M I N U T E S

SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

June 24 and 25, 1975
(Room 510-S - State House)

Members Present

Senator Wesley H. Sowers, Chairman
Representative Earl D. Ward, Vice-Chairman
Senator D. Wayne Zimmerman
Senator Robert V. Talkington
Senator Frank D. Gaines
Senator Bert Chaney
Representative Harry A. Sprague
Representative Michael G. Johnson
Representative Marvin L. Littlejohn
Representative Loren H. Hohman, II
Representative Rex B. Hoy

Staff Present

*Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes Office
Bill Edds, Revisor of Statutes Office

Conferees

Robert A. Olsen, Office of the Governor, Topeka
Jack Roberts, Blue Cross-Blue Shield, Topeka
L.M. Cornish, Kansas Association of Property and Casualty Insurance Companies, Topeka
Mark L. Bennett, American Insurance Association, Topeka
Edwin Bideau, Kansas Insurance Department, Topeka
Kevin Alexander, Kansas Insurance Department, Topeka
Cathy Talbert, Kansas Trial Lawyers Association, Topeka
Hal DesJardins, Department of Social and Rehabilitation Services, Topeka
Jerry Slaughter, Kansas Medical Society, Topeka
Mike Friesen, Office of the Senate President, Topeka
Dave Williams, Office of the Lt. Governor, Topeka
Larry Zanto, AMIA, Chicago, Illinois
Jim Clark, Kansas Optometric Association, Topeka

Conferees (Continued)

Mary Browne, Kansas Association of Osteopathic Medicine, Topeka
Carl Schmitthenner, Kansas State Dental Association, Topeka
Joan M. Baker, Kansas Insurance Department, Topeka
Ira Dennis Hawver, Kansas Department of Health and Environment, Topeka
Cinda Vogel, Kansas Chiropractors Association, Topeka
Frank L. Gentry, Kansas Hospital Association, Topeka
William Gough, Jr., Kansas Association of Commerce and Industry, Topeka
Dick Brock, Kansas Insurance Department, Topeka
Representative Bill Brock, Wichita
Nick Muller, Kansas Insurance Department, Topeka
Ray Rathert, Kansas Insurance Department, Topeka
Gary Robbins, Kansas State Nurses Association, Topeka
Paul E. Fleener, Kansas Farm Bureau, Manhattan
J.B. Barbee, United Transportation Union, Wichita

June 24, 1975

The meeting was called to order at 10:05 a.m. by the Chairman, Senator Wesley Sowers, who summarized the problems of medical malpractice. He referred to a study done by the Legislature in 1971, and bills relative to the medical malpractice problem introduced during the last session of the legislature. He informed the Committee that Fletcher Bell, Commissioner of Insurance, is doing an in-depth study which, along with recommendations, should be available in August.

The meeting was turned over to the Legislative Research Department staff, who gave an overview of the issues, discussed factors leading to and contributing to the problem; presented statistics which put the problem in perspective; and explained the points of view of the medical providers, the insurance industry, the bar, and the consumer -- including third party payees. (See Attachment No. A).

Staff pointed out that it is not clear that the problem has reached crisis proportions in Kansas. There is not a lot of hard data available. The best study is probably the one commissioned by the Secretary of HEW in 1971, and this is the report which staff will be using, even though it is some years out of date and national in scope.

In clarification, staff explained that the term "opening claims file" means that a person has reported to the carrier that a claim may be filed, that there is talk that a claim may be filed, or a claim is filed or action started.

Committee members were given a summary of recommendations from the study commissioned by the Secretary of HEW (Attachment No. B). Copies of the complete study will be available for loan from the Legislative Research Department.

Studies are currently being conducted to update the 1971 study. Committee members were asked to make copies of any new data they receive for distribution to the other members.

The medical malpractice bills introduced during the last session were summarized:

S.B. 354 - Requires that the amount of money asked for in a pleading be stated as over or under $10,000, rather than listing an actual amount.

S.B. 356 - Reduces the discovery period from 10 to 4 years.

S.B. 433 - Creates an arbitration panel to be appointed by the district court - the arbitration panel's decision is to be binding.

S.B. 483 - Provides medical malpractice coverage for students in the K.U. School of Medicine during the time they are assigned outside of the Medical Center. An item for this was put in the adopted budget and the state is now advertising for bids. The recent ruling regarding governmental immunity affects the need for this coverage.

H.B. 2008 - Extensively amends the Kansas Healing Arts Statutes and includes recommendations regarding licensing, continuing education requirements for chiropractors only, and authority to take disciplinary action other than complete revocation of license.

S.B. 353 - Enacted by the 1975 Legislature, S.B. 353 require that insurers who provide medical malpractice coverage report claims, settlements and awards to the Commissioner of Insurance in order that we will have data on which to base decisions.

Attention was called to the Trial Lawyers Association's publication, Trial, for May-June, 1975, which is devoted to the problem of medical malpractice. The Kansas Trial Lawyers Association will provide copies of these for Committee members.

Committee members were given copies of an article from the Journal of American Insurance, Vol. 51, No. 1 (Attachment No. C) and a copy of an article which appeared in the Topeka State Journal, June 5, 1975 (Attachment No. D).

Some persons are advocating a no-fault approach and others a system similar to travel insurance.

In discussion the following points were made:

There is some concern that if the decisions of panels are binding, the right of a person to trial by jury is denied. An alternative is to have a screening panel whose decisions are not binding, but whose proceedings are available to the court. All professionals who appear before the panel would appear before the court if asked to do so.

In some states a patient must file an action in order to obtain access to his medical records to determine if he has a justifiable claim. The feeling was expressed that a person should not have to go this far to gain access to his records.

Family practitioners, especially in rural areas, may be placed in Class IV or V of insurance company risk categories because they perform several different functions which make their rates higher. A suggested alternative was to classify doctors according to their malpractice experience.

Although there is some feeling that doctors may settle out of court because of pressure from insurance companies, there seems to be no factual data to confirm this.

There is some indication that group practices are having difficulty acquiring insurance, although individual practitioners are not.

Some court decisions have extended the responsibility of the hospital to include all people working in the hospital, which makes them more vulnerable to malpractice claims.

There is some concern that insurance rates are based not only on experience but on investment losses of the company. Statistics from New York were quoted showing a large margin between premiums collected and losses paid during a specific time period. Although other factors need to be taken into account - the amount of reserves required by state law, overhead costs of handling and dispensing of claims, for which information is missing - the margin does raise questions.

The American Hospital Association is considering developing a group plan for member hospitals.

A court can reduce or increase the amount awarded by a jury. However, to acquire information regarding such instances would necessitate going through the records of the courts in each county.

Staff was asked to keep the Committee informed on any federal legislation that will require enabling legislation at the state level. Staff reported that the prevailing attitude seems to be that the federal government should not be involved.

If Committee members know of anyone who wants to appear before the Committee, the Chairman asked that they notify him.

The meeting was recessed for lunch.

Afternoon Session

The Revisor of Statutes' Office staff discussed the meaning of malpractice in a legal sense. Malpractice is defined as consisting "of a negligent or unskillful performance by a physician of duties which are devolved and incumbent on him because of his relations with his patients or of a want of proper care and skill in performance of a professional act." Although generally malpractice arises because of negligence, it may result through lack of skill or neglect to apply skill possessed, and it may be either intentional, willful or with criminal intent.

Legal negligence exists when the following elements are present: (a) a person has a legal duty or obligation to conform to a certain standard of conduct to protect others against unreasonable risks; (b) the person fails to conform to that standard; (c) the person's conduct is so closely related to the resulting injury that such conduct can be said to have caused the injury - to have been its proximate cause; and (d) actual damages result from the conduct.

The courts, in determining objective criteria for judging conduct in negligence cases, have established the standard of a reasonable or prudent man -- a person is supposed to do what a reasonable man would have done, and not to do what he would not have done.

In negligence cases, the plaintiff bears the burden of proof, but need only establish the truth of his claim by "a preponderance of the evidence".

As determined by the Kansas Supreme Court, a physician must possess that reasonable degree of learning and skill ordinarily possessed by members of his profession and of his school of medicine in the community where he practices or similar communities, having due regard for the advance in medical or surgical science at the time, and that he will use such learning and skill in his treatment of the patient with ordinary care and diligence. Where two or more courses of action may be pursued, the physician is required to use his best judgment. No civil liability arises based solely on bad results or if bad results are due to a cause other than the physician's treatment. These same principles apply to diagnosis.

While a physician is not liable for arbitrarily refusing to render professional services, once initiated, the Kansas court has held that "the relationship of physician and patient continues until it is ended by the consent of the parties, revoked by the dismissal of the physician, or until his services are no longer needed. Under certain conditions a physician has the right to withdraw from a case.

The Kansas court also has recognized the general rule that a physician may specifically contract for a particular result. In such cases, negligence does not have to be proved. Damages are based on a breach of contract.

In regard to informed consent, Kansas has adopted the rule that "in the absence of an emergency a physician has a legal obligation to make a reasonable disclosure to his patient of the nature and probable consequences of the suggested or recommended treatment, and to make a reasonable disclosure of the dangers within his knowledge. . . But the duty of the physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." This is not extended to infinitesimal, imaginative or speculative elements.

In Kansas the mature minor doctrine has been established by the courts.

In Kansas a physician is liable for the negligence or malpractice of another physician acting as his agent, employee or assistant -- those under his control whether or not that control is exercised.

The Kansas Court has established the following rule relative to the doctrine of res ipsa loquitur: it has application "to those situations in which the injury results from an unusual occurrence, not ordinarily found where the services performed followed the usual procedure of those skilled in that particular practice, provided a layman is able to say as a matter of common knowledge and observation, that the consequences of professional treatment were not such as would ordinarily have followed if due care had been exercised."

The Revisor of Statutes' Office staff also discussed the limitations on actions in civil procedure cases. (Attachment No. E).

In answer to a question regarding the responsibility of the anesthesiologist, it was explained that he probably has some responsibility to indicate risks to the patient, and ascertain what the surgeon had told the patient and whether that information was accurate. The surgeon, likewise, needs to tell the patient about the anesthesia and its risks.

