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INDIANA	SB 85—Dram shop liability is now abolished except where a defendant furnishes alcohol to a visibly intoxicated person or where a plaintiff can show that service was a proximate cause of injury.
IOWA	SB 2265—Liability of servers has been limited to only those licensees who knew or should have known that a person consuming alcohol was already intoxicated; servers other than licensees or permittees may not be held liable for injuries resulting from a person's intoxication; consumption rather than service is legislatively declared the proximate cause of injury.
LOUISIANA	ACT 18—Those who sell, serve, or furnish alcoholic beverages generally not liable.
MAINE	LD 2080—Immunity to servers unless minors can prove negligent service. Does not apply when adult was visibly intoxicated. $250,000 cap exclusive of medical expenses.
MICHIGAN	HB 455—The liability of retail servers of alcohol has been limited to injuries resulting from service to a minor or visibly intoxicated person.
NEW HAMPSHIRE	HB 513—Limitations on dram shop liability have been enacted. Intoxicated drivers need to show gross negligence in future suits; defines "good business practices" for defense purposes.
NEW MEXICO	HB 244—Personal injury/death damages in dram shop actions is capped at $50,000/person, $100,000/incident. $20,000 for property damage. Establishes certain limitations of such liability.
TENNESSEE	HB 1199—Dram shop liability has been abolished except where a defendant serves an intoxicated person or a minor or where injury was caused by such service.
UTAH	SB 182—Liability in dram shop actions is limited to $100,000/$300,000 and is subject to one-year statute of limitations.
WYOMING	HB 13—Dram shop suits now may be brought only in circumstances where a licensee or other person sells or provides alcohol in violation of law.

J. GOVERNMENT LIABILITY (GOV)

ALABAMA	HB 178, SB 369—Grants immunity to certain members and associated 178 parties of various staff boards and commissions.
COLORADO	HB 1185-1187, HB 1196—Various limits on municipal liability including that arising out of water flow; clarifies immunity of public entities and employees.
CONNECTICUT	HB 6134—A measure limiting liability for acts of municipal employees has been enacted.
GEORGIA	HB 1471, HB 1549, HB 1526—Clarifies sovereign immunity of municipal corporations and establishes immunity for government employees and officials.
HAWAII	SB S1(SS)—The state and its subdivisions now have the option of paying judgments against them in excess of $1,000,000 by means of periodic payments.
HAWAII	HB 1993-86—Provides for additional exemptions to the state's tort claim act.
ILLINOIS	SB 1200—Public officials and employees are free from punitive damages claims when they arise from conduct of their official activities; the statute of limitations period in actions brought against public entities is shortened from two years to one year; local government liability is limited in actions arising from provision of traffic control devices and certain police, fire, and emergency services; local government liability is limited where a person is injured as the result of a hazardous recreational activity or on waterways adjacent to public property; local governments would no longer waive immunities by the purchase of insurance.
IOWA	SB 2265—Actual malice or a criminal offense must be proved for liability to be imposed upon officers and employees or municipalities and limits their liability for punitive damages; liability is limited regarding licensing decisions, the granting of permits, inspections, and financial regulatory activities.

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MAINE	SB 700—Immunity is now provided to mediators under contract with the state judicial department.
MICHIGAN	HB 5154, HB 5153—Joint as several liability is completely eliminated for municipalities; limits liability of the state and its subdivisions when engaged in the exercise of its governmental functions.
MISSISSIPPI	SB 2166—Sovereign immunity has been totally reinstated.
MISSOURI	SB 647—Reestablishes sovereign immunity with several exceptions.
MONTANA	SB 22XX—The liability of the state and its political subdivisions is capped at $750,000 per claimant and $1,500,000 per incident.
NEW HAMPSHIRE	HB 513—All civil damages against governmental subdivisions are limited to $150,000/$500,000. Joint and several immunity only applies against municipalities when over 50 percent at fault. Acts of a government unit or employee that result in a pollutant incident are conclusively presumed to be reasonable; this presumption applies where the unit acted in accordance with state-of-the-art technology; strict and absolute liability is not available in such actions.
SOUTH CAROLINA	HB 2266—Restores some of the state's sovereign immunity by reestablishing about 20 categories of qualified immunities and limited liability of the state and its subdivisions to $250,000/incident and $500,000/occurrence.
SOUTH DAKOTA	SB 216—Joint and several liability was modified in actions against local governments; sovereign immunity for public entities applies only to the extent of their liability insurance coverage.
TENNESSEE	SB 1701—Except where conduct amounts to willful, wanton, or gross negligence, members of boards of governmental entities are now immune from civil suit.
VIRGINIA	HB 624—A cap of $25,000 or the amount of insurance coverage carried is provided and awards

	of prejudgment interest and punitive damages are prohibited in actions against transportation districts.
WASHINGTON	SB 4630—Immunity has been provided for school board members and directors of hospitals.
WEST VIRGINIA	SB 3—Limits noneconomic damages in suits involving political subdivisions to $500,000, deploys 25 percent rule regarding joint and several liability, lays out standards for liability immunity or political subdivisions employees.
WYOMING	WY 39—Grants officers and board members of governmental entities immunity.

K. MEDICAL MALPRACTICE AND PROFESSIONAL & DIRECTORS/OFFICERS LIABILITY (MMPL)

ALASKA	AK SB 377—Civil liability has been limited for members of boards of not-for-profit organizations, hospitals, school boards, and municipalities.
COLORADO	SB 1201—Limits liability for mental health professionals when they use an accepted standard of care but fail to anticipate a patient's violent behavior.
CONNECTICUT	HB 6134—Plaintiffs in malpractice action are required to file a certificate of merit with their complaints indicating that another provider believes their claims have merit. Also limits liability of directors and officers of nonprofit organizations.
DELAWARE	SB 533—Except for breaches of loyalty, bad faith acts, intentional misconduct, and wrongful transactions from which a director derives personal benefit, shareholders of a corporation may now limit the liability of directors.
HAWAII	SS S1—All attorneys' fees in medical malpractice cases are subject to cost approval; also provides for a statute of limitations of two years after discovery or six years after act (except for minors).

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ILLINOIS	SB 1200—Immunity would be provided for officers and directors of certain not-for-profit corporations.
INDIANA	HB 1284—Directors of not-for-profit corporations have been given immunity for acts and omissions not covered by liability insurance coverage.
IOWA	SB 2265—Expert witnesses in medical and dental malpractice actions must have qualifications directly related to problems or treatments at issue; new requirements for disclosure of expert witnesses in professional liability actions; restricts the discovery and use of medical malpractice peer review and disciplinary proceedings; expands use of voluntary agreements.
KANSAS	HB 2661—Noneconomic damages are capped at $250,000 and all damages at $1,000,000 in medical malpractice actions; the noneconomic damage cap will be annually adjusted to reflect the consumer price index; new expert witness requirements; pre-trial settlement conferences are now required; courts are now able to review attorneys' fee arrangements in malpractice actions. Mandatory itemization of noneconomic damage awards and period payment of all settlements; "pinhole" provisions for court award of supplemental medical expenses up to $3 million.
MAINE	SB 958—Mandatory prelitigation screening by mediation panels in malpractice actions; three-year statute of limitations for actions for professional negligence; prohibits wrongful birth and wrongful life actions; mandatory periodic payments of future awards in excess of $250,000; establishes an attorneys' contingent fee scale in malpractice actions.
MARYLAND	SB 600—Personal immunity for directors of charitable organizations if the organization is insured.
MASSACHUSETTS	HB 5700—Noneconomic damages in medical malpractice actions are now capped at $500,000 unless special circumstances are demonstrated indicating a plaintiff will not be justly compen-

	sated. Collateral source rule modified. Attorney fees limited in medical malpractice cases.
MICHIGAN	HB 5154—Noneconomic damages in medical malpractice actions are capped at $225,000 and the cap will be adjusted to reflect the C.P.I. (this cap does not apply in wrongful death actions, intentional torts, foreign objects left inside, actions involving reproductive system injuries, and actions for loss of a vital bodily function and a few other exemptions); stricter standards for expert witnesses, and a prohibition contingent fee on compensation of expert witnesses; option for defendants to file an affidavit of noninvolvement rather than an answer; itemized damages; collateral source rule modifications; a new mediation system for medical malpractice actions; a statute of limitations is now six years regardless of when injury was discovered, and other miscellaneous provisions.
MISSOURI	SB 663—A cap of $350,000 has been enacted on damages for noneconomic loss in medical malpractice actions; the cap amount is the limit that may be awarded against each individual provider. Requires submission of an affidavit that the action is not frivolous.
NEW HAMPSHIRE	HB 513—Directors' and officers' liability is now limited; the burden of proof in medical malpractice actions has been revised.
NEW YORK	SB 9740—Medical malpractice plaintiffs are now required to file a certificate of merit with their pleadings and a new arbitration procedure is available in medical malpractice actions when defendants concede liability; new provisions for monitoring professional competence and investigating misconduct are provided.
	SB 9351—The liability of directors, officers, and trustees of not-for-profit corporations is limited to cases of "gross negligence."
OHIO	SB 366—Immunity has been extended to uncompensated members of boards of directors of charitable organizations.

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RHODE ISLAND — SB 2891—Attorneys' fees and costs are now available as sanctions in frivolous malpractice actions; additionally, the collateral source rule has been modified to provide for introduction of evidence of additional sources of a malpractice plaintiff's recovery and an offset of such sources.

SOUTH DAKOTA — SB 282—The previous cap on noneconomic damages in medical malpractice actions has been changed to a cap of $1,000,000 covering all damages; the cap was broadened to include actions against all health care providers.

TENNESSEE — SB 1701—Except for willful, wanton, or gross negligence, directors and members of boards of not-for-profit entities are immune from suit.

UTAH — SB 111—Noneconomic damages in medical malpractice actions are capped at $250,000 (specifically included are damages for pain and suffering and inconvenience; punitive damages are specifically excluded from the cap).

SB 155—Periodic payment of damages in medical malpractice actions is now mandated upon request of either party.

WASHINGTON — SB 4630—Immunity has been provided for school board members, directors of hospitals, and officers and directors of nonprofit organizations.

WEST VIRGINIA — SB 714—A $1,000,000 cap on noneconomic damages has been enacted on medical malpractice damages; the use of ad danmum clauses is now prohibited in medical malpractice pleadings; a two-year malpractice statute of limitations includes a discovery standard for accrual; all medical malpractice actions must be brought within 10 years of the injury; the period for which minor causes of actions are preserved has been shortened; medical malpractice actions accruing for a minor under 10 years of age must be brought within two years or by the child's twelfth birthday, whichever is later; greater peer review powers have been granted to the Board of Medicine; mandatory pretrial conferences are now required;

frivolous suit sanctions are provided; expert witness standards are specified; joint and several liability has been modified in medical malpractice actions; joint and several liability applies to defendants who are 25 percent or more negligent; several liability applies to defendants who are less than 25 percent negligent.

WISCONSIN

AB 4—Damages in medical malpractice actions have been capped at $1,000,000; attorney's fees have been regulated in malpractice actions; tougher medical disciplinary standards have been enacted.

WYOMING

HB 12, HB 40—Modifies the standard of care used to determine medical malpractice; pretrial screening panels.

HB 39—Grants nonprofit officers and board members of nonprofit entities immunity.

L. MISCELLANEOUS PROVISIONS (MISC)

ALASKA

SB 377—The definition of fault used in the state's comparative fault language has been expanded to include reckless actions, strict liability, and product liability. Bars a party from recovering losses for personal injury or death if it occurs during his or her commission of a felony.

ARIZONA

HB 2377—Raises limits for mandatory arbitration.

COLORADO

SB 69—A measure has been enacted shortening the statute of limitations peri[illegible] the bringing of civil actions from four [illegible] to two years (intentional torts are one year).

SB 76—A Good Samaritan provision has been enacted.

SB 1192—Limits liability for the manufacturing of firearms.

SB 1205—Limits a homeowner's liability when the property is entered illegally.

HAWAII	SB 1(SS)—An arbitration provision has been enacted applicable to actions seeking damages up to $150,000. Punitive damages are now uninsurable unless specifically provided. Also abolishes cause of action for serious emotional distress arising from damage to property or material objects.
INDIANA	HB 1284—Good Samaritan Rule applies to volunteers unless entity assisted has insurance.
IOWA	SB 2265—Plaintiffs found to have prosecuted three or more frivolous actions within five years may be required to post security. Ad damnum clauses have been prohibited in personal injury and wrongful death actions. The liability of non-manufacturers for product liability injuries has been limited. Creates state-of-the-art defense in P.L. suits. No discovery of a defendant's liability permitting prior establishment of a prima facie case.
KANSAS	SB 668—Evidence of product improvements may not be introduced in product liability actions; design feasibility evidence may be used only to impeach a witness who has denied feasibility.
LOUISIANA	ACT 952—Provides for limited civil liability connected with hazardous waste and asbestos abatement and cleanup.
MICHIGAN	HB 5154—A new mediation system for civil actions other than medical malpractice actions is now provided (this system is parallel to, but separate from, the medical malpractice mediation system described in Section II C).
	HB 5154—Reforms have been enacted in rules determining proper venue.
NEW YORK	A 10664, S 9391A—Statute of limitations extends from three years after exposure to three years after discovering an injury with a one-year revival of claims.
NEW HAMPSHIRE	HB 513—The statute of limitations period for personal injury actions has been shortened from six years to three years.

NEW JERSEY	SB 1678—Provides immunity to volunteer unpaid athletic coaches under certain circumstances.
OHIO	SB 366—Immunity to volunteers of nonprofit or charitable associations (some exemptions).
TENNESSEE	SB 1854—Asbestos removal immunity for local education agency employees.
WASHINGTON	SB 4630—Voluntary intoxication of a plaintiff by means of alcohol or drugs that is responsible for more than 50 percent of an injury is now a complete defense in wrongful death actions; defendants are protected from liability if the injured party was engaged in the commission of a felony.
WYOMING	HB 59—Makes certain entities not liable for injuries at amateur rodeos absent willful neglect.

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A special bibliography (SB 1064) provides a list of other RAND publications in the civil justice area. To request the bibliography or to obtain more information about The Institute for Civil Justice, please write the Institute at this address: The Institute for Civil Justice, The RAND Corporation, 1700 Main Street, P.O. Box 2138, Santa Monica, California 90406-2138, (213) 393-0411.

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STATE OF MINNESOTA

DEPARTMENT OF COMMERCE
ST. PAUL 55101

OFFICE OF THE COMMISSIONER

300 METRO SQUARE BUILDING
ST. PAUL, MN 55101

February 8, 1989

FEB 1 6 1989

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

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.

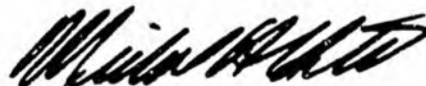
3. The number of purchasers of speciality lines of insurance such as medical malpractice is not sufficient to generate substantial numbers of competing vendors. Insurers must insure large numbers of policyholders to spread risk, and that the limited number of policyholders in a niche makes it clear that 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:nl
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. It's 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 representating 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 13a. ________
2. Individual
3. Group

14. List any other defendants in this case covered by the <u>same</u> <u>policy</u> given in #11. 14. ________

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

15. List any other defendants also covered by this insurer but under a <u>different</u> 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. ________

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02–576(2/77)

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 <u>paid to claimant</u>:

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:

____

____

____

____

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 accomodated 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	2,51[illegible],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 INSUREDS	QUANTITY CLAIMS	CLAIMS PER 100 INSUREDS
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

	AVERAGE LOSS PAYMENTS				
NOTICE YEAR	CLAIMS CLOSED YEAR 1	CLAIMS CLOSED YEAR 2	CLAIMS CLOSED YEAR 3	CLAIMS CLOSED YEAR 4	CLAIMS CLOSED YEAR 5
1982	$5,391	$11,567	$21,857	$49,668	$41,963
1983	1,801	4,885	13,665	17,602	36,649
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 3B 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 3B.

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	7,550	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 Judgement	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 INSUREDS	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 INSURED S	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
Rheumotologist	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	835	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
Opthalmologist	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, Inadvertent 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	18,422
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 artifically 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 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.

PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY INSURANCE POLICY

INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE

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

PROFESSIONAL PREMISES LIABILITY INSURANCE

MINNESOTA
mie
MINNESOTA MEDICAL INSURANCE EXCHANGE

MMIE IS A "RECIPROCAL" INSURANCE COMPANY

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 [illegible] 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.**

MMIE
MINNESOTA MEDICAL INSURANCE EXCHANGE
2221 University Avenue S.E. • Suite 222
Minneapolis, Minnesota 55414
612 623-1132 • 800 462-5326

PROFESSIONAL LIABILITY
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 limit 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

Individual Professional Liability

Class

Premium

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 occurr

Location Address

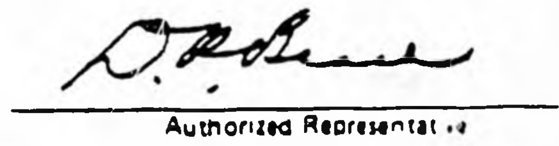
Prem

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 Minnesota Medical Insurance Exchange (MMIE) in consideration of the [illegible] in reliance upon the representations and warranties contained in the application made a part hereof, and subject to all of the provisions of this Policy, agrees with the 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 which any **Named Insured** or any carrier as his insurer may be held liable under any worker's compensation, unemployment compensation or disability benefits law or under any similar law;

(e) to liab[illegible] Named Insured [illegible] Damages resulting [illegible] is a w[illegible] statute, ordinance or regulation imposing [illegible] including punitive damages;

(f) to liability of any **Named Insured** for any punitive **Damages;**

(g) to liability of any **Named Insured** arising out of acts or omissions which [illegible] any time the **Named Insured's** license to practice medicine has been [illegible] revoked or voluntarily surrendered;

(h) to liability of any **Named Insured** arising out of acts or omissions of any **Employed Physician** which occur during any time such **Employed Physician's** license to practice medicine has been suspended, revoked or voluntarily surrendered;

(i) to liability of any **Named Insured** for **Damages** arising out of the dispensing or prescribing of controlled substances by any **Named Insured** during any time such **Named Insured's** controlled substance registration has been suspended, revoked or surrendered;

(j) to liability of any **Named Insured** for **Damages** arising out of the dispensing or prescribing of controlled substances by any **Employed Physician** during any time such **Employed Physician's** controlled substance registration has been suspended, revoked or voluntarily surrendered;

(k) to liability of any **Named Insured** for **Damages** with respect to:

(1) any claim made against any **Named Insured** at any time during any **Prior Policy Period,** regardless of whether or not such claim has been reported to any applicable liability insurer;

(2) any potential claim against any **Named Insured** of which any **Named Insured** is aware, or reasonably should have been aware, as of the date this Policy is issued, regardless of whether or not such claim has yet been made or reported to any applicable liability insurer. For purposes of this section (k)(2), potential claim includes without limitation instances where any **Named Insured** has received either an oral or written communication from a patient or his legal representative, and/or a request by a patient or his legal representative for copies of medical records under circumstances reasonably indicative of a potential claim;

(3) any claim based, in whole or in part, upon any act or omission of the **Named Insured** while outside the territorial United States and Canada.

PART II - PROFESSIONAL PREMISES 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:

BODILY INJURY,
PROPERTY DAMAGE, or
PERSONAL INJURY

caused by **an Occurrence** and arising out of the ownership, maintenance or use, as a **Professional Office,** of the **Insured Premises** and all operations necessary or incidental thereto, and **MMIE shall** have the right and duty to defend any claim or suit against the **Named Insured** alleging Damages, even if such suit is groundless, false or fraudulent, and may make such investigation and 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 hereunder has been exhausted by payment of judgments or settlements.

Exclusions:

Part II does not apply:

a. to **Bodily Injury** or Property **Damage** arising out of the ownership, operation, use, loading or unloading of
   (1) any automobile, aircraft or other air, sea or land vehicle owned or operated by or rented or loaned to the **Named Insured**, or
   (2) any other automobile, aircraft or other air, sea or land vehicle operated by any person in the course of his employment by the **Named Insured**;
   (3) this exclusion does not apply to the parking of an automobile on the **Named Insured's professional** office premises, if such automobile is not owned by or rented or loaned to the **Named Insured**;

(b) to any obligation for which the **Named Insured** or any carrier as his insurer may be held liable under any worker's compensation, unemployment compensation or disability benefits law, or under any similar law;

(c) to **Bodily Injury** to any agent or employee, partner, fellow worker or tenant of the **Named Insured** arising out of and in the course of his engagement or employment by the **Named Insured**;

(d) to **property damage** to
   (1) property owned or occupied by or rented to the **Named Insured**,
   (2) property used by the **Named Insured**, or
   (3) property in the care, custody or control of the **Named Insured** or as to which the **Named Insured** is for any purpose exercising physical control;

   but part (3) of this exclusion does not apply with respect to **property** damage, other than to elevators, arising out of the use of an elevator at the insured premises;

(e) to **Bodily Injury** or Property Damage due to nuclear reaction, nuclear radiation or radioactive contamination or escape of pollutants, or to any act or condition incident to any of the foregoing;

(f) with respects to Personal Injury, to liability assumed by the **Named Insured** under any contract or agreement;

(g) to liability of any **Named Insured** for **Personal** Injury resulting from an act or ommission which is a willful violation of a statute, ordinance or regulation imposing criminal penalties (including punitive damages);

(h) to **Personal Injury** arising out of any publication or utterance described in Group (2), if the first injurious publication or utterance of the same or similar material by or on behalf of the **Named Insured** was made prior to the effective date of this insurance;

(i) to **Personal Injury** arising out of a publication or utterance described in Group (2) of Section IV, a., (2) hereof concerning any organization or business enterprise, or its products or services, made by or at the direction of any **Named Insured** with knowledge of the falsity thereof;

(j) to any obligation for which the **Named Insured** may be liable arising out of the **performance** of **Professional Services.**

(k) to **liability** of any **Named** Insured with respect to:
   (1) **any claim** made against any **Named Insured** at any time during any **Prior Policy Period,** regardless of whether or not such claim has been reported to any applicable liability insurer;
   (2) any potential claim against any **Named Insured** of which any **Named Insured** is aware, or reasonably should have been aware, as of the date this Policy is issued, regardless of whether or not such claim has yet been made or reported to any applicable liability insurer. For purposes of this Section, k., (2), potential claim includes without limitation instances where any **Named Insured** has received either an oral or written communication from a patient or his legal representative, and/or a request by a patient or his legal representative for copies of medical records under circumstances reasonably indicative of a potential claim;

3 any claim based, in whole or in part, upon any act or omission of the Named Insured while the Named Insured is outside the territorial United States or Canada.

SUPPLEMENTARY PAYMENTS

In addition to the applicable limit of liability, MMIE will pay:

(a) all expenses incurred by MMIE, all costs taxed against the **Named Insured** in any suit defended by MMIE and all interest on that part of any judgment which does not exceed the limit of MMIE's liability thereon which accrues after entry of the judgment and before MMIE has paid or tendered or deposited in court such part of the judgment;
(b) premiums on appeal bonds required in any suit defended and appealed by MMIE and premiums on bonds to release attachments in any such suit for an amount not in excess of the applicable limit of liability of this Policy, but MMIE shall have no obligation to apply for or furnish any such bonds;
(c) expenses incurred by the **Named Insured** for first aid to others at the time of an accident, for **Bodily Injury** to which this Policy applies;
(d) the reasonable expenses incurred by the **Named Insured** for each day or part of a day the **Named Insured** is required to attend the trial of a civil suit against the **Named Insured** for **Damages** resulting from causes of action as described under Parts I and II, not in excess of $200.00 per day;
(e) if coverage is purchased under Part II, reasonable medical expenses for **Bodily Injury** sustained by any person (i) which resulted from an **Occurrence** on the **Named Insured's professional office premises**, or during any operations necessary or incidental thereto regardless of the **Named Insured's** liability for such **Bodily Injury**, and (ii) which were incurred by the **Named Insured** within one (1) year from such **Occurrence**; provided, however, that payments under this provision shall not exceed $1,000 per person and $10,000 per accident, and shall not apply to **Bodily Injury**:
    1 arising out of the ownership, maintenance, operation, use, loading or unloading of
        a any automobile, aircraft or other air, sea or land vehicle owned or operated by or rented or loaned to the **Named Insured**, or
        b any other automobile, aircraft or other air, sea or land vehicle operated by any person in the course of his employment by the **Named Insured**;

    but this exclusion does not apply to the parking of an automobile on the **Named Insured's professional office premises**, if such automobile is not owned by or rented or loaned to the **Named Insured**;
    2 due to war, whether or not declared, civil war, insurrection, rebellion or revolution or to any act or condition incident to any of the foregoing;
    3 to the **Named Insured**, any agent, employee, fellow worker, partner, tenant or other person regularly residing on the **Named Insured's professional office premises**, or any employee of any of the foregoing if the **Bodily Injury** arises out of and in the course of his employment therewith;
    4 to any other tenant if the **Bodily Injury** occurs on that part of the **Named Insured's professional office** premises rented from the **Named Insured** or to any agent or employee of such a tenant if the **Bodily Injury** occurs on the tenant's part of the insured premises and arises out of and in the course of his employment for the tenant;
    5 to any person while engaged in maintenance and repair of or alteration, demolition or new construction at the **Named Insured's professional office premises**;
    6 to any person if any benefits for such **Bodily Injury** are payable or required to be provided under any worker's compensation, unemployment compensation or disability benefits law, or under any similar law.

II. DEFINITION OF INSURED

(a) The word **Named Insured** shall mean as respects Part I:

1. under **Individual Professional Liability** each [illegible] Page;
2. under Partnership, Professional Association, Business Trust or [illegible] **Professional** Liability the Partnership, Professional [illegible] Proprietorship [illegible] named on the Declarations Page, and [illegible] respect to [illegible] omissions of others, provided that [illegible] **Named Insured** with respect to liability for his personal [illegible] nature;
3. any **Paramedical Employee** of the **Named Insured**, while [illegible] his employment duties, provided that notice of the employment [illegible] **Paramedical Employees** is given to MMIE when required;
4. any other employee not a physician or **Paramedical Employee** of the **Named Insured** while acting within the scope of his duties as such.

The insurance afforded applies separately to each **Named Insured** against [illegible] is made or suit is brought except with respect to limits of MMIE's liability [illegible] in Article IV, Section b.

(b) The word **Named Insured** shall mean as respects Part II:
the **Named Insured**, and includes any executive officer, director, or [illegible] thereof while acting within the scope of his duties as such, and any organization or proprietor with respect to real estate management for the **Named Insured**. If the **Named Insured** is a Partnership, Professional Association, Business Trust or Proprietorship, the unqualified words "**Named Insured**" also include any partner, shareholder, beneficiary or proprietor or member therein but only with respect to his liability as such.

III. POLICY PERIOD - TERRITORY

(a) Under Part I the insurance provided hereby only applies to **Professional Services** rendered or which should have been rendered subsequent to the retroactive date stated on the Declarations Page and then only if claim is first made during the **Policy Period** or a **Reporting Period** purchased in accordance with Article IV, Section c.

A claim shall be considered to be first made when MMIE first receives notice of the claim or of an event which may subsequently give rise to a claim (see Article IV, Section c for **Named Insured's** rights to have extended reporting endorsements issued).

A claim shall be considered to be "first made during the **Policy Period**" or "first made during a **Reporting Period**" only under the following conditions:

(1) If during the **Policy Period** or a **Reporting Period** (if purchased) the **Named Insured** shall have knowledge or become aware of any event, arising out of the rendering or failure to render **Professional Services** covered hereby, which may subsequently give rise to a claim and shall, during the **Policy Period** or such **Reporting Period**, give written notice thereof to MMIE in accordance with Article IV, Section [illegible] of this Policy, then such notice shall be considered a claim hereunder;

(2) if any claim is first made during the **Policy Period** or a **Reporting Period** (if purchased), alleging injury to an individual that would be covered under this Policy, any additional claims which are made, or suits or proceedings [illegible] connection therewith which are brought subsequent to the **Policy Period** [illegible]

Reporting Period [illegible] Damages [illegible] [illegible] part of the claim which was [illegible] Policy Period or [illegible] Reporting Period.

b. Under Part II, the insurance [illegible] hereby applies to **Bodily Injury**, **Property Damage** or **Personal Injury** which occurs during the **Policy Period** in the [illegible] States and Canada.

IV. CONDITIONS

a. **Definitions** - when used in this Policy or Endorsements forming a part hereof:

(1) Applicable to Part I:

"**Damages**" means all **Damages**, including **Damages** for death, which are payable because of injury to which this insurance applies, including any counter claim made in a suit brought by the **Named Insured** in the process of attempting to collect fees.

"**Named Insured**" means the person named on the Declarations Page.

"**Paramedical Employee**" includes medical assistants, technicians (including, but not limited to, [illegible] inhalation therapy, laboratory and x-ray), nurse anesthetists [illegible], obstetrical registered nurses (midwives), opticians, optometrists, [illegible], physical therapists, psychologists, psychotherapists, [illegible], nurse practitioners (e.g., cardiac, pediatric, [illegible]) and any other nurse practitioner or nurse employed [illegible] function in the practice of the **Named Insured's** profession.

"**Policy Period**" means the period of coverage commencing on the date shown on the Declarations Page attached to this Policy as Policy effective date and ending with the effective date of termination, expiration or cancellation of coverage under this Policy, and specifically excludes any **Reporting Period** purchased hereunder.

"**Policy Year**" means each consecutive annual period of the policy.

"**Prior Policy Period**" means the period of coverage commencing on the retroactive date shown on the Declarations page attached to this policy and ending upon the date shown as Policy Effective Date.

"**Professional Services**" means those services performed in the practice of the **Named Insured's** profession as physician including service as (1) a member of any committee of Minnesota Medical Insurance Exchange or Minnesota Medical Management, Inc.; (2) a member of any committee of the American Medical Association or any constituent or component society thereof; (3) a member of any committee of [illegible] national medical society recognized by the American [illegible] constituent or component society thereof; (4) a member [illegible] of any hospital accredited by the Joint Commission on Accreditation [illegible] or the American Osteopathic Association; (5) a member of [illegible] accreditation or professional standards review board or committee.

"Reporting Period" [illegible]
[illegible]
arise out of **Professional Services** rendered [illegible]
subsequent to the retroactive date and prior to the end of the Policy Period.

"Employed Physician" includes any duly licensed [illegible]
employed by the Named Insured.

(2) Applicable to Part [illegible]

"**Bodily Injury**" means Bodily Injury, sickness or disease or death [illegible]
person.

"**Damages**" means 1. Damages for death and for care and loss of [illegible]
resulting from Bodily Injury, 2. Damages for loss of use of property [illegible]
from Property Damage and 3. Damages which are payable because of Personal Injury.

"**Medical Expense**" means expenses for necessary medical, surgical, [illegible]
dental services, including prosthetic devices, and necessary ambulance, [illegible]
professional nursing and funeral services.

"**Named Insured**" means the person named on the Declarations Page.

"**Occurrence**" means an accident, including injurious exposure to conditions, which results, during the Policy Period, in Bodily Injury, Property Damage or Personal Injury neither expected nor intended from the standpoint of the **Named Insured.**

"**Personal Injury**" means one or more of the following groups of offenses [illegible]
committed during the Policy Period:

Group 1. false arrest, detention or imprisonment, or malicious prosecution;

Group 2. the publication or utterance of a libel or slander or of other defamatory or disparaging material, or a publication or utterance in violation of an individual's right of privacy, except publications or utterances in the course of or related to advertising, broadcasting or telecasting activities conducted by or on behalf of the **Named Insured;**

Group 3. wrongful entry or eviction, or other invasion of the right of private occupancy.

"**Property Damage**" means injury to or destruction of tangible property.

"**Professional Office Premises**" means (1) the professional office premises designated on the Declarations Page (2) professional office premises alienated by the **Named Insured** other than premises constructed for sale by the **Named Insured**, if possession has been relinquished to others, and 3 professional office premises as to which the **Named Insured** acquires ownership or control and reports his intention to insure such premises under this policy and no other within 30 days after such acquisition; and includes the ways immediately adjoining such premises on land.

C. Limits of Liability

1. Under Part I, the limit of liability stated on the Declarations Page [illegible] to "each claim" [illegible] the limit of MMIE's liability for loss resulting [illegible] claim or suit or [illegible] claims or suits first made during the Policy Year [illegible] injury to or death [illegible] of any one person, subject to the following [illegible] liability:

   If the Named Insured applies for the Reporting Endorsement [illegible] [illegible] the limit of liability stated on the Declarations [illegible] Page [illegible] "each claim," at the time the Policy is terminated, [illegible] the limit of [illegible] for loss resulting from any one claim or suit or all claims [illegible] during each Reporting Endorsement because of [illegible] injury [illegible] of any one person.

   Subject to the [illegible] respecting "each claim," the limit of liability stated on the Declarations Page as "aggregate" is the total limit of MMIE's liability [illegible] during the effective Policy Year or during each Reporting Period. [illegible] Reporting Period exceeds one year, the "aggregate" limit applies separately [illegible] annual period commencing with the effective date of the reporting endorsement.

   Regardless of the [illegible] of Named Insureds under this Policy the inclusion of more than one Named Insured hereunder shall not operate to increase the limits of MMIE's liability.

2. Under Part II:

   The limit of liability stated on the Declarations Page as applicable to "each Occurrence" is the limit of MMIE's liability for all Damages because of Bodily Injury, Property Damage or Personal Injury regardless of the number of (1) Named Insureds under this Policy, (2) persons or organizations who sustain Bodily Injury, Property Damage or Personal Injury, or (3) claims made or suits brought on account of Bodily Injury, Property Damage or Personal Injury. For the purpose of determining the limit of MMIE's liability, all Bodily Injury, Property Damage and Personal Injury arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one Occurrence.

D. Reporting Endorsement

Under Part I, in the event of termination of insurance either by non-renewal or cancellation of this Policy or termination of a Reporting Period, the Named Insured shall have the right upon the payment of an additional premium (to be computed in accordance with MMIE's rules, rates, rating plans and premiums applicable on the effective date of the endorsement) to have issued an endorsement(s) providing additional Reporting Period(s) in which claims otherwise covered by this Policy may be reported. Such right [illegible] must, however, be exercised by the Named Insured by [illegible] thirty (30) days after such termination date.

E. Named Insured's Duties in the Event of an Occurrence, Claim, or Suit

1. [illegible] the Named Insured obtaining knowledge or becoming aware of any alleged [illegible] give rise to a claim, written notice containing the [illegible] with respect to the circumstances out of which it arose, including the name and address of the injured, the nature and extent of the Professional Services rendered or which should have been rendered and the nature and extent of the type of claim or claims anticipated, shall be given by or for the

Named Insured to MMIE or any of its authorized representatives [illegible] practicable.

2) If claim is made or suit is brought against the **Named Insured**, the Named Insured **shall** immediately forward to MMIE every demand, notice, [illegible] process received by him or his representative.

3) The **Named Insured** shall cooperate with MMIE and, upon MMIE's request, [illegible] making settlements, in the conduct of suits and in enforcing [illegible] contribution or indemnity against any person or organization who may [illegible] the **Named Insured** because of **Bodily Injury, Property Damage** or Personal Injury with respect to which insurance is afforded under this Policy; and the Named **Insured** shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The **Named Insured** shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

e. **Action Against MMIE**

No action shall lie against MMIE unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this Policy, nor until the amount of the **Named Insured's** obligation to pay shall have been finally determined either by final judgment after expiration of period for appeal against the **Named Insured** after actual trial or by written agreement of the **Named Insured**, the Claimant and MMIE.

Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this Policy to the extent of the insurance afforded by this Policy. No person or organization shall have any right under this Policy to join MMIE as a party to any action against the **Named Insured** to determine the **Named Insured's** liability, nor shall MMIE be impleaded by the **Named Insured** or his legal representative. Bankruptcy or insolvency of the **Named Insured** or of the **Named Insured's** estate shall not relieve MMIE of any of its obligations hereunder.

f. **Other Insurance**

With respect to Part I, if the **Named Insured** has other insurance against a loss covered by this Policy, MMIE shall not be liable under this Policy for a greater proportion of such loss than the limit of liability stated on the Declarations Page bears to the total limit of liability of all valid and collectible insurance against such loss.

With respect to Part II, the insurance afforded by this Policy is primary insurance, **except when stated** to apply in excess of or contingent upon the absence of other **insurance.** When this insurance is primary and the **Named Insured** has other insurance **which is stated** to be applicable to the loss on an excess or contigent basis, the amount of **MMIE's liability** under this Policy shall not be reduced by the existence of such other insurance. When both this insurance and other insurance applies to the loss on the same basis, whether primary, excess or contingent, MMIE shall not be liable under this Policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(1) **Contribution by Equal Shares**

If all of such other valid and collectible insurance provides for contribution by equal shares, MMIE shall not be liable for a greater proportion of such loss than

would be payable if each insurer contributes an equal share until the share of each insurer equals the lowest applicable limit of liability under any one policy or the full amount of the loss is paid and with respect to any amount of loss not so paid, the remaining insurers continue to contribute equal shares of the remaining amount of the loss until each such insurer has paid its limit in full or the full amount of the loss is paid.

2) **Contribution by Limits**

If any of such other insurance does not provide for contribution by equal shares, MMIE shall not be liable for a greater proportion of such loss than the applicable limit of liability under this Policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

g. **Subrogation**

In the event of any payment under this Policy, MMIE shall be subrogated to all the **Named Insured's** rights of recovery therefore against any person or organization (excluding, under Part I, employees of the **Named Insured**) and MMIE may require an assignment of such rights from the **Named Insured** to the extent of any payments made under this Policy plus reasonable cost of collection. The **Named Insured** shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The **Named Insured** shall do nothing either before or after loss to prejudice such rights and shall cooperate with MMIE in assisting it to protect its rights under this provision. The **Named Insured** acknowledges that MMIE's rights under this provision shall be considered as the first priority claim against any such person or organization, to be paid before any other claims which may exist. MMIE may, at its option, take such action as may be necessary and appropriate to preserve its rights under this provision, including the right to bring suit in the name of the **Named Insured**. MMIE may, at its option, collect such amounts from the proceeds of any settlement or judgment that may be recovered by the **Named Insured** or his legal representative. Any such proceeds of settlement or judgment shall be held in trust by the **Named Insured** for the benefit of MMIE, and MMIE shall be entitled to recover reasonable attorneys' fees from the **Named Insured** incurred in collecting proceeds held by him.

h. **Changes**

Notice to any representative or knowledge possessed by any representative or by any other person shall not effect a waiver or a change in any part of this Policy or prevent MMIE from asserting any right under the terms of this Policy; nor shall the terms of this Policy be waived or changed, except by endorsement issued to form a part of this Policy. Failure of MMIE to require performance by the **Named Insured** of any obligations under this Policy shall not affect its right to require performance of such obligation. Any waiver by MMIE of any breach of any provision of this Policy shall not be construed as a waiver of any continuing or succeeding breach of such provision, a waiver or modification of the provision itself, or a waiver or modification of any right under this Policy.

i. **Assignment**

Assignment of interest under this Policy shall not bind MMIE until its consent is endorsed hereon; if, however, the **Named Insured** shall die, such insurance as is afforded by this Policy shall apply (1) to the **Named Insured's** legal representative, as the **Named Insured**, but only while acting within the scope of his duties as such, and

with respect to the property of the Named Insured, [illegible] temporary custody thereof, as Named Insured, but [illegible] qualification of the legal representative.

j. **Cancellation**

This Policy may be canceled by the Named Insured by surrender [illegible] any of its authorized representatives or by mailing to MMIE written [illegible] when thereafter the cancellation shall be effective. This Policy may be [illegible] MMIE by mailing to the Named Insured at the address shown in this P[illegible] notice stating a date not less than ten days thereafter when such cancel[illegible] effective. The mailing of notice as aforesaid shall be sufficient proof of [illegible] time of surrender or the effective date and hour of cancellation stated in the [illegible] shall become the end of the Policy Period. Delivery of such written notice either b[illegible] the Named Insured or by MMIE shall be equivalent to mailing.

If the Named Insured cancels this Policy, earned premium shall be computed in accordance with the customary short rate table and procedures. If MMIE cancels, earned premium shall be computed pro-rata. Premium adjustment may be made either at the time cancellation is effected or as soon as practicable after cancellation becomes effective, but tender by MMIE of unearned premium is not a condition of cancellation.

This policy may be canceled by MMIE without cause and made retroactive to the inception of the Policy if fraud by the Named Insured with regard to the information the Named Insured provided MMIE is proved.

k. **Declarations**

By acceptance of this Policy, the Named Insured agrees that the statements in the Declarations Page are his agreements and representations, that this Policy is issued in reliance upon the truth of such representations and that this Policy embodies all agreements existing between himself and MMIE or any of its agents relating to this insurance.

l. **Inspection and Audit**

MMIE shall be permitted but not obligated to inspect the Named Insured's premises at any time. Neither MMIE's right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the Named Insured or others, to determine or warrant that such premises are safe or healthful, or are in compliance with any law, rule or regulation.

MMIE may examine and audit the Named Insured's books and records at any time during the Policy Period and extensions thereof and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.

m. **Governing Law**

The validity, construction and enforceability of this Policy shall be governed in all respects by the law of the State of Minnesota or such other states in which the Named Insured performs Professional Services and MMIE is qualified to sell insurance. Any and all provisions of this Policy which are in conflict with statutes of these states are understood, declared and agreed to be automatically changed to conform to the laws.

n. Assessability

This Policy is non-assessable. The **Named Insured** hereby acknowledges that [illegible] nor other members of MMIE shall be obligated for any debts and liabilities [illegible].

o. **Severability**

In the event any portion of this Policy shall be held to be invalid, the same shall not affect, in any respect whatsoever, the validity of the remainder of this Policy.

p. **Gender**

Any personal pronoun of the masculine gender used in this Policy shall be deemed to include the feminine gender.

q. **Notices**

Except as otherwise specifically stated in this Policy, all notices or other communications required or contemplated by this Policy shall be addressed:

1) If to MMIE, at its offices;
2) If to the **Named Insured**, at its address stated on the Declarations Page or at such new address as the **Named Insured** may designate by written notice to MMIE.

V. NUCLEAR ENERGY LIABILITY EXCLUSION

A. This Policy does not apply:

1. to injury or death (including all forms of radioactive contamination)
   a) with respect to which an **Named Insured** under this Policy is also an **Named Insured** under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an **Named Insured** under any such policy but for its termination upon exhaustion of its limit of liability; or
   b) resulting from the hazardous properties of nuclear material and with respect to which (1) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or (2) **Named Insured** is, or had this Policy not been issued would be, entitled to indemnity from the United States of America, or any agency thereof, under any agreement entered into by the United States of America, or any agency thereof, with any person or organization.

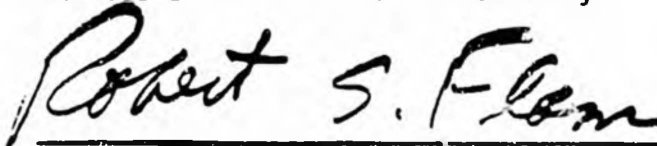
2. to injury or death (including all forms of radioactive contamination) resulting from the hazardous properties of nuclear material, if
   a) the nuclear material (1) is at any nuclear facility owned by, or operated by or on behalf of, an **Named Insured** or (2) has been discharged or dispersed therefrom;
   b) the nuclear material is contained in spent fuel or waste at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of **Named Insured**; or

(the injury or death arises out of the furnishing ... materials, parts or equipment in connection with the ... construction, maintenance, operation or use of any nuclear facility ...

B. **As used in this exclusion:**
"**hazardous properties**" include radioactive, toxic or explosive properties;
"**nuclear material**" means source material, special nuclear material or byproduct **material;**
"source material," "special nuclear material," and "byproduct material" have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof;
"spent fuel" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a nuclear reactor;
"waste" means any waste material (1) containing byproduct material and (2) resulting from the operation by any person or organization of any nuclear facility included within the definition of nuclear facility as set forth hereinafter under paragraph (a) or (b);
"nuclear facility" means
(a) any nuclear reactor,
(b) any equipment or device designed or used for (1) separating the isotopes of uranium or plutonium, (2) processing or utilizing spent fuel, or (3) handling, processing or packaging waste,
(c) any equipment or device used for the processing fabricating or alloying of special nuclear material if at any time the total amount of such material in the custody of the insured at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235.

IN WITNESS WHEREOF, the said Minnesota Medical Insurance Exchange has caused this Policy to be signed by its Chairman, and Secretary, but it shall not be valid unless countersigned on the Declarations Page by a duly authorized representative of MMIE.

Secretary
Minnesota Medical Insurance Exchange



Chairman
Minnesota Medical Insurance Exchange

St Paul

INTRODUCTION

This policy protects against a variety of losses. There are also some restrictions. We've written the policy in plain, easy-to-understand English. We encourage you to read it carefully to determine what is and is not covered, as well as the rights and duties of those protected.

The words you, your and yours mean the insured named here:

Which is a:

- corporation
- partnership
- other
- individual
- joint venture
- condominium

We, us, our and ours mean the **St. Paul Fire and Marine Insurance Company**. We're a capital stock company located in St. Paul, Minnesota.

Your policy is composed of General Rules, an explanation of What To Do If You Have A Loss, one or more Coverage Summaries, and one or more Insuring Agreements explaining your coverage. It may also include one or more endorsements. Endorsements are documents that change your policy. The agreements and endorsements included when this policy begins are listed below. One of our authorized representatives must also countersign the policy before it is valid.

This policy will begin on ______________
and continue until ______________
Your former policy, number ______________
is automatically cancelled on the date this policy begins.

In return for your premium, we'll provide the protection stated in this policy.
Your premium is ______________

Forms Included When This Policy Begins

Form number and edition date

Our authorized representative is:

President Secretary

Authorized Representative Date

The St. Paul

Important Note: This is a claims made coverage. Please read it carefully, especially the When A Claim Is Made and Optional Reporting Endorsement sections.

Physicians' Professional Liability Protection–Claims Made

Policy issued to	Agreement takes effect	Policy number

How this agreement protects you

This agreement provides protection against professional liability claims which might be brought against you in your practice as a physician or surgeon.

Who's protected under this agreement

Name	Retroactive Date	Name	Retroactive Date
Name of Covered Professional Organization			

Each person and organization named above or in the "Who's protected" section of the Introduction page is covered under this agreement. The words you, your and yours refer to these people or this organization.

Limits of your coverage

Two limits apply to the amount we'll pay for professional claims. These limits are shown below or on the Introduction page. The limits apply separately to each covered person. When an organization is also covered, the limits apply separately to that organization.

$ ______ Each person limit. This is the most we'll pay for all claims resulting from the injury or death of any one person.

$ ______ Total limit. This is the most we'll pay for all claims first made in a policy year. By policy year we mean each consecutive annual period of the policy. If no total limit is shown, the total limit is 3 times the each person limit.

When you're covered

To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also first be made while this agreement is in effect.

When is a claim made?

A claim is made on the date you first report an incident or injury to us or our agent. You must include the following information:

- Date, time and place of the incident.
- What happened and what professional service you performed.
- Type of claim you anticipate.
- Name and address of injured party.
- Name and address of any witness.

What this agreement covers

Individual coverage. Your professional [illegible] protection covers you for damages resulting from:
1. Your providing or withholding of professional services.

This agreement must be signed only when it's issued after the effective date of the policy.

Authorized Representative

These rules apply to the entire policy unless you're notified otherwise.

Special Rights And Duties Of The First Named Insured

You agree that when more than one insured is named in the introduction, the first named insured has special rights and duties. These rights and duties are explained in the following General Rules:
- Premiums.
- Cancellation.
- Policy Changes.

Your Policy Period

Insuring agreements in this policy begin at 12:01 a.m., standard time, on the effective date. If this policy replaces policies ending at noon, rather than 12:01 a.m., coverage begins at noon when the old policy ends.

Insuring agreements added to this policy after its effective date begin on the effective date of the added agreement.

Coverage ends at 12:01 a.m., standard time, on the expiration data. If all or part of this policy is cancelled for any reason before that data, that coverage will end at 12:01 a.m., standard time, on the cancellation data.

Premiums

We compute the premium you pay for this policy using information available at the time. So, all or part of your premium may be based on estimates. If estimates are used, we'll compute your actual premium when complete information is available at the end of the policy period. If it's more than you've paid, you'll owe us the difference. If it's less, we'll return the difference. But you won't pay less than any minimum annual premium agreed on. The first named insured is responsible for paying all premiums and will be the one to whom we'll pay any return premiums.

You must keep accurate records of the informa tion we'll need to compute your premium. Your agent can explain the type of records we'll need. The first named insured agrees to send copies of these records at the end of each poli cy period - or any other time we request them.

Our Right To inspect And Audit

You agree to let us inspect your property and business operations during normal business hours while this policy is in force. We're not, however, required to make inspections. Nor wi we guarantee that your property or operations are safe, or that they conform to any laws, codes, standards or regulations. This rule also applies to any organization which makes insurance inspections, surveys, reports or recommendations for us.

You also agree to let us examine and audit you financial books and records that relate to this insurance at any time up to 3 years after this policy ends.

Policy Changes

This policy contains all the agreements between you and us concerning this insurance. Th first named insured is authorized to make changes in this policy with our consent. This policy can only be changed by a written form included as part of the policy. This form must be signed by one of our authorized representatives.

We make changes in our standard insurance pc icy forms from time to time. These changes must conform to state law and are filed with i surance supervisory authorities for approval. While your coverage is in force we can make any change in the form of this policy that broa dens or extends your coverage. If we do, and the change can be added to your policy withou increasing the premium, you'll automatically r ceive the benefit of the extended or broadene

Lawsuits Against Us

No one can sue us to recover under this policy unless all of its terms have been lived up to.

If your policy includes property insurance. Any lawsuit to recover on a property claim must begin within 2 years after the date on which the direct physical loss or damage occurred. State law gives you more time for property located in these states:
- North Dakota, North Carolina, Maryland - 3 years;
- Wyoming - 4 years; and
- Kansas, Nebraska - 5 years.

If your policy includes liability insurance. No one can sue us on a liability claim until the amount of the protected person's liability has been finally decided either by a trial or by a written agreement signed by the protected person, by us and by the party making this claim. Once liability has been determined by judgment or by written agreement, the party making the claim may be able to recover under this policy, up to the limits of coverage that apply. But that party can't sue us directly or join us in a suit against the protected person until liability has been so determined.

If the protected person or his or her estate goes bankrupt or becomes insolvent, we'll still be obligated under this policy.

Provision Required By Law

"This policy is issued under and in pursuance of the laws of the State of Minnesota, relating to Guaranty Surplus and Special Reserve Funds." Chapter 437, General Laws of 1909. (This provision applies only if this policy is issued in the St. Paul Fire and Marine Insurance Company.)

Loss Or Damage To Covered Property

If an accident or incident causes a property loss that's covered under this policy you must:

1. Notify the police if a law may have been broken.

2. Tell us or our agent what happened as soon as possible. Include the time and place of the event, a description of the property and the names and addresses of any witnesses.

3. Do what is reasonable and necessary to protect covered property from further damage. Keep a record of your expenses for consideration in your claim.

4. If feasible, separate the damaged property from the undamaged and make an inventory of the damaged items. This doesn't apply to Auto insurance if included in your policy.

5. Cooperate with us in the investigation and settlement of the claim. Show us the damaged property and any records you have to prove your loss at such times as may reasonably be required. Also permit us to take samples of damaged property for inspection, testing, and analysis. If your loss involves a covered auto, permit us to inspect the auto before it is repaired or disposed of.

6. Allow us to question you under oath at such times as may be reasonably required about any matter relating to this insurance or your claim, including your books and records. If we do, you agree to sign a copy of your answers.

7. Send us a signed, sworn statement of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We'll supply the forms. We'll pay within 30 days after we reach agreement with you.

Someone Is Injured Or Something Happens Which Can Result In A Liability Claim

If an accident or incident occurs that may involve this policy, you or any other protected person involved must:

1. Notify the police if a law may have been broken.

2. Tell us or our agent what happened as soon as possible. Do this even though no claim has been made but you or another protected person is aware of having done something that may later result in a claim. This notice should include:
- The time and place of the event;
- The protected person involved;
- The specific nature of the incident including the type of claim that may result; and
- The names and addresses of any witnesses and injured people.

Important Exception For Hospitals

If Professional Hospital Liability Protection - Claims Made is included in this policy, we won't consider a "Patient Incident Report" or "Variance Report" to be your report of a claim made - even if you send it to us or one of our agents.

3. Send us copies of all demands or legal documents if someone makes a claim or starts a lawsuit.

4. Cooperate and assist us in securing and giving evidence, attending hearings and trials, and obtaining the attendance of witnesses.

5. Not assume any financial obligation or pay out any money without our consent. But this rule doesn't apply to first aid given to others at the time of an accident.

©St. Paul Fire and Marine Insurance Co. [illegible]

PREJUDGMENT INTEREST ENDORSEMENT

St Paul

This endorsement changes your:

How Your Coverage Is Changed

Your Liability Protection is changed by adding the following to the Additional Benefits section.

Prejudgment interest. We'll pay the prejudgment interest awarded on that part of any judgment we pay. But if we make an offer to pay the limit of coverage that applies, we won't pay the prejudgment interest that accumulates after the date of our offer.

Other Terms

All other terms of your policy remain the same.

Endorsement __ to Insuring Agreement _____

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COMBINED COMPANIES
LOSS EXPERIENCE
MINNESOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	595	$17,889,490	$13,579,982	$ 2,566,569	$ 1,840,000	$ 177,822	$ 18,164,373	101.5%
1983	660	21,186,512	6,584,016	1,888,960	2,890,501	458,015	11,821,492	55.8
1984	662	25,677,303	9,324,311	2,267,169	7,850,000	1,266,545	20,708,025	80.6
1985	811	34,469,869	9,170,537	2,756,639	16,608,353	2,311,973	30,847,502	89.5
1986	635	45,306,249	3,280,682	1,282,389	21,075,356	4,123,340	29,761,767	65.7
1987	659	55,612,065	1,157,647	454,174	26,701,391	5,812,193	34,125,405	61.4
TOTALS	4,022	$200,141,488	$43,097,175	$11,215,900	$76,965,601	$14,149,888	$145,428,564	72.7%

COMBINED COMPANIES
LOSS EXPERIENCE
NORTH DAKOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	77	$ 2,907,823	$1,152,407	$ 921,361	$ 645,000	$ 91,328	$ 2,810,096	96.6%
1983	66	3,298,398	931,254	507,344	125,000	16,718	1,580,316	47.9
1984	58	3,939,474	2,459,148	1,155,779	880,000	144,862	4,639,789	117.8
1985	67	5,116,721	846,894	663,964	2,126,000	211,323	3,848,181	75.2
1986	69	6,569,294	1,399,882	616,777	3,100,000	1,004,435	6,121,094	93.2
1987	76	9,222,907	149,950	195,066	4,958,000	552,172	5,855,188	63.5
TOTALS	413	$31,054,617	$6,939,535	$4,060,291	$11,834,000	$2,020,838	$24,854,664	80.0%

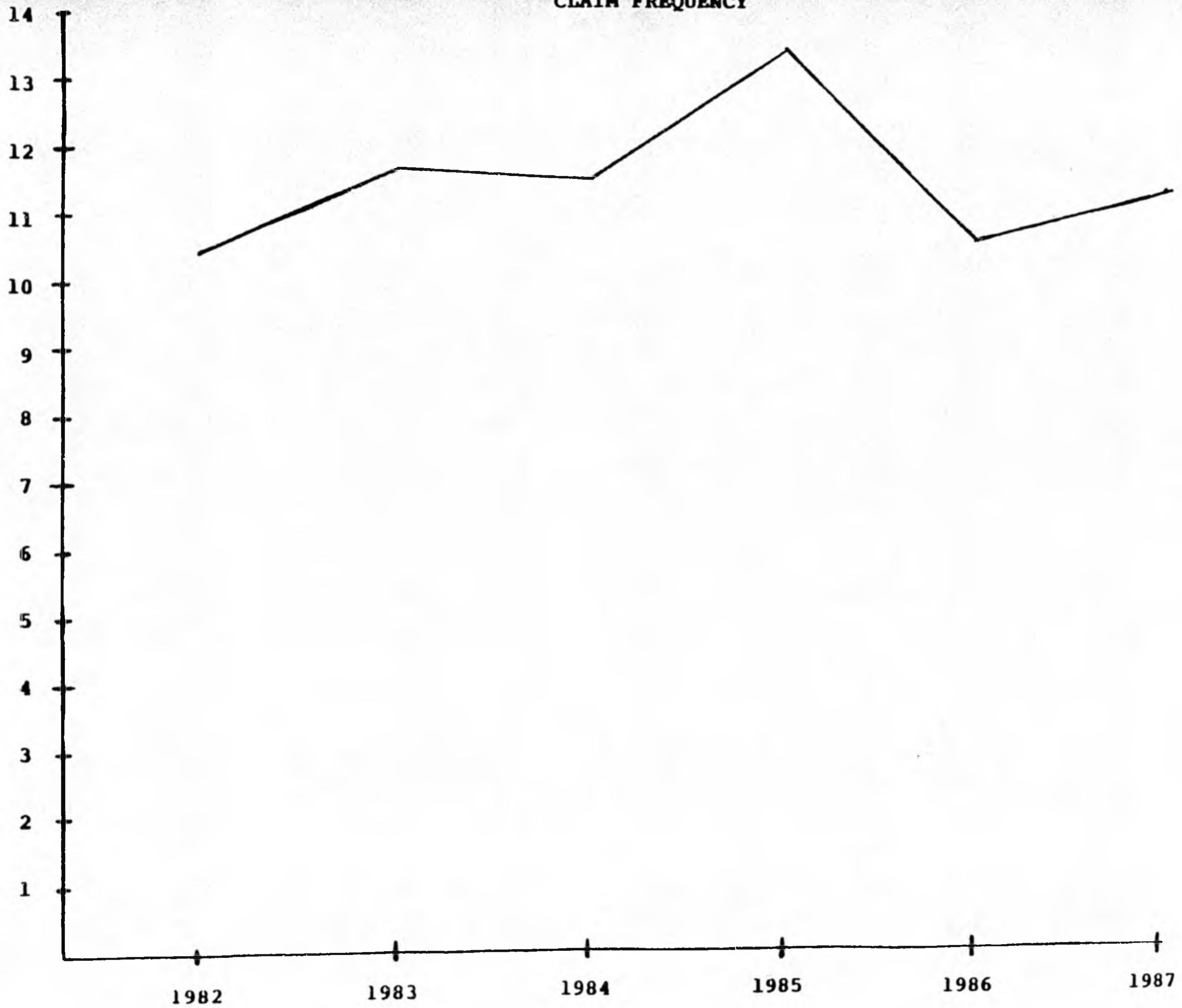
COMBINED COMPANIES
LOSS EXPERIENCE
SOUTH DAKOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	49	$ 2,572,536	$1,301,980	$ 345,782	$ 70,000	$ 20,855	$ 1,738,617	67.6%
1983	50	2,455,518	214,614	117,394	25,000	73,791	430,799	17.5
1984	48	2,873,114	226,205	123,179	50,000	19,630	419,014	14.6
1985	59	3,864,849	630,623	456,637	940,000	183,685	2,210,945	57.2
1986	54	5,126,260	550,282	172,648	2,944,500	509,662	4,177,092	81.5
1987	52	6,509,527	685,474	111,813	996,500	552,165	2,345,952	36.0
TOTALS	312	$23,401,804	$3,609,178	$1,327,453	$5,026,000	$1,359,788	$11,322,419	48.4%

LOSS PAYMENT AND OPEN RESERVE

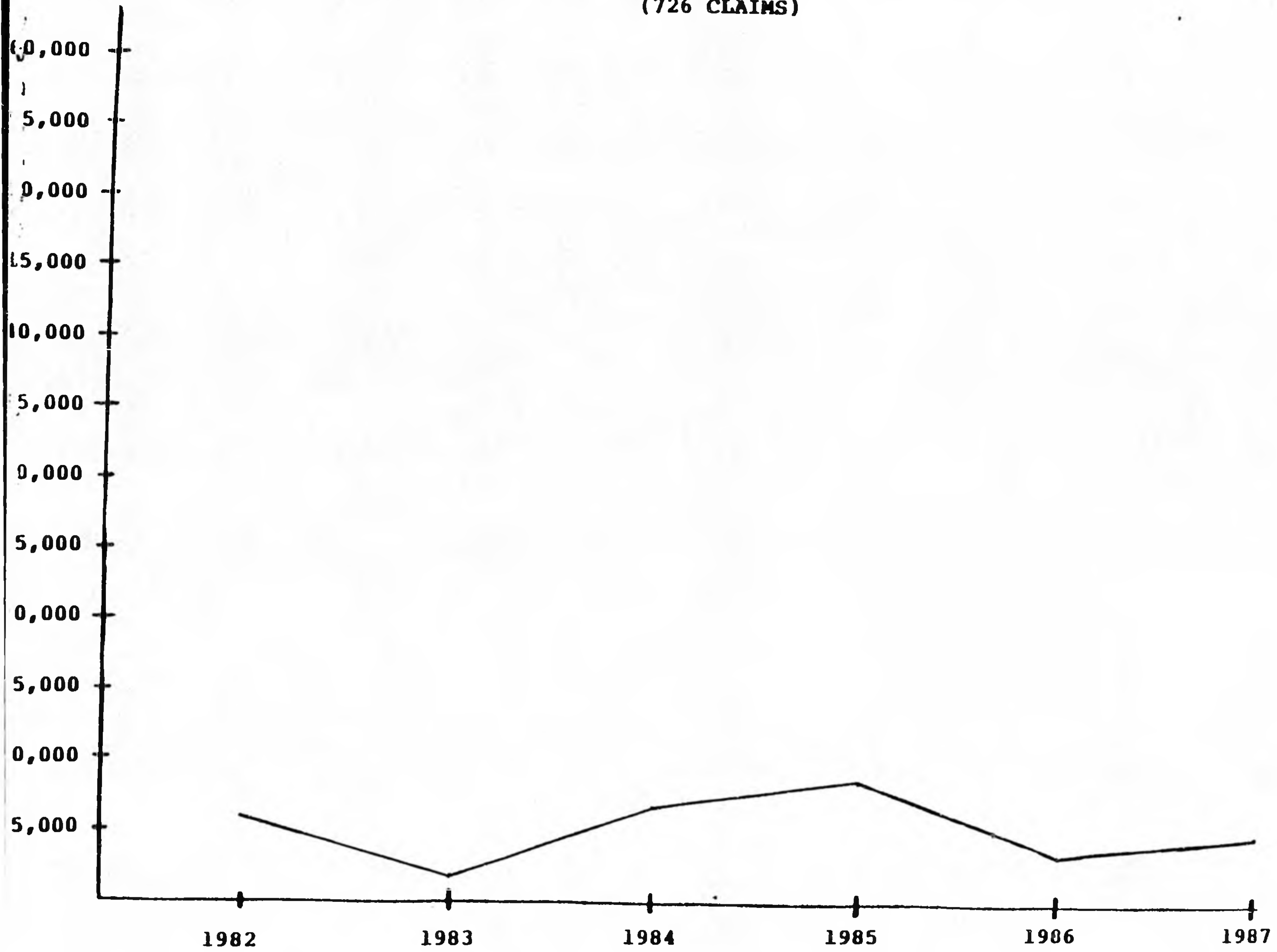
DISTRIBUTION COMPARISON

Payment/Reserve Distribution		Number of Payments (Closed Claims)	Number of Reserves (Open Claims)
$ -	0	2,707	0
1 -	999	82	55
1,000 -	4,999	182	28
5,000 -	14,999	199	165
15,000 -	24,999	111	109
25,000 -	49,999	151	145
50,000 -	99,999	112	179
100,000 -	249,999	97	157
250,000 -	499,999	33	97
500,000 -	999,999	12	26
1,000,000 -	Over	3	8
	Unknown	0	89
	TOTAL	3,689	1,058



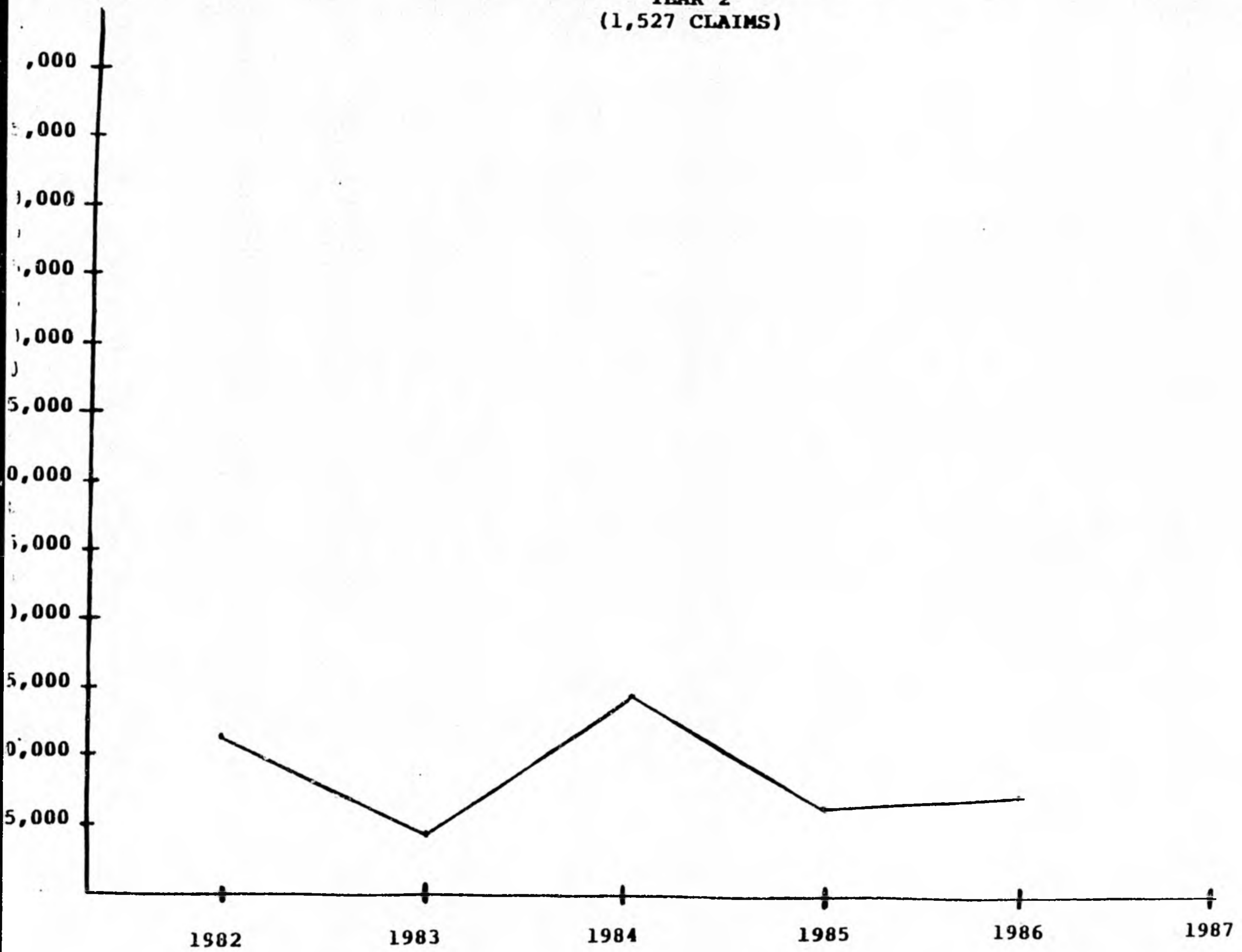
APPENDIX D-1

CLAIM SEVERITY AT EQUAL LOSS DEVELOPMENT YEARS YEAR 1 (726 CLAIMS)



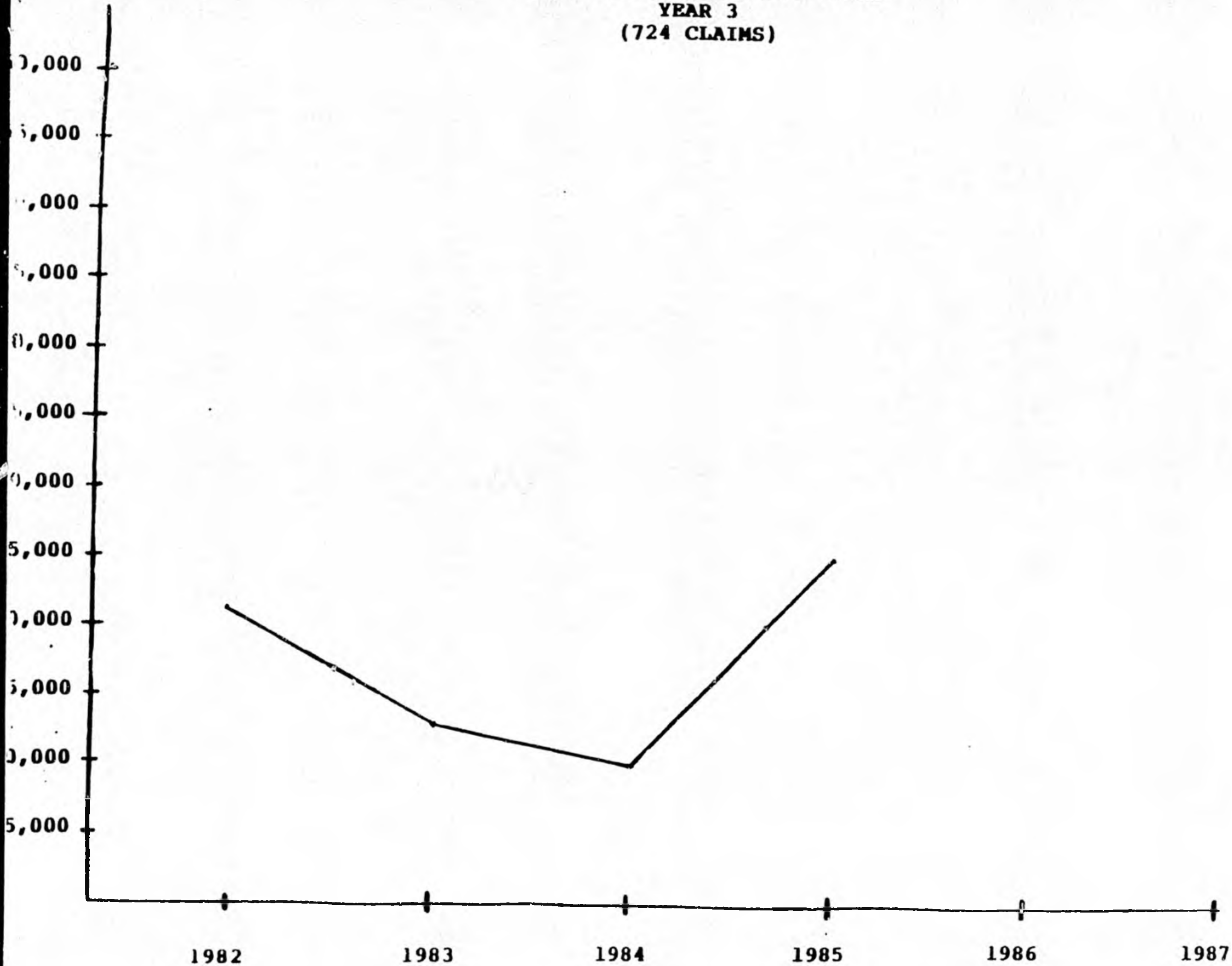
APPENDIX D-2

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 2
(1,527 CLAIMS)



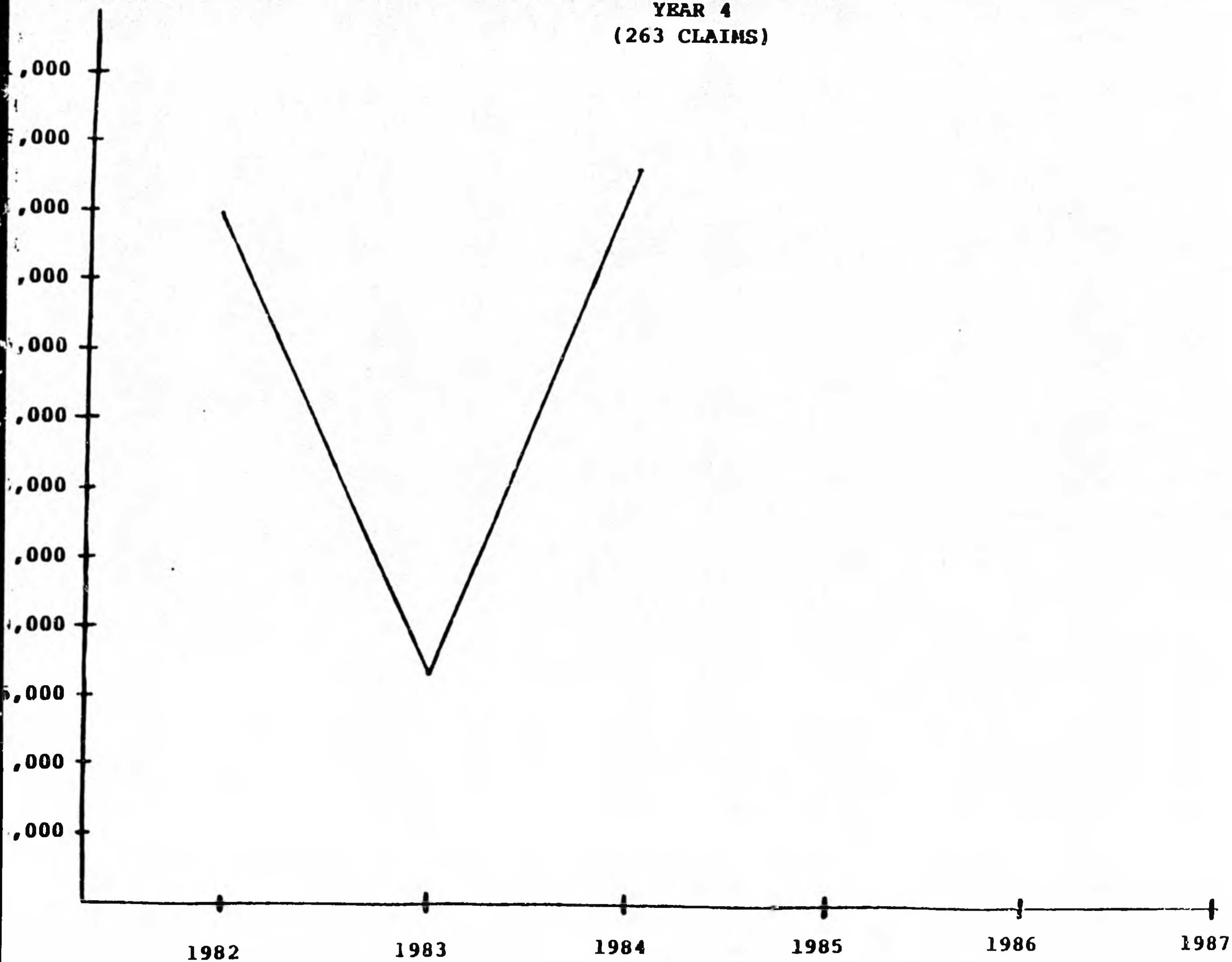
APPENDIX D-3

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 3
(724 CLAIMS)



APPENDIX D-4

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 4
(263 CLAIMS)



APPENDIX D-5