIE have been criticized nationally by the commercial insurance industry for poor management and the use of artificially low rates.

However, the study data indicates that MMIE's claims management is, in fact, more efficient than St. Paul's. For example, St. Paul Companies spent on average more than twice as much in allocated loss adjustment expenses per claim compared to MMIE. The St. Paul also paid a higher average loss per claim, one and one half times

the average loss payment of MMIE. The companies also differed in the amount of time needed to close a claim. This trend is particularly evident in recent years where, in 1986 and 1987, MMIE has closed approximately 20 percent more of their total claim files in each year than St. Paul has.

Tables 17 and 18 compare allocated LAE, average loss payments and the percentages of total claims that have been closed, by year, for each company.

TABLE 17: MMIE LOSS EXPERIENCE

REPORT YEAR	TOTAL FILES	PERCENT CLOSED	AVERAGE LOSS PAYMENT	AVERAGE LAE
1982	298	99.7%	\$15,795	\$3,577
1983	347	95.4	7,714	1,952
1984	380	90.5	10,357	1,855
1985	464	87.7	11,481	1,986
1986	355	79.4	14,156	1,289
1987	407	42.5	6,650	383
TOTAL/AVG.	2,251	81.5%	\$11,245	\$1,955

TABLE 18: ST. PAUL COMPANIES LOSS EXPERIENCE

REPORT YEAR	TOTAL FILES	PERCENT CLOSED	AVERAGE LOSS PAYMENT	AVERAGE LAE
1982	423	95.3%	\$28,147	\$6,205
1983	429	95.6	12,622	3,838
1984	388	87.9	24,771	5,723
1985	473	79.5	15,892	4,248
1986	403	58.1	5,294	2,279
1987	380	23.9	9,259	2,494
TOTAL/AVG.	2,496	74.3%	\$17,802	\$4,519

## V. FAILURE OF COMPETITIVE RATING IN "NICHE" MARKETS

Medical liability underwriting requires a high degree of expertise that takes time and money to develop. There are a number of reasons why it is not feasible for insurers to move in and out of the medical liability market in the same way they may enter and exit other, less complex liability insurance markets.

First, accurate and comprehensive data is not available to potential insurers. The same type of loss information found in this report is necessary for an insurer contemplating market entry to make an informed decision. The insurance industry has its own data gathering organizations such as the Insurance Services Office (ISO). Neither St. Paul Companies nor MMIE, however, report medical malpractice loss experience to ISO. Thus, the data published by ISO for this line of insurance lacks credibility, at least with respect to Minnesota experience. In addition, neither the state or federal government has obtained the necessary loss data. The result has been a significant information gap and consequently, a competitively weak market.

Second, the number of purchasers in specialty markets such as medical malpractice are not sufficient to generate substantial number of competing vendors. Insurers must insure large numbers of policyholders to spread risks. Just as airlines cannot sustain long term competition in niche markets where there is limited market demand, the limited number of policyholders in the malpractice market makes it clear that new competitors will not likely survive market entry against a well established and financial competitor.

Third, the demand for malpractice insurance is highly inelastic. Unlike other lines of insurance where coverage type, policy limits or coverage needs vary and may provide a basis for non-price competition, competition in the physician malpractice market is based almost solely on price. A potential new insurer cannot create a market niche by offering a unique product. There is little variation in coverage types and policy limits are frequently determined by a physician's employer or by hospitals where a physician has privileges. Physicians are unlikely to buy more coverage than what is required regardless of the price. Perhaps the only non-price competitive base is a "good reputation" particularly with respect to defending and paying claims, something that a new insurer entering the market could not readily acquire.

Thus, the degree of specialization required for successful underwriting of ~~medical~~ malpractice necessitates that a new insurer quickly build a significant volume of business not only to spread risk but to justify the high cost of entering such a specialized market. An insurer like St. Paul Companies that has been in the market for over 50 years has an overwhelming advantage in terms of access to long-term loss data as well as the company's long-standing reputation and underwriting expertise.

MMIE's successful entry into the market is likely a product of the built-in expertise of its physician management and the market draw of its original organizational structure as a mutual-type company. MMIE has succeeded in keeping their rates below St. Paul's and has managed claims in a more cost-effective manner.

It is obvious that insurers are charging considerably higher rates than are necessary to cover losses and expenses and also realize a healthy profit. The ratemakers have not accounted for the historically consistent disparity between actual loss payments and loss reserves. Indeed, the data on file indicates that when all claims are closed, the 1985-87 loss ratios will be substantially lower than the 80-85 percent range targeted by the carriers. Indeed, when the reserves are properly calculated, the loss ratio will likely be under 50 percent.

## VI. CONCLUSIONS

- ° With the exception of self-insured groups, the St. Paul Companies and Minnesota Medical Insurance Exchange insure nearly 100 percent of Minnesota's physicians. Thus, this report's data represents the only known comprehensive study of physician loss experience for any jurisdiction over the last six years.
- ° The frequency of claims per year has not materially changed over the past six years.
- ° The severity of the claims payment has not materially changed over the six year period.
- ° Fewer than one-half of one percent of all malpractice claimants are awarded damages by a jury. Most important, this figure has remained constant over the period of the study;
- ° Claims determined by the insurer to be frivolous have not increased over the past six years.
- ° The likelihood of receiving compensation as a result of filing a malpractice claim is approximately 25 percent. This rate has not materially changed over the period of the study;
- ° No punitive damages were found to be awarded against a physician.
- ° The average cost of investigation and defending a claim has changed little in the last six years. Indeed, the amount appears to be decreasing; and
- ° Despite unchanging claim frequency and declining loss payments and loss expense, on average, physicians paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982.

## VII. RECOMMENDATIONS

- ° An independent government agency should periodically conduct claims examinations in specialty lines of insurance.
- ° The data collected and compiled as a result of these examinations shall be made readily available to the public. This would:

- \* enable competing insurers to recognize competitively weak markets to enter.
- \* enable public policy makers to debate insurance and liability issues with credible statistics.
- \* enable the regulators to address difficulties with pricing and availability of coverage.
- ° On the basis of the data collected through such examinations, the government should review and, if necessary, regulate the premium.
- ° When the market become less competitive, the government should establish underwriting pools to make coverage available. The rates charged by these pools, however, should not undercut or discourage a competitive market.

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# PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY INSURANCE POLICY

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INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE

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PARTNERSHIP/PROFESSIONAL ASSOCIATION/BUSINESS TRUST/PROPRIETORSHIP  
PROFESSIONAL LIABILITY INSURANCE

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PROFESSIONAL PREMISES LIABILITY INSURANCE

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MINNESOTA  
**mie**

**MINNESOTA MEDICAL INSURANCE EXCHANGE**

MMIE IS A "RECIPROCAL" INSURANCE COMPANY

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## TO OUR POLICYHOLDERS

This is a "claims-made" Policy. It only covers claims arising from the performance of **Professional Services** subsequent to the retroactive date indicated on the Declarations Page attached hereto and then only to the extent provided in the provisions of the Policy while the Policy is in force. No coverage is afforded for claims first made prior to the effective date of this Policy, and no coverage is afforded for claims first made after the termination of this Policy unless and to the extent that reporting endorsements are purchased in accordance with Article IV, Section (c) of this Policy. Please review the Policy carefully.

**mie**

**MINNESOTA MEDICAL INSURANCE EXCHANGE**

2221 University Avenue, S.E. • Minneapolis, MN 55425

Minnesota: Minnesota 88-13

612 623 1132 • 800 480 8226

PROFESSIONAL PREMISES LIABILITY

Name and Address of Insured

Policy Number

In consideration of the required premium, the policy is effective from \_\_\_\_\_ to \_\_\_\_\_

12 01 A.M. standard time at the address of the Named Insured as stated

Insurance is afforded only with respect to the Coverage Part(s) for which a premium charge or "NO CHARGE" is indicated. The limits of MMIE's liability shall be as stated, subject to all the provisions of the policy, attached hereto.

**PART I PROFESSIONAL LIABILITY INSURANCE**

- ( ) Individual Professional Liability
- ( ) Partnership, Corporation, Professional Association or Business Trust Professional Liability

Limits of Liability

each claim aggregate

The Insured's principal specialty is:

The Insured's Basic Retroactive Date is

**SAMPLE**

Class

Premium

Individual Professional Liability

Partnership, Corporation, Professional Association or Business Trust Professional Liability

Paramedical Personnel Coverage

Endorsements Part I

**PART II PROFESSIONAL PREMISES LIABILITY COVERAGES**

Injury Limits

each occurrence

Property Damage Limits

each occurrence

Location Address

1

2

3

4

Endorsements Part II

Total Policy Premium

Issued by Minnesota Medical Insurance Exchange  
(A Reciprocal Insurance Company, organized in the State of Minnesota,  
herein called MMIE)  
Issue Date

Authorized Representative

The Mutual Reinsurance Exchange (MMIE) hereby certifies that the  
- the entire text of the representations and warranties contained in the  
- made a part hereof, and subject to all of the provisions of this Policy, with  
person named on the Declarations Page the "Named Insured" as follows:

## I. INSURING AGREEMENTS

### PART I - PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

**Individual Professional Liability:** To pay on behalf of the Named Insured all sums which the Named Insured shall become legally obligated to pay as Damages because of any claim or claims first made against the Named Insured during the Policy Period arising out of the performance of Professional Services rendered or which should have been rendered subsequent to the retroactive date in the practice of the Named Insured's profession as a physician, by the Named Insured or by any person for whose acts or omissions the Named Insured is legally responsible, except when such legal responsibility is related to the Named Insured's status as a member of a Partnership, Professional Association, Business Trust or Proprietorship.

**Partnership, Professional Association, Business Trust or Proprietorship Professional Liability:** To pay on behalf of the Named Insured all sums which the Named Insured shall become legally obligated to pay as Damages because of any claim or claims first made against the Named Insured during the Policy Period arising out of the performance of Professional Services rendered or which should have been rendered subsequent to the retroactive date in the practice of the profession of physician by any person for whose acts or omissions the Named Insured Partnership, Professional Association, Business Trust or Proprietorship is legally responsible.

MMIE shall have the right and duty to defend any suit against the Named Insured alleging such Damages, even if any of the allegations of the suit are groundless, false, or fraudulent, and may make such investigation or such settlement of any claim or suit as it deems expedient, but MMIE shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of MMIE's liability has been exhausted by payment of judgments or settlements.

#### Exclusions:

Part I does not apply:

- a to liability of any Named Insured as a proprietor, partner, shareholder, executive officer, administrator, committee member, director, or medical director of any hospital, sanitarium, infirmary, clinic with bed and board facilities, nursing home, abortion clinic, drug abuse clinic, surgi-center, blood bank, commercial laboratory, Health Maintenance Organization, preferred provider organization or other professional or business enterprise, but with respect to the term commercial laboratory this exclusion does not apply to laboratory facilities maintained primarily for testing of the Named Insured's own patients nor to an x-ray or pathological laboratory if the Named Insured is a radiologist or pathologist;
- b to liability of any Named Insured when any Named Insured is enrolled in, and rendering Professional Services pursuant to, a bona fide medical or surgical training program;
- c to liability of others assumed by any Named Insured under contract or agreement;
- d to any obligation for or on any Named Insured or any carrier as his insured under the held liable under any worker's compensation, unemployment compensation or disability benefits law or under any similar law;