The staff pointed out that a hospital as an entity is required to show a reasonable and prudent degree of care under the prevailing circumstances.

Questions were raised regarding the recent Kansas Supreme Court decision relative to governmental immunity. Governmental immunity is divided into two areas: (1) governmental functions and (2) proprietary or nongovernmental functions. The Court held that governmental immunity did not apply in the latter case. The Court recommended that the legislature pass a tort claims act.

The Legislative Research Department staff discussed legislation enacted by other states. Only the eleven states for which copies of legislation were available for review or where there was someone with whom bills could be discussed were included. A summary sheet (Attachment No. F) was distributed.

States discussed were:

Arkansas - (See Attachment No. G)
California - (See Attachment No. H)
Florida - (See Attachment No. I)
Hawaii - Hawaii passed legislation creating a JUA
Indiana - (See Attachment No. J)
Iowa - Information relative to the comprehensive medical malpractice legislation passed in the last two weeks of the session was received by phone. It prohibits a statement of the amount of money asked; spells out conditions of informed consent and limits liability. There is no arbitration panel, but pending legislation is being studied this summer with action anticipated during the next session.

Maryland - (See Attachment No. K)
Missouri - Missouri enacted legislation giving authority to doctors and hospitals to form their own insurance corporation to provide coverage.
Nevada - (See Attachment No. L)
New York - (See Attachment No. M)
Wisconsin - (See Attachment No. N)

Staff concluded its presentation with a summary of proposed federal legislation, including H.R. 6100, Medical Malpractice Claims Settlement Assistance Act, Congressman Hastings, et. al.; S 215, National Medical Injury Compensation Insurance, Senators Inouye and Kennedy; and S 482, Medical Malpractice Insurance and Arbitration Act of 1975, Senators Kennedy and Inouye. (See Attachment No. O).

In the discussion which followed, it was pointed out that hearings were scheduled in April on the Hastings bill, but staff had not been able to determine if they had taken place or how extensive they had been. Hearings on the Senate bills have not been scheduled. In all three bills, state participation is optional.

Congress has declined to repeal an existing requirement to establish Professional Standards Review Organizations. There seems to be an assumption that states are moving toward implementing this requirement. The three previously discussed bills seem to interject the whole question of quality control at the state level, by providers themselves, or by groups outside the professional groups.

Concern was expressed over a method of relating information relative to a provider's malpractice records to the state licensing agency or board. There was also a question raised as to whether or not hospitals might be subject to legal action if they tried to remove someone from their staff, or if they notified other hospitals that they did remove a staff person because of incompetence.

The agenda for June 25 was reviewed and the meeting was adjourned.

June 25, 1975

The meeting was called to order at 9:00 a.m., by the Chairman, Senator Wesley H. Sowers.

Fletcher Bell, Insurance Commissioner, discussed the factors contributing to the medical malpractice problem. He stated that the Insurance Department has tried to maintain a viable malpractice insurance market in Kansas and to keep health care providers, the insurance industry, the legislature and the public informed of their actions. The Department held a series of meetings with the medical, legal and insurance communities separately and collectively. Loss prevention activities suggested included: relicensure; recertification; continuing education requirements; peer review; a safety program similar to that under workmen's compensation; a formalized grievance procedure; re-establishing the personal relationship between doctors and patients; arbitration; claims review procedure; review of ad damnum clause; review of contingency fee system; informed consent; discovery period; and statute of limitations. He stated that each of these areas will be studied by task forces he is establishing. (See Attachment No. P).

Packets of material were distributed to Committee members. (Attachment No. Q). These packets contained specimens of policies, a rate filing, medical professional liability insurance uniform claims report and other information.

Mr. Bell stated he would have at least a preliminary report from the task forces to present to the Committee on August 27 or 28.

Mr. Bell explained that under an occurrence policy, the insurance company covers claims for actions occurring during the policy period, even though they may not be filed until after the expiration of the policy. Under a claims made policy, the insurance company covers only claims filed during the policy period. In Kansas a company offering a claims made policy is required to offer the professional the option of extended coverage for acts which may have occurred during the policy period. If the professional elects to take the extended coverage, he pays the premium in three yearly installments.

A claims made policy is not designed to reduce premiums except for the first year, when company exposure is less, or to reduce payments. It is designed to improve the company's bookkeeping system to give a more accurate view of money being paid in and money being paid out.

In answer to a question, Mr. Bell stated that in his opinion, the Insurance Department has the authority to implement an assigned risk or insurance pool program. However, this would eliminate the volunteer market now providing coverage, and it would also bring companies with limited or no experience into this highly complex type of liability coverage. Mr. Bell indicated that he might discuss with the Committee at a later time: (1) permitting him to approve group policies in the area of medical malpractice, and (2) the formation of a re-insurance pool to be financed by private and/or federal funds. He stated he is reluctant to involve the state in the insurance business. However, since so few companies are currently writing medical malpractice insurance, he may recommend that consideration be given to forming a type of pool for excess insurance coverage, and possibly to providing for some of the cost to be covered by state funds.

Mr. Bell stated he did not have a comparison of the increase in Blue Cross-Blue Shield rates and medical malpractice rates, but he could prepare one if the Committee wished.

Annual statement forms filed by insurance carriers prior to this year included medical malpractice in a general category, "liability other than auto", and did not indicate what portion of premiums collected were paid out in claims, or how much money was actually received by the plaintiffs. Some of this information is available for individual companies through rate filings which they are required to submit when requesting a rate change. This latter form, for example, includes premiums and losses, but not the number of claims made or settlements. By Kansas law, rates are basically determined by premiums received and losses paid. This information is received and verified by the Department of Insurance. Mr. Bell referred to the sample rate filing in the material distributed. At the request of the Committee, Mr. Bell is to furnish copies of the rate filings for the two companies writing most of the medical malpractice insurance in Kansas.

Referring to a Topeka Daily Capitol news story which stated that 3.1% of malpractice claims are filed seven years after the act, questions were raised as to whether or not this represents a significant enough number of claims to justify company statements that the "long tail" experience requires changes in the discovery period or in the statute of limitations. Mr. Bell referred to Table VI in the March 14, 1975 report (Attachment No. R). He pointed out that any changes made in the discovery period or statute of limitations for medical malpractice would be applicable to all types of liability coverage.

Another problem in rate setting is that insurance companies collect premiums based on the current economy, but may be paying claims based on the economy ten years from now.

He pointed out that 1974 was a disaster year for insurance companies in the area of liability coverage. Losses also were incurred in the investment portfolios of insurance companies because of the bad market. In answer to questions, Mr. Bell stated he doubted if any agreement in violation of the anti-trust laws existed between insurance companies, although he had been unable to broaden the base for medical malpractice insurance in Kansas.

Medical malpractice insurance premiums (two million dollars in 1974), represents only one-tenth of one percent of the liability insurance premiums collected in the United States. This means that insurance companies do not need Kansas business which is not sufficient to be creditable in establishing rates. Therefore, companies are allowed to take their Kansas experience and trend it with the national experience to establish rates.

Other factors affecting rates are loss ratios trended with jury actions, and a changing economy which has had an effect on rate increases.

However, as of March, Kansas ranked 37th in medical malpractice insurance costs. Mr. Bell stated he felt rates were still reasonable in terms of the coverage offered, and although a study had not been conducted, he felt there had been substantial rate increases for other types of liability insurance as well. At the present time availability is more of a problem than the rates themselves.

Because of limited coverage under basic policies, doctors and hospitals are finding it necessary to purchase umbrella coverage. This latter type policy provides for excess coverage above the basic policy. The Insurance Department is finding it difficult to arrange umbrella policies when they are needed.

In answer to questions raised regarding the classification of doctors and the varying rates within a classification, Mr. Bell stated that rates for a given classification will vary from state to state because of differences in experience. Rates

also vary as much as 50% from company to company within a state and will vary according to the amount of coverage included. Then, too, the policy could be written by a non-admitted company, one not under the Department's control, such as Lloyd's of London. He stated he would be reluctant to change the classification system without very good reason.

Questions were asked about the percentage of premiums which go to the victims. Mr. Bell stated no specific limitation is set by statute governing how much of a premium must be used to pay claims. A considerable amount of expense, which must be taken into account, is incurred by companies in defense costs whether or not a claim is actually filed or made. A reduction in incidents and the use of a screening panel concept could reduce this amount. He also stated that although a large enough percentage of premiums may not be going to the victim, he is reluctant to advocate discontinuing the contingency fee system as a solution. However, if a sliding fee contingency scale could be developed, he recommended it be given serious consideration by the Committee.

Mr. Bell pointed out that a doctor must give his consent before a case can be settled. Legally the company can drop him if he refuses to settle. However, the Insurance Department has an understanding with the companies that they will not refuse to renew policies until the legislature has had time to review the situation and make constructive changes.

Mr. Frank Gentry, Kansas Hospital Association, stated that their testimony would be in three parts: (1) indication of the severity of the problem, (2) what those in the health field can be doing to help solve the problem, and (3) what the Hospital Association believes the legislature can do towards alleviating the severity of the problem. Mr. Gentry then discussed the severity of the problem as reflected in availability of insurance, increased rates and claim experience of Kansas hospitals (see Attachment No. S).

Mr. Gentry stated he would make available for Committee members a memo from the American Hospital Association, including a summary and analysis of the American Insurance Association's Model Temporary Underwriting Association Bill, a Survey of State Malpractice Activities and a proclamation by Governor Brown of California (see Attachment No. T).

In answer to a question, Mr. Gentry stated that some companies will write insurance only for hospitals in rural areas. This is true of the company writing most of the insurance in Kansas. Staff pointed out this may be due to the fact these are smaller hospitals with a limited type of service. Mr. Gentry stated he had not received a satisfactory answer to how national figures are related to Kansas experience in setting rates. However, he felt that Kansas hospitals were being overloaded in terms of their experience.

The Association is currently gathering information relative to the most common causes of suits. Hopefully this will enable them to get material out on preventing suits. This information will be sent to the Committee.

The American Hospital Association has developed a Bill of Rights, but there is no indication whether it has been of benefit. The doctors and hospitals of Kansas issued their own standards which spoke of mutual responsibility. A copy will be sent to the Committee.

In answer to other questions, Mr. Gentry stated that a suit is usually filed against both the hospital and the doctor; court decisions have made it clear that the hospital is responsible for what happens in the hospital; it is difficult to take action against a doctor in a small hospital because of the limited number available; there is no difference in rates if osteopaths are admitted to hospital privileges; some hospitals have initiated a grievance process and in some cases have a patient ombudsman within the hospital, but the Hospital Association has no stand on this.

The meeting was recessed for lunch.

Afternoon Session

Mr. Jerry Jorgensen, Executive Director, Stormont-Vail Hospital, Topeka, stated that comprehensive liability, of which medical malpractice is a part, is a more accurate term relative to hospitals. Their insurance covers anyone who comes under the definition of hospital employee, but individuals must also carry their own insurance. Several reasons explain hospital incident and rate increases: technological advances in treatment; increased expectations of patients and relatives; insufficient funds to meet the best safety measures for patient care; and an increase in volume of services and number of patients served with no comparable increase in number of beds. Because attorneys tend to file suit against any and all parties, more staff time is required to investigate, and fill out forms even though the hospital involvement may be slight. It is becoming necessary to keep more detailed records so actions can be defended. These factors increase costs for the hospital.

To help reduce the number of incidents, hospitals can improve and maintain standards of care; the board can ask for better peer review and screening of members of the medical staff; better guidelines for establishing comprehensive medical staff privileges and for establishing fences around various types of medical practice; better review of procedures used in the hospital;

develop better training and continuing education programs for all staff; encourage groups to develop recertification programs; more adequate use of informed consent concept; resist paying off nuisance and unfounded claims; improve documentation methods and records; encourage the insurance industry to help develop safety and prevention programs for hospitals; work with attorneys to find a less expensive way for hospitals to handle paper work on cases where their involvement is slight; hospitals share information about errors made and problems experienced; updating and maintaining equipment; and initiate some type of patient grievance procedure.

Mr. Jorgensen then answered questions about policies, procedures, and costs at his hospital.

In answer to a question, he stated that it is the medical malpractice portion of their comprehensive liability which is increasing.

Mr. Stephen Blaes, attorney, appeared for Wayne Stratton, legal counsel for the Kansas Hospital Association. He discussed the crisis, legislation considered by the legislature last year, and an omnibus bill being developed by the Kansas Hospital Association and the Kansas Medical Society (see Attachment No. U).

In answer to questions, Mr. Blaes stated that under their proposal, doctors serving on a panel would be obligated to testify in a court trial to support the decision made by the panel.

In answer to other questions, Mr. Blaes stated that insurance companies carrying policies for hospitals must take into account the fact that hospitals are often enjoined in a suit filed against a doctor; he felt that it was a mistake to settle claims for their nuisance factor; he felt claims filed tended to be excessive.

It was suggested that the Kansas Hospital Association might play a role in disseminating information concerning errors made by hospitals, problems they were having, and make recommendations for their correction or solution. The Board of the Association also might want to consider taking a stand on the availability of a patient grievance procedure.

Staff was asked to research the question of whether, in fact, the hospital does become responsible for orders given by a doctor if the doctor makes a mistake.

The meeting was adjourned.

Prepared by William G. Wolff

Approved by Committee on:

7/22/75
(Date)

ATTACHMENT A

"MALPRACTICE CRISIS", PART OF A LARGER PROBLEM

Emalene Correll
Legislative Research Department

What has recently been identified in state legislatures and the media as a medical malpractice crisis probably is far more broad than the issue of providing malpractice insurance for doctors and hospitals at rates which are equitable and assuring that such insurance is available.

In general, there is probably no area of human society in whidh there have been more social and technilogical changes within the lifespan of people in this room than in the area of health care.

Today the health care system routinely saves lives and preserves the health of persons for whom there would have been no help even several decades ago. Medical care has become so sophisticated that there is a tendency to forget that new drugs, new techniques and new machinery also mean new risks and that no degree of professional competence or training can guarantee a successful outcome in medical treatment.

Patient expectations apparently have changed. The influence of TV, or what some persons have called the "Marcus Welby syndrom", media reports of medical advances and, to some degree, the health care system itself have led some people to have a totally unrealistic concept of what medicine can accomplish and to set unrealistic goals for the outcome of medical procedures.

Just since the mid 1960's with the advent of medicare and medicaid, thousands of persons have been brought into the health care system for the first time for all practical purposes. This, added to the enormous expansion of all the forms of third party coverage which has taken place since the 1940's and which has not only brought an overload on the health delivery system but has brought into the system a number of people whose expectations for health care have not been met, has created some dissatisfaction with the whole health care system.

What is sometimes called "consumerism" has also had an impact on health care. One of the manifestations of social change is that people no longer consider that providers of health care are above criticism or question. The result is a more critical look at providers and recognition that some providers may not be qualified or may not be living up to the highest standards of care.

These changes which have been noted, whether justifiable or not, really set the stage for an increase in claims by persons who believe they have suffered adverse results from health care, and have in turn resulted in attitudes and positions being taken by providers, the bar, insurers, and consumers that may or may not be justified by experience or factual data but which never-the-less contribute to the present problem. The entire range of social and technical change involved in health care is the reason for the number of different "solutions" proposed for the "malpractice problem".

"Malpractice Crisis", Part of a Larger Problem

To place the malpractice question in perspective, some data from the Report of the Commission on Medical Malpractice may be useful

1. What is the chance of a claim being filed? Based on an estimated 14,500 claims-producing incidents reported in 1970, there was less than one change in 100,000 each time a physician or dentist treats a patient, of an incident occuring that will give rise to a malpractice suit. There was a greater chance that malpractice claims will be filed in some parts of the country than others and against certain categories of practitioners or as a result of certain medical procedures.

2. Where are the increased claims located? Although there was an increase in the percentage of claims files opened to claims files closed in 1970, the increase was above the average for only five states: Maryland, Tennesee, Texas, Missouri and California.

3. What is the hospital experience? Fifteen percent of the hospitals accounted for over half the claims against hospitals.

4. Are claims being filed baseless? The Commission asked insurance carriers to indicate the claims files they judged to have merit in terms of liability and the carriers surveyed judged about 46% to be meritorious.

5. Are large claims a major concern? An analysis of the claims paid in 1970 indicates that more than half the claimants paid got less than $3,000 and only about 6.1% were above $40,000. However, the number of large awards or settlements has been increasing. (Referred to Commission Report-p. 12)

"Malpractice Crisis", Part of a Larger Problem

The Kansas Medical Society reported to American Medical News, February 24, 1975, that premiums have increased 50% to 150% during the past three years with some increases going as high as 300%. Physicians in Class I (lowest risk) pay an average of $340 and those in Class V (highest risk) pay an average of $2,750. There are great variation in rates and in increases.

In this same publication, Kansas reported that since the Medical Society did not sponsor a malpractice insurance program, no information has been compiled on whether or not there has been an increase in claims filed or how great any such increase might be. For the most part, awards have not been extremely high although a few cases have been settled for more than $500,000.

Medical Protective Insurance Company underwrites 55% to 60% of all physicians in the state. St. Paul, Hartford, Travelers and a few small companies also do business but are not accepting new physicians for coverage. Physicians who have had any claims filed against them have a chance of being cancelled. Letters have been received from practitioners in the state who are having trouble finding an insurer.

According to the newspapers, the ratio of malpractice claims per doctor in the state went from 1 in 33 in 1969 to 1 in 8 in 1973. We do not know the source of this date.

Viewed By Medical Providers

The Secretary's Commission commissioned a survey by the magazine, Medical Opinion, in December 1971, to determine what doctors considered to be the cause of the medical malpractice

problem. The first most common cause and the major cause cited by the doctors was poor communication between the patient and the physician. The second most common cause cited was aggressive lawyers. (77% of the doctors who had been sued and 66% of those who had not been sued listed these two factors as the major causes of suits. Only 2% of both groups listed "bad medicine" as the most important reason for malpractice suits.

The medical community frequently charges that lawyers and the legal system are in large part responsible for the increase in malpractice claims and awards. In particular, the medical community has attacked the contingency legal fee system as a major factor in the malpractice problem by prompting overzealous attorneys (1) to accept non-meritorious cases and (2) to magnify the nature of their client's injuries in order to win high awards from sympathetic juries.

The Commission's findings (pp. 32-33) may be of interest in respect to this.

The legal doctrines most often attacked by the medical community as affecting the initiation or outcome of malpractice litigation are:

1. res ipsa loquitur which some doctors believe is a prime example of judicial discrimination. (The evidence is that re ipsa has been extended judicially in California in some medical cases but not significantly elsewhere.) Three factors are involved in res ipsa: (a) injury ordinarily does not occur unless someone is negligent, (b) the conduct which caused the injury was under the exclusive control of the defendent, (c) the complainant was free of contributory negligence.

2. Informed consent to treatment - The patient can show he was not adequately informed of a particular treatment, procedure or medication or of the risks involved.

3. The discovery rule as applied to statutes of limitations - There are problems relative to the discovery rule as applied to the statute of limitations in terms of defining when the statute of limitations begins to run.

4. The locality rule - Did the action of the physician comply with what was considered as a standard of practice in that particular community.

5. Strict liability - Whether or not there is an implied warranty in regard to blood banks in an example.

6. Oral guarantees of good medical results - Suits can be brought under the contract theory of law alleging there was an oral guarantee of good results. This seems to go beyond the legal obligation to exercise due care and skill.

Doctors also are critical of the amount of jury awards being given, believing they are being asked to pay for more than the damage to the patient. Doctors feel they are being asked to support the person rather than to pay for their negligence. This raises the question of the purpose of the malpractice concept.

Doctors are also critical of the collateral rule which prohibits the disclosure of other recovery the claimant may have received.

Doctors point out that the news media tends to report the amount listed as damages in the pleading when in fact the amount awarded is less. The latter amount gets very little if any media coverage. The medical profession would like the amount of damages in a pleading to be eliminated (ad damnum clause).

Another recommendation of the providers is that the state legislatures enact legislation authorizing the creation of a provider owned underwriter or insurance company.

Viewed by Insurance Industry

The basic objective of insurance companies is to sell insurance at a rate that is competitive and which will result in a profit for the company. The insurance industry contends that medical malpractice insurance is very expensive and difficult for the company and cites these reasons for the decrease in the number of companies handling such coverage.

According to the industry, actuarial principles are difficult to apply to medical malpractice rates because: (1) the medical malpractice market is relatively small (premium volume for physicians and surgeons was less than 2.5% of the total property liability insurance in 1970) so the base on which actuarial calculations must be made is relatively small; (2) the dramatic changes in the last ten years in terms of the number of claims and their average cost mean that the basic components for rate setting - frequency and average claim cost - are not available; and (3) the period of time before the actuary can know what his actual experience has been. A large claim can "wipe out" the premium rate and profit or result in actual loss.

Malpractice insurance is subject to a "long tail" which means basically that a claim may be filed and/or settled a number of years after the policy year in which the incident

occurred. Insurers blame the "long tail" on: (1) court congestion, (2) the long time it takes for both plaintiff and defense attorneys to prepare a case, (3) the statutes of limitations, but more particularly the discovery period especially as applicable to a minor. The committee may want to look at the new policy, claims made policy, of St. Paul in this regard.

The insurance companies now group practitioners into five risk classes for rate-making purposes (Commission report p. 43) rather than on the basis of individual claims experience.

Traditionally hospitals were rated as individual institutions. The malpractice rate for any institution was based on that institution's claims experience. In 1953 a group program, a new approach, was started in California. In this program every hospital in a given area is rated on a level premium basis regardless of its individual claims experience.

Recently the industry has stated that "central data collection" is a prerequisite for industry decision making. Currently very little data seems to be available except perhaps in the individual files of each company. There is some feeling that data collection should be a role of the federal government.

There is a feeling on the part of the industry that the statute of limitations should be shortened, and there should be an upper limit on awards.

Questions are raised but not answered because data is not available collectively or is not released by individual companies.

The effectiveness of state regulatory agencies in this field is being questioned.

"Malpractice Crisis", Part of a Larger Problem

Another area of concern is that the marketing practices of the industry have meant a concentration on group marketing and a failure to serve the individuals insured or to take into account the experience of the individual.

It is being suggested that the industry look at the possibilities of developing loss prevention activities and programs similar to programs in industry.

There is the possibility that the reduction in reserves has affected the rate increases. However, data does not seem to be available to confirm or to refute this or to indicate to what extent such a reduction would or should affect rates.

Availability of reinsurance, irrespective of previous record, seems to be becoming a problem. Some companies are withdrawing from this field and those remaining seem hesitant to take new policies. Even if a physician is willing to pay any premium asked, the insurance is just not available.

Also there seemingly is no data on the real amount of the premium dollar which goes to claims and which therefore might affect the rates.

Viewed by the Bar

Lawyers contend that the growing number of medical malpractice claims are the result of increasing awareness of legal rights for redress of injuries and that, if anything, there is a wide gulf between the number of legally compensable injuries to patients and the number of claims which patients file. In this regard, a study undertaken for the Secretary's Commission sampled over 800 medical records in two hospitals. The investigators concluded that about 7.6% of the total patients discharged

suffered from medical injuries and about 2.2% suffered medical injuries caused by negligence. Another source estimates that the number of medical injuries may be as high as two million and the number of those caused by negligence as high as 700,000.

The lawyers defend the contingency fee system as the only way that most persons can get a case before a court and note that many small but meritorious claims are never filed because no plaintiff attorney can afford to take the case. Fee studies done indicate that an average of 450 hours are spent per case and that the hourly wage received by plaintiff's attorney is $63.00 and by defendent's attorney is $50.00.

Lawyers also point to the difficulty in obtaining expert witnesses because of the practitioner's reluctance to testify against a colleague. They also defend legal rules opposed by the medical community on the basis that they apply to tort cases in general, that physicians should be treated in the same manner as other litigants, and that such rules serve a valid public purpose.

Plaintiff attorneys also point out that proof of negligence is still the prevailing legal standard and that about 80% of the trials result in a finding for the defendent.

Attorneys seem to be opposed to any limit being put on the individual's basic right to sue and to recover. However, there is not total opposition to a schedule for contingent fees. In some instances such a schedule has been imposed by the courts and in other instances by state legislation.

Viewed By the Consumer (includes third party)

The consumers of health care have seemingly become critical of the health care system and the degree to which the medical

profession has in the past disciplined its own members for incompetence or failure to adhere to high standards of practice.

There is some tendency to suspect that licensing boards or agencies which do not have lay members "protect their own peers whether practitioners or facilities." Licensing boards, on the other hand, have been critisized because they have lacked the legal authority to take action against members of their profession. There is also the problem of ex parte orders which allow the physician to continue to practice while a decision is being reached.

Some consumer groups are critical of the degree to which practitioners and facilities have failed to concentrate an accident prevention and of what they consider to be a "conspiracy of silence" in regard to accidents which may affect them.

Consumers of health care appear to be increasingly frustrated by communication failures between patients and practitioners and hospital personnel. If a consumer has a grievance there seemingly is no place for him to go. He is critical of the fact that practitioner and regulatory agencies have not set up grievance mechanisms to which they can funnel their complaints. The feeling of frustration which results can in itself lead to a filing.

In some cases, the consumer's inability to find legal assistance in filing a claim and the long period of time which elapses between a negligent act and recovery are also voiced as problems.

Some recommendations are: (1) mandatory, but not binding arbitration; (2) better communication between patient, doctor and hospital personnel; (3) practitioners subject themselves to peer review; (4) high quality control programs; (5) development of

alternatives to total removal of a practioner's license; (6) both practitioners and hospitals set up some type of a grievance procedure

Attachment B

Summary of Recommendations

Defensive Medicine

The Commission finds that defensive medicine is the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted. p. 15

The Commission recommends that over-utilization of health-care resources by any provider should be aggressively attacked by physician-directed regulatory efforts. Hospital utilization committees should be mandatory in every hospital, and their efficiency should be subject to statistical analysis and review by physician-directed supervisory groups. p. 15

In order to encourage physicians to render the highest possible quality care and to reduce the practice of unwarranted defensive medicine the Commission recommends that medical and osteopathic organizations exert maximum moral suasion over physicians who avoid professional responsibilities on the basis of fear of malpractice liability. p. 15.

Good Samaritans

The Commission finds that there is no factual basis for the commonly-asserted belief that malpractice suits are likely to stem from rendering emergency care at the scene of accidents. p. 16

The Commission recommends that widespread publicity be given to this fact in order to allay the fears of physicians, nurses, and other health-care providers in this regard and to encourage the rendering of aid in non-hospital emergency situations. p. 16

Qualified Immunity

The Commission recommends that the states enact legislation to provide qualified immunity to hospitals and members of hospital rescue teams while they are attempting to resuscitate any person who is in immediate danger of loss of life, provided good faith is exercised. p. 17

The Commission recommends that the states enact legislation designed to provide qualified immunity to physicians and other health-care personnel who respond to emergencies arising from unexpected complications that arise in the course of medical treatment rendered by other physicians or other health-care personnel. p. 17

The Commission recommends that all physicians who regularly practice in hospitals be encouraged, through continuing medical education, to become proficient in cardiac arrest and cardiopulmonary resuscitation techniques. p. 17

Allied Health Personnel

The Commission finds that there does not appear to be any indication that the use of allied health-care personnel, particularly registered nurses and technicians, where properly qualified or supervised, has led to any significant problems of medical malpractice liability or malpractice insurance coverage. Where the use of such allied health-care personnel is medically justified, it has not been shown that malpractice problems have significantly restrained their use. p. 17

Media

The Commission finds that despite isolated instances of emotionalism, bias, and inaccuracy, press, radio and television coverage of medical malpractice cases and problems is, on the whole, straightforward, factual, and balanced. p. 19

Patient Injuries

The Commission finds that patient injuries, real or imagined, are prime factors in the malpractice problem. p. 24

Legal Doctrines

The Commission finds that some courts have applied certain legal doctrines for the purpose of creating or relieving the liability of health professionals. The Commission further finds that such special doctrines, or the application thereof, are no longer justified. p. 31

Informed Consent	The Commission finds that the doctrine of informed consent is subject to abuse imposes an unreasonable responsibility upon the physician. p. 29
Res Ipsa Loquitur	The Commission finds that the doctrine of *res ipsa loquitur* in its classical sense performs a useful purpose in common law, but that it should not be applied differently in medical malpractice cases than in other types of tort litigation. p. 29
Application of Legal Doctrines	The Commission recommends that legal doctrines relating to the liability of health professionals should be applied in the same manner as they are applied to all classes of defendants, whether they be favorable or unfavorable to health professional defendants. Such doctrines would include (a) the application of the discovery rule under the statute of limitations; (b) the terms of the statute of limitations; (c) the application of the doctrine of *res ipsa loquitur* to injuries arising in the performance of professional services; (d) the rule allowing liability based on oral guarantee of good results, and (e) the doctrine of informed consent to treatment. p. 31
Restatement of Medical-Legal Principles	The Commission believes the time has come to develop greater logic, consistency, and uniformity in the medical-legal rules and doctrines affecting the delivery of health-care, and therefore recommends that all such medical-legal rules and doctrines be clarified and made uniform in application throughout the United States. In order to achieve this objective, the Commission recommends that a broad-based group, representing all segments of the health-care system, the legal profession, and the general public, be convened to develop the appropriate definitions and guidelines in the nature of a Restatement of the Law of Medical-Legal Principles. p. 31
Contingent Fee	The Commission recommends that courts adopt appropriate rules and that all states enact legislation requiring a uniform graduated scale of contingent fee rates in all medical malpractice litigation. The contingent fee scale should be one in which the fee rate decreases as the recovery amount increases. p. 34
Defense Costs	Realizing that the matter of defense costs is an important element in the cost of malpractice insurance, the Commission recommends that a method of minimizing these costs be studied. p. 35
Legal Aid	The Commission recommends that public legal assistance mechanisms be established, or expanded where they already exist, to assure adequate legal representation to persons with small malpractice claims. p. 35
Medical-Legal Cooperation	The Commission recommends that the professions of law and medicine seek to improve their level of understanding and cooperation, specifically in the area of malpractice litigation to facilitate the handling of claims in the most equitable manner. p. 36
Expert Testimony	The Commission recommends that organized medicine and osteopathy establish an official policy encouraging members of their professions to cooperate fully in medical malpractice actions so that justice will be assured for all parties; and the Commission encourages the establishment of pools from which expert witnesses can be drawn. p. 37
Notice of Intent to File Suit	The Commission recommends that state laws be amended to require that a written notice of intent to file a malpractice suite be given to the potential defendant within a specific time period prior to the running of the statute of limitations. Upon the filing of such notice, the statute of limitations would be automatically extended for a specified period, to enable the parties to negotiate an amicable settlement in good faith. p. 37
Ad Damnum	The Commission recommends that the states enact legislation eliminating inclusion of dollar amounts in *ad damnum* clauses in malpractice suits. p. 38
Insurance Availability	The Commission finds that malpractice insurance is currently available to health-care practitioners under group plans and the market for such insurance is competitive. Malpractice insurance is also available to individual health-care practitioners, although they appear to have more difficulty in locating insurance sources. p. 38

Umbrella and excess coverage are also available both to individuals and under group pl
p. 38

Insurance Contingency Plan

The Commission recommends that the insurance industry and health-care provider groups work together to develop a contingency plan to provide medical malpractice insurance in the event such insurance becomes unavailable through normal market channels. p. 39

Reinsurance

The Commission finds that to the extent that medical malpractice insurance is available in the primary market, it is available in the reinsurance market. p. 39

Insurance for Free Clinics

The Commission recommends that the free clinic movement consider medical malpractice insurance necessary protection for patients and health-care personnel. To assist in remedying this situation, the Commission recommends that governmental authorities consider the overall need for medical malpractice insurance and its cost in evaluating applications for grants to free clinics, not just the need for coverage of the activities covered by the grant. p. 41

Rate Making

The Commission finds that the present methods for establishing malpractice insurance rates, including groupings of physicians and institutions for rating purposes, may not be equitable for all providers or in the best interests of the public. p. 43

Rating Classifications

The Commission finds that health-care providers by encouraging numerous separate specialty rating classifications have contributed to the establishment of a rating classification program which may be inequitable to some practitioners and which under some circumstances may adversely affect the cost and availability of professional liability insurance. p. 43

The Commission recommends that the American Medical Association, American Osteopathic Association, American Nursing Association, American Dental Association and the American Hospital Association meet with the leaders of the insurance industry to study alternative methods of classifying individual practitioners and institutions for rate making purposes; for example: on a group basis to the medical staff of a hospital or to a county society. p. 43

Rating Hospitals

The Commission recommends that serious consideration be given to establishing level premium rates for hospitals within a distinct area based on the number of beds and/or out-patient visits. p. 44

Statistical Reporting

The Commission finds that inadequacies in the collection and analysis of appropriate data have precluded the development of sound actuarial practices and rates, and that state insurance departments are generally inadequately equipped to monitor effectively the rate making process employed in establishing malpractice insurance rates. p. 45

The Commission recommends that the National Association of Insurance Commissioners work with the insurance industry to establish a uniform statistical reporting system for medical malpractice insurance and that data be reported to a single data collection agent who will compile it, validate it and make it available to state insurance regulators, carriers and other interested users. p. 45

Marketing Malpractice Insurance

The Commission recommends that the insurance industry develop improved channels of communication concerning the marketing, economics and quality of medical malpractice insurance so that responsible sources of medical malpractice insurance are more widely known to health-care providers, insurance brokers, and independent insurance agents. p. 45

Insurance Services

The Commission recommends that purchasers of medical malpractice insurance, especially associations and institutions, give due regard to the loss prevention and claims handling capabilities of prospective insurance carriers and that active programs be instituted and encouraged in cooperation with insurance carriers designed to prevent the

occurrence of injury as well as to assist in disposing of meritorious cases as quickly and as fairly as possible. p. 45

The Commission recommends that states require insurers issuing medical malpractice policies to disclose loss prevention and claims settlement practices on request by purchasers and in any sales promotional material distributed to prospective purchasers. p. 45

Medicare

The Commission recommends that Congress and the Secretary of HEW review those portions of Title 18 of the Social Security Act (Medicare) which contain benefit payment restrictions and other limitations that impede patient rapport and, which may tend to increase the number of malpractice claims. The Commission urges re-evaluation of Title 18 so that patient frustrations are reduced to the extent feasible. p. 46

The Commission recommends the launching of an educational and public relations program aimed at Medicare participants in order to increase understanding of the program's statutory limitations and to decrease public dissatisfaction and frustration which may lead to malpractice claims. p. 47

The Commission recognizes the need to measure and evaluate the impact of malpractice claims and litigation on the costs of Medicare and other Federally-supported health-care programs and the Commission therefore recommends that appropriate studies be initiated to achieve that objective. Such analysis should include not only the premiums involved but the cost of handling the claims and the costs to other Federally-sponsored programs that may also be providing benefits to medically injured persons. p. 47

National Health Insurance

The Commission recommends that new third party payment proposals, such as national health insurance, have benefit structures which are easily understood by patients and providers and that the administration of such plans be as simple as possible to avoid, to the extent possible, retroactive denials of claims and other administrative impediments which might exacerbate the patient-provider relationship and create an environment conducive to disputes, claims, and suits. p. 48

Overlapping Benefits

The Commission recommends that an indepth analysis be made to identify the cost of overlapping health insurance benefits and to identify methods of using these resources to assure more complete coverage to all. No new Federal or Federally-funded program should be initiated without taking these factors into considerations, and all existing programs should be reviewed to achieve these objectives. p. 49

Licensure

The Commission finds that the competence of individual providers of health-care affects the overall quality of care. The Commission also finds that most State medical practice acts do not have adequate provisions for disciplining practitioners who have been found incompetent. p. 52

The Commission recommends that all State medical practice acts include specific authority to State licensing bodies to suspend or revoke licenses for professional incompetence. p. 52

Re-Registration of Health-Care Providers

The Commission recommends that the states revise their licensure laws, as appropriate, to enable their licensing boards to require periodic re-registration of physicians, dentists, nurses and other health professionals, based upon proof of participation in approved continuing medical education. p. 53

Expediting Sanctions

The Commission recommends that the States enact legislation which limits the duration of judicial *ex parte* stay orders to the minimum period necessary to hold an adversary hearing in cases of suspension or revocation of the licenses of health professionals by State Boards. The adversary hearing should be given priority on any court docket. p. 54

Rehabilitation of Practitioners

The Commission recommends that State licensing laws emphasize rehabilitation of practitioners who have been found guilty of infractions. p. 54

The Commission recommends that State Boards of medical and osteopathic examiners be authorized to prescribe a range of intermediate disciplinary actions in addition to suspension or revocation of licenses, such as requiring remedial education. p. 54

Nationwide Standards

The Commission recommends that a feasibility study be made regarding the establishment of uniform national procedures for examining and licensing health professionals and the establishment of uniform standards of practice. p. 54

Re-Certification of Physicians

The Commission recommends that specialty boards periodically re-evaluate and recertify physicians they have certified. p. 55

Public Scrutiny

The Commission recommends that all state boards of medical examiners include lay members. p. 55

The Commission recommends that all disciplinary hearings be open to the public. p. 56

Institutional Licensure

The Commission recommends that studies be made to determine the impact on the quality of care of institutional and organizational licensure for allied health personnel (other than registered nurses) as an alternative to individual licensure. p. 56

Staff Privileges

The Commission recommends that the States enact legislation to authorize, with due process, the appropriate committee of a hospital medical staff to suspend, revoke, or curtail the privileges of a physician or hospital staff member for good cause shown. The committee members and the hospital should have qualified immunity from suit for their acts. Notification of such actions should be forwarded to the appropriate State licensing boards. p. 57

Continuing Education

The Commission recommends that continuing education be directed toward known needs and that it be designed around performance criteria. p. 59

The Commission recommends that there be imposed upon the existing system of self-regulated continuing education control mechanisms which will require continuing medical education and evidence of provider proficiency. p. 59

Clinical Pharmacology

The Commission recommends that clinical pharmacology, that is, the teaching of actions, indications, side effects, etcetera of drugs used therapeutically be required as part of an integrated program for teaching the basics of therapeutics to all medical and nursing students and that similar attention be given to the same subjects in post-graduate and continuing medical education curricula. p. 60

Using More Nurses

The Commission recommends that physicians, hospitals, nursing homes and other institutions increase the number of professional nurses giving direct care to patients in the interests of better patient care and of minimizing malpractice suits. p. 60

Clinical Education for Nurses

The Commission recommends that in the interests of better patient care and of minimizing medical malpractice suits, nurses should be required to complete clinical practice courses in the areas of planning patient care, assessment of patient's problems, recording and reporting, clinical nursing procedures, working with other medical personnel, and educating patients in implementation of doctors' orders. p. 60

The Commission recommends that clinical courses which include human anatomy, psychology and human relations be required in the nursing curriculum. p. 61

Injury Prevention

The Commission recommends the development of intensified medical injury prevention programs for every health-care institution in the nation, such programs to be predicated on the following:

1. investigation and analysis of the frequency and causes of the general categories and specific types of adverse incidents causing injuries to patients;

2. development of appropriate measures to minimize the risk of injuries from adverse incidents to patients through the cooperative efforts of all persons involved in the providing of patient care in such institutions. p. 61

Quality Control

The Commission recommends that institutional quality control mechanisms of all types be constantly evaluated and, where proven desirable, modified so that the information they generate can be fed into a nationwide information system and into continuing education programs. p. 62

Loss Prevention

The Commission finds that where genuine cooperation and support of insurance company loss-prevention programs can be achieved, a meaningful reduction in patient injuries can also be achieved. p. 63

The Commission finds that loss-prevention activities generally are limited to group plans. For the most part, activities aimed toward the individual practitioner have been minimal. There is a need for intensified loss-prevention efforts on the part of the medical malpractice insurance industry working with health-care providers and the consumer community. p. 63

The Commission recommends that the medical malpractice insurance industry develop sophisticated loss-prevention programs based on both injury and claims prevention techniques. This development will require the active participation of the provider and consumer community. p. 63

The Commission recommends that a portion of the premium dollar for institutional medical malpractice insurance be specifically identified and allocated towards loss-prevention. Health-care providers should implement and monitor the loss-prevention programs developed in cooperation with their insurance carriers. p. 63

The Commission recommends that medical malpractice carriers provide analyses of incidents to institutional health-care providers in order to aid the institutions' injury prevention programs. p. 63

Nationwide Data Collection

The Commission recommends that health-care providers, consumers, attorneys, and the insurance industry form a consortium to collect and report information relating to medical injuries and medical malpractice to a Federal or Federally-sponsored data-gathering service. p. 65

It is further recommended that the Secretary of Health, Education, and Welfare convene representatives of these groups (1) to determine the kind of data needed, and (2) through existing data facilities in HEW, to work with private industry to develop the information. p. 65

Individual Privacy

The Commission recommends that the Congress, by appropriate legislation, confer privacy to the raw data collected for a nationwide medical malpractice data system comparable to the privacy that has already been accorded to data collected by the Social Security Administration and the Internal Revenue Service. p. 65

Federal Assistance

The Commission recommends Federal sponsorship of research and demonstration programs in order to develop the recommended injury prevention programs. The Federal Government should also support the development of a nationwide system for the continuous monitoring and evaluation of medical injury prevention measures, in order to assure the cross-fertilization of new techniques and approaches between and among all categories of health-care providers. p. 65

Human Relations Training

The Commission recommends that all medical, dental, and nursing schools develop and require participation in programs which integrate training in the psychological and psychosocial aspects of patient care with the physical and biological sciences. p. 69

The Commission recommends that all categories of health-care personnel receive training in order to develop attitudes and skills in the interpersonal aspects of patient care. This

training should utilize the most advanced educational technology and should be inclu in post-graduate and continuing education programs as well as throughout the enti period of undergraduate training. p. 69

The Commission recommends that staff conferences be expanded to include discussion of the ethical, social, and psychological aspects of patient care, and that periodic faculty-student seminars be devoted exclusively to discussion of these matters. p. 69

Improving the Health-Care Environment

The Commission recommends that improvements be made in the physical environment and methods of management of hospitals and other health-care facilities to assure greater attention to the psychological and psychosocial needs of patients. p. 70

Education of the Public

The Commission recommends that special programs be developed to educate the public on health-care subjects about which patient knowledge is deficient, and which may contribute to later malpractice litigation. These subjects should include: health and hygiene (including the origins of disease, function of the body organs, nutrition needs, etc.); how to communicate with health-care personnel; the economics of medical care; the conventions of medical practice (e.g., consultation, referrals, use of surgical assistants, etc.); and the limitations of medical science. p. 70

The Commission recommends continuing programs of research and analysis aimed at increasing knowledge and understanding of patients' psychological and psychosocial needs and that findings of such research be translated into specific action programs aimed at improving the physical design and methods of management of health-care facilities and at improving the training of health-care personnel in the human relations aspects of patient care. p. 71

Patients' Rights

The Commission recommends that hospitals and other health-care facilities adopt and distribute statements of patients' rights in a manner which most effectively communicates these rights to all incoming patients. p. 71

Teaching Hospitals

The Commission recommends that the functions of teaching hospitals be explained to all patients entering such hospitals, and that these functions be emphasized in other forms of consumer education. p. 74

Socio-Economic Distinctions

The Commission recommends that where they exist, distinctions in the treatment of patients in teaching hospitals based on the patient's race or socioeconomic status be eliminated. p. 74

Informed Consent

The Commission finds that there is a generally recognized right of a patient to be told about the danger inherent in proposed medical treatment. That right is consistent with the nature of the doctor-patient relationship and with fundamental fairness. A much greater degree of communication between health-care providers and patients is really good, basic medical practice and should be encouraged. p. 74

The Commission finds that the law relating to the nature of information which the health-care provider must supply to obtain valid consent for treatment is presently in flux. Adoption of uniform standards requiring full disclosure of material risks would eliminate much confusion as to the basis and nature of informed consent. Under such standards, both patient and doctor would gain a clearer understanding of their respective rights and obligations. p. 75

The Commission recommends that a responsible member of the patient's family be given appropriate explanations where the physician is justifiably reluctant to explain such matters directly to the patient because of his concern that the explanation itself is likely to have an adverse effect on the patient. p. 75

Access to Medical Records

The Commission finds that the unavailability of medical records without resort to litigation creates needless expense and increases the incidence of unnecessary malpractice litigation. p. 75

The Commission finds that patients have a right to the information co[illegible] in their medical records and recommends that such information be made more easil[illegible]essible to patients, and the Commission further recommends that the States enact legislation enabling patients to obtain access to the information contained in their medical records through their legal representatives, public or private, without having to file a suit. p. 77

Alteration of Medical Records

The Commission recommends that the states enact legislation to prohibit modification, alteration, or destruction of medical records with the intent of misleading or misinforming the patient. p. 77

Clinical Research Standards

The Commission recommends that physicians engaged in clinical research consider as minimum standards of ethical conduct the World Medical Association's Declaration of Helsinki and the American Medical Association Guidelines for Clinical Investigation. p. 77

The Commission recommends that where clinical investigation necessarily involves the participation of persons who are not legally competent to give valid consent, extraordinary precautions be established to protect the interest of such persons. p. 77

The Commission recommends that the biomedical research community make every effort to educate its prospective members in the fundamental principles of research ethics. p. 78

Protection of Human Subjects

The Commission recommends that the Department of Health, Education, and Welfare guidelines on medical research involving humans be applied to all persons participating in medical research regardless of the source of funds which support the investigation. p. 79

Insurance for Research Subjects

The Commission recommends that whenever a grant or other funding is provided by the Federal Government for medical research involving human subjects, that the grant include a sum sufficient to provide either insurance or a self-insurance fund in order to provide compensation to any human subject who may be injured in the course of the research. Where the Federal Government itself conducts the research, precisely the same rules should apply, either through the Federal Employees' Compensation Act or other funding. p. 79

The Commission recommends that whenever research involving human subjects is conducted by the private sector, that insurance be provided to protect against mishaps, injury, or illness directly arising out of that research. p. 79

Consumer Involvement

The Commission recommends that the Secretary of Health, Education, and Welfare and the administrators of other Federally supported health-care delivery and medical research and demonstration programs establish and continue consumer involvement activities at the planning, services, supervisory, management, and coordination levels by means of board membership, advocacy and advisory mechanisms. p. 81

The Commission recommends that the same degree of consumer involvement be fostered by all appropriate non-Federal health-care delivery and research programs. p. 81

Grievance Mechanisms

The Commission recommends that all health-care institutions establish a patient grievance mechanism capable of dealing with patient care problems. p. 84

The Commission recommends that, to the extent possible, patient grievance mechanisms be established to deal with patient care problems in non-institutional settings. p. 85

The Commission recommends that the Secretary require, as a condition of receiving Medicaid and Medicare payments, that all health-care institutions establish a patient grievance mechanism capable of dealing with direct patient care problems. p. 84

The Commission recommends the initiation of research programs to determine the best way to utilize patient grievance mechanisms to deal with problems involving patient care,

including all health-care providers: hospitals, nursing homes, HMO's, clinics, and priv practitioners, and also all levels of regulation—Federal, State, and professional. p. 85

State Office of Consumer Health Affairs

The Commission recommends that there be established in each State an Office of Consumer Health Affairs. The Commission further recommends that Federal financial assistance be made available to the States to encourage the establishment of such offices at the earliest possible date. p. 86

Claims Handling

The Commission recommends that medical malpractice carriers develop mechansims for improved claims handling. In particular, we recommend attention be given to the detection and analysis of incidents having a claims potential to allow early disposition, and to further experimentation with advance medical payments. p. 90

Screening Panels

The Commission recognizes the value of local efforts to mediate medical malpractice disputes, and therefore recommends continuous experimentation with voluntary mediation devices. The Commission also recommends that persons other than attorneys and members of the profession involved in the disputes be included as members of any mediation board or panel. p. 91

Imposed Arbitration

The Commission recommends more widespread use of imposed arbitration as an alternative mode for resolving small medical malpractice disputes, providing the arbitration mechanisms have the following characteristics and do not preempt contractual arbitration agreements:

1. Arbitration statutes enacted by the States should be designed to give jurisdiction over all parties, plantiffs and defendants, involved in a specific medical malpractice case.
2. State arbitration laws should set a maximum monetary limit for invoking the jurisdiction of the arbitration board, with cases demanding higher amounts being handled through the present jury system.
3. Arbitration panels should include some persons who are neither attorneys nor persons involved in the delivery of health-care services.
4. There should be the right of trial *de novo* subsequent to arbitration in the highest level jury court in the State.
5. The State arbitration statute should provide economic and legal sanctions, in order to discourage subsequent trials *de novo* of questionable merit, (e.g. evidentiary rules, presumptions, taxation of court costs).
6. A fairly detailed synopsis of each arbitration decision should be made and published in order to establish precedents, provide information necessary to evaluate and improve the arbitration system, and provide adequate feedback information to the health-care system.
7. Although the Commission has recommended that the results of formal arbitration proceedings be published, publicity focused on the names of parties involved in disputes should be avoided or minimized. p. 93

Enabling Legislation

The Commission recommends that all States that have not adopted legislation to make binding arbitration awards possible enact such legislation. p. 94

Contractual Arbitration

The Commission finds that the utilization of contractual arbitration as an innovative method of resolving malpractice disputes is an important development that justifies continued experimentation and study prior to universal adoption. p. 96

Freedom of Contract

The Commission recommends that no patient be required, as a condition for receiving service, to sign an agreement requiring him to agree to arbitrate any future dispute arising out of the service. p. 96

Note: This recommendation does not apply to agreements for comprehensive health-care services in which the arbitration agreement may be a part of the overall contract for health-care services.

Lay Representation

The Commission recommends that the panel of arbitrators include representatives from the public other than members of the professions involved in the dispute. p. 96

Public Record

Furthermore, the Commission recommends that the results of contractual arbitration, including the award and the basis of the award, be made a matter of public record for the purposes of study and improvement of quality of care and the avoidance of unnecessary injury to patients. p. 96

Federal Coercion

The Commission is opposed in principle to any form of government activity which would induce or compel a health-care provider or a patient to agree to arbitrate disputes prior to the event which gives rise to the dispute. p. 96

Alternative Compensation Systems

The Commission recommends that the Federal Government fund one or more demonstration projects at the State or local level in order to test and evaluate the feasibility of possible alternative medical injury compensation systems. p. 102

The Commission finds that further study is warranted and essential for better definition of the event for which compensation should be paid and for developing a method of financing whatever new system is recommended. p. 102

State Pilot Programs

The Commission recommends that one or more State governments study and investigate, by all appropriate means, including pilot programs, the feasibility of establishing a patient injury insurance program, similar to workmen's compensation insurance, to provide designated compensation benefits for injuries arising from health-care, whether caused by medical malpractice or not. p. 102

The Commission recommends that the various proposals suggested here be developed, tested and demonstrated through both public and private initiatives, especially those which, if possible, would promptly compensate medically injured patients without regard to a finding of fault. p. 102

Implementation of Recommendations

The Commission recommends the creation of a non-governmental, non-profit organization which would be the nationwide focal point for malpractice research, information, education, and prevention activities. The proposed organization should be broadly based and representative of the public at large, including health-care providers and third party payors, both public and private, the legal profession, insurance industry, and consumers. p. 103

Funding for this entity should come primarily from health, legal, and insurance organizations, as well as from philanthropic foundations and individuals. Federal assistance could come through the research grant mechanism and the sponsorship of conferences and activities necessary to establish the organization. p. 104

Journal of American Insurance
Vol 51, No 1

Attachment C

Malpractice Insurance:

A Medical-Legal Dilemma

Squeezed in the middle, insurers reflect soaring costs in patient suits, jury awards and defensive medicine.

To the patient on the operating table, life or death may rest with the delicate incision of the surgeon's scalpel.

Yet the surgeon, to successfully employ his highly trained skill, must depend upon the availability and adequacy of the hospital's facilities as well as the performance of other health care professionals—those who assist him, plus those involved in the patient's care before and after the operation.

Further, beyond all this, there is still another essential element: medical malpractice insurance.

Without this professional liability insurance, especially today, the doctor cannot practice, the hospital cannot admit the patient, and the host of other health care providers cannot function.

Unfortunately, this massive and sensitively interdependent system is not serving the patient today as well as it should. The growing surge of patient lawsuits is commanding serious attention by all concerned to improve the ways the health care system treats the patient.

Insurers, including their trade associations such as the American Mutual Insurance Alliance, are dedicated to the task. The Alliance, for example, proposes both short-term and long-term measures to help ease the crisis and seek basic medical-legal reforms.

Why has this all happened?

The plain fact is that the patient is suing his doctor out of business. The plain fact also is that in certain cases the doctor may well deserve being called to account. But hardly to the extent the malpractice lawsuit trend suggests—America's generally high quality of medical care didn't deteriorate that much just overnight.

In former years, a patient wouldn't think of suing his family doctor. But today's world is very nonpersonal. Today's patient is consumer educated. He is satiated with visions of medical miracles in his daily media diet. He feels good health is everyone's right and he expects treatment that delivers sure results, though medicine is still art and not science.

Thus, as medical technology grows, becomes more complex, specialized and impersonal, the patient finds it easier to be disappointed and dissatisfied with the treatment itself or perhaps the bills for its cost. His desire for "satisfaction" leads to the next step. Why not sue?

Medical-Legal Malpractice Dilemma: Insurers Caught In The Middle

To sue costs the patient nothing. It's a high-stakes gamble in which the patient's lawyer gets paid only if he wins—the contingent fee system. It's called "the poor man's key to the courthouse."

But to the defendant doctor and his insurer it is expensive litigation, an average cost of almost $15,000 even if the suit never goes to trial.

Under this present contingent fee legal system,

MEDICAL MALPRACTICE CRISIS	HEALTH CARE PROVIDERS		PUBLIC	
	PHYSICIANS	HOSPITALS	PATIENTS	JURIES
LAWSUITS	Doctor/patient relationship has become impersonal since times when human errors of family doctor were overlooked.	Nearly 75% of all medical malpractice occurs in hospitals.	Patients have unrealistic expectations of total success from medical treatment (Marcus Welby syndrome).	Wider publicity of higher dollar demands affects jury decision on the "value" of patient injury claims (ad damnum clause).
AWARDS	Patient can win awards if doctor has not enlightened him on virtually every conceivable treatment risk (informed consent rule).	Surgeons, anesthesiologists and other highly skilled specialists are subject to higher insurance rates because of increased risks of extra large judgments.	Less than 20¢ of premium dollar goes to injured patient, rest taken by litigation, other costs.	More and more juries show overzealous sympathy in helping out patient, whether or not fault is proven.
INSURANCE AVAILABILITY	More complicated the medical procedure, the greater the health risk, the higher the premium or the declining availability of insurance at a lower rate.	Hospitals require staff doctors to carry malpractice insurance in order to have staff privileges.	Problem of insurance availability affects medical quality and ultimate cost of health care.	Seldom recognize impact of exorbitant awards on insurance availability, effect upon health care of public at large.
INSURANCE PREMIUMS	HEW report notes between 1960-70 premiums for physicians (other than surgeons) rose 541%. For surgeons, premiums rose 949%. This reflects high losses by insurers.	HEW report notes between 1960-70 premiums for hospitals rose 262%. Rates reflect greater frequency and higher amounts of awards.	Rising insurance cost is passed on to public and government as part of higher charges for office visits, hospital stays, medical tests and health insurance (including Blue Cross, Medicare and Medicaid).	
TIME FACTORS	In most states a 20-year-old today can bring suit against the doctor who delivered him and hospital where he was born (long-tail or time-bomb cost effect).		Only half of malpractice claims are settled in 18 months and over 10% still pend after 6½ years, HEW report cites. Big awards can hit after 8-10 years or more.	
OVERALL IMPACT	Spectre of malpractice suits compels health care providers to practice defensive medicine, require unnecessary diagnostic tests and other treatments to build defense record. Estimated additional cost for defensive medicine runs to $10 billion annually.		Cost of defensive medicine is passed on to public. Quality of health care suffers, as many medically-indicated operations and treatment are avoided for fear of malpractice suits.	

the patient's suit is pressed with understandable persistence and purpose by a lawyer who is quite willing to invest his time and his experience in such cases with the incentive of sharing in the possible prize. Even though he loses more often than he wins, the lawyer when he does win gets 30 percent to 50 percent of the award which with greater frequency may exceed the $1 million mark.

Can you guess who pays? The insurance carrier, of course, the scorekeeper or middleman who holds the money and awaits the outcome in this exorbitantly costly medical-legal confrontation.

The result of all this has been that the insurance carriers, those comparatively few companies which ventured to serve in this relatively small field of highly specialized liability coverage, have been hard

INSURER	ATTORNEYS		LEGAL SYSTEM
	DEFENSE	PLAINTIFF	CURRENT LAWS & REGULATIONS
More patient claims going to suit, more suits going to judgment, higher awards and settlements have mushroomed insurer losses, placing insurers in unfair position of subsidizing malpractice costs.	Average suit costs insurance company $10,000-$15,000 even if case never goes to court.	Maintain suits will multiply until medical profession assures public it will take action against those who are negligent or incompetent.	In claims of negligence, burden of proof has been shifted to health care providers to convince jury there was no negligence (res ipsa loquitar concept).
Prolonged statutes of limitation allow suits many years after the fact. Drastic loss impact of single jumbo award makes it impossible for insurers to predict with accuracy the number and amount of future claims.	Cannot be hired on contingent fee basis, hence their legal services must be paid for, even if the accused health care provider is found innocent.	Successful plaintiff attorney can receive 30% to 50% of award for himself under contingent fee system.	Although courts have authority to reduce exorbitant jury awards not justified by facts in a given case, few judges do so. This judicial power may be lost as a result of legislated remedies.
Increasing frequency of awards from $100,000 to over $1 million can deplete insurance company reserves, force exit from market.	Claim present tort system makes it impossible for companies to plan for future losses on malpractice claims (long-tail or time-bomb cost effect).	Maintain insurers are abandoning malpractice due solely to current sag in stock market, even though number of insurers of malpractice has been decreasing for 6 to 8 years.	Current statutes and legal interpretations mitigate against insurers being able to provide medical malpractice coverage at a rate realistically reflecting amount of losses.
Excessive losses have forced insurers to raise rates, be more selective in writing malpractice insurance.	Contend premiums can't be reduced until malpractice suits are limited to cases of demonstrable incompetence or negligence.	Maintain premiums would not have soared if state medical societies had policed their own members better.	Insurers are the cost scorekeepers in the medical-legal confrontation; rising claims costs must be reflected eventually in higher premiums.
Under occurrence policy, insurer must maintain a reserve from single year's premium to cover potential large awards for a decade or more from future unknown claims.	Cite long statutes of limitation put fuse on time-bomb of future claims and costs.	Maintain the effect of negligence accident and the impact of drugs and treatment may not become discernable for many years.	Health providers have no safeguards from extremely long exposure to suits. A physician can be sued for malpractice a decade or more after he has retired.
Insurance companies, which by law must operate with prudence, are caught in middle of medical-legal dilemma. They are forced to double and redouble premiums to cover rising losses, avoid subsidies from other policyholders.	Are inclined to settle nuisance suits out of court to avoid exorbitant award by runaway jury. Every nuisance suit settlement fuels cost spiral of malpractice crisis.	Many are becoming proficient in handling malpractice suits, which are spreading to include nurses, physician assistants, dentists, lab technicians and psychiatrists.	Present legal system encourages suits, fosters jumbo awards to detriment of quality health care at reasonable cost. Equitable tort reform could protect competent doctors, still provide public right of redress in cases of genuine medical malpractice.

pressed to increase their rates fast enough to keep up with the skyrocketing costs of runaway jury awards and settlements—both present and prospective. Because of their losses, some companies have been withdrawing from the market or reducing the extent of their involvement. They simply refuse to imperil their ability to properly protect policyholders in their other lines of insurance, such as homeowners and auto.

One financially vicious factor in this alarming and continuing cost spiral for the insurer is the "time-bomb" or "long-tail" effect of malpractice suits filed many years following the doctor's policy year, but which must be paid from the premium collected for that given year and held in reserve for this purpose. Even suits promptly filed the same year of the allegedly improper treatment can take several years in litigation. Estimating reserve funds for 8, 10 or even 20 years to cover unknown high-dollar claims in the future has become a task companies cannot do easily, yet such contingency is a key factor of cost.

Meanwhile there is another critical cost factor. It is the move by the doctor to order more tests, X-rays and other treatment than necessary to protect himself from litigation. This defensive medicine cost now may run as high as $10 billion annually. Like all costs, it is the patient who ultimately pays, as was noted in the extensive 1973 report of the HEW Secretary's Commission on Medical Malpractice.

One estimate of the claims payout for a big insurance company for a five-year period (1967-72) even before the current crisis will be more than $150 for each $100 of premiums collected. Adding company expense and other costs will bring this to some $180 loss for each $100 collected.

This large carrier in the field reports it had only one claim for every 23 doctors covered in 1969 but this was up to one for 10 by 1974. And in the same period the average value of each claim also had nearly doubled. Signs show this pace is much worse now.

Court data in Cook County, Illinois, show that 522 malpractice suits were filed in 1973 and 818 in 1974. In January-February 1975 alone 158 suits were filed, compared to 116 suits in the first two months of 1974. Also significant: the average verdict per successful plaintiff was $116,799 for 1974-75 midterm six months, compared to $40,019 for 1973-74 full-term 12 months.

As the insurance carriers push for still higher premiums to pay for these astronomical costs, the doctor and his medical associations in turn have sounded the public alarm. Especially since the first of this year as the crisis has worsened, the doctor claims he cannot or will not pay the higher insurance rates, he has gone on strike or threatened to strike, and in other cases he has gone into early retirement or closed his practice entirely. The new young doctor is concerned and says the insurance cost is yet another formidable hurdle to starting in practice.

As of late May, some form of legislative relief was being pushed in a total of 38 states and action of some sort had been taken in as many as 17 of them. However, the search for viable solutions to appropriately reflect the interests and concerns of all involved is expected to continue for some time and may include efforts by some for federal relief as well.

The Alliance's state-level approach includes a "package" of proposals designed to provide a reliable source of insurance to health care professionals and institutions, to initiate measures that would reduce the incidence of claims for medical injury and bring the cost of such claims under control, to reliably protect the financial integrity of participating insurance carriers, and to make certain that the cost of medical injuries is borne by the health care system and not by other policyholders. This approach recognizes that no solution is going to work for the long term unless it includes fundamental reforms in medical practice and in the legal rules that govern malpractice claims.

One remedy that could be initiated promptly already lies within the power of the state courts to regulate attorney contingent fees, as New Jersey has done. The Alliance has urged the courts to do so before possible legislative intervention. Further, judges also have been urged to make more active use of their power to review jury awards and to amend them if they are excessive.

As the HEW Secretary's Commission report summarizes, there have been nearly 100 major reform recommendations set forth for all concerned to consider. Among these, already cited in some state legislative proceedings, are the following:

- Shortening of the statute of limitations, or the number of years within which suit may be filed.
- Not requiring doctor to prove his innocence or to disprove that somehow he "guaranteed" perfect cure.
- Use of arbitration or screening panels to reduce need for litigation in first place.

However it ends, the public will know insurers are part of the solution, not the problem. □

Attachment 2

Physicians, patients suit effort to halt malpractice

By the Associated Press

A group of doctors and patients has filed a $100 million lawsuit in Rhode Island against four insurance companies, and the American Medical Association president says a doctors' union may have to formed to solve the malpractice insurance crisis.

The class action suit was filed Wednesday in federal court at Providence on behalf of eight doctors and seven patients. It accuses the firms of conspiring to restrain trade in the sale of malpractice policies to Rhode Island doctors.

The suit alleged the four companies violated the Sherman Antitrust Act in the introduction of a new form of malpractice insurance coverage, the "claims-made" policy.

"Claims-made" insurance protects a doctor against claims filed during the life of a policy. But the doctor may be unprotected if sued after the policy expires, even though the alleged malpractices occurred during the life of the policy.

"Occurrence policies" protect a doctor as long as the alleged malpractice occurred while the doctor carried the insurance.

The defendants are St. Paul Fire and Marine Insurance Co., Aetna, Travelers and Hartford.

The suit asked the federal court to issue injunctions against the four companies to end their refusal to insure all physicians and hospitals on an occurrence basis.

Meanwhile, Dr. Malcolm Todd, the AMA president, said in Chicago that the malpractice crisis could be solved by state legislatures within hours, but doctors may have to unionize to force them to act.

"In Atlantic City (site of the upcoming AMA convention) I am going to recommend creation of a committee ... to inform our members about collective bargaining," Todd told a group of doctors and nurses in a speech at Columbus Hospital here.

"It may be imperative that we take this militant stance," he said. "It seems to be the only way we can get the attention of our legislators."

Todd said the AMA will consider forming a doctor-owned company to underwrite malpractice insurance. He also said the organization will concentrate on limiting contingency fees paid to attorneys handling malpractice suits.

In Pennsylvania, an out-ofcourt settlement between a firm which owns 40 hospitals in 11 states and one of the nation's largest malpractice insurance companies was reached Wednesday to assure continued coverage through next year.

American Medicorp, Inc., based in Bala Cynwyd, Pa. had sought an injunction against the Argonaut Insurance Co. from canceling a malpractice insurance contract with Medicorp.

An attorney for Medicorp, William Taylor, said Argonaut agreed to honor its contract through May 1976. "They will write the same policy with the same terms for the same rate," Taylor said.

The final details are still being worked out, he said.

Work slowdowns continued Wednesday in several states, including New York where Gov. Hugh Carey set up a special panel to review the malpractice insurance situation.

Leaders of a doctors' protest over New York's new medical malpractice insurance law planned to meet with colleagues today to persuade them to end a job action in the New York City area.

After a two-hour meeting with Carey and legislative leaders on Wednesday, leaders of dissident doctor groups met and decided that continuation of a slowdown in services, begun Sunday, aould not further their cause in seeking further protection from malpractice suits, sources said.

Leaders of the state Medical Society, who had never favored the job action, emerged from the meeting saying they were optimistic that the slowdown could be defused. But they, too, said they would first have to talk with colleagues.

Attachment E

VII. Damages

Generally the liability of a physicial or surgeon for damages for injuries resulting from his negligence in treating or caring for a patient is governed by the general principles of the law of damages. In malpractice actions damages recoverable are only those which are the natural and probable consequences of the wrongful act complained of; that is, a physician or surgeon is liable only for such damages as are the proximate result of his negligence in the respect charged against him. He is not chargeable for anything on account of the original injury or ailment, or for pain, suffering or anguish which arises therefrom.

The amount of recovery is for the trier of fact to determine. In assessing the amount of recovery, a jury should have the benefit of instructions pointing out definitely just what limits are to be observed. Ordinarily, the measure of damages is the reasonable compensation for the bodily suffering of the patient, for the mental suffering accompaning and following it and for any permanent impairment of earning ability.

Generally one who has been injured by the negligence of a physician or surgeon in the course of treatment or an operation is entitled to recover compensatory damages only. The law may, however, permit an award of punitive damages in such cases where the negligence is wanton or gross, as where the physician is shown to have been actuated by bad motives or intent to injure the patient, or where the treatment was given or the operation performed with utter indifference as to the effect upon the patient.

III. Statute of Limitations

The applicable statute of limitations in medical malpractice cases is found in K. S. A. 1974 Supp. 60-513(4) which requires the injured party's cause of action to recover damages to be filed within two years after the cause of action accrues. 60-513 was enacted by the 1963 legislature (eff. Jan. 1, 1964) as a part of the code of civil procedure. The section was amended in 1968 to include actions to recover for ionizing radiation injuries.

The significant change in the 1963 enactment was the addition of a new provision specifying when a cause of action accrues. Prior law (G.S. 1949, 60-306) limited the time of commencement of such an action to 2 years after the cause of action had accrued or the time when the negligent act occurred. The Kansas court adhered to the rule that the cause of action accrued and the statute of limitations began to run on an action for malpractice at the time the tort was committed, although it was clear in a later case that the court did not approve of such rule (Hill v. Hays, 193 K 453, 1964) but declined to alter it adhering to the philosophy that limitations are created by statute and are legislative not judicial acts.

Under the new provision (referred to as the discovery rule) the period of limitation does not commence until the act giving rise to the cause of action first causes substantial injury, or in the alternative, if the fact of injury is not reasonably ascertainable until some time after the initial act, than not until the fact of injury becomes reasonably ascertainable to the injured party...but in no event shall the period be extended more than 10 years beyond the time of the act giving rise to the cause of action.

Under the old rule the injured party's knowledge of the injury was immaterial. Assuming a diligent plaintiff should become aware

of his injury within the statutory period, justifications for such a rule were that it prevented ficticious claims and safeguarded against state evidence and that it insured that an injured party would not knowingly sit on his rights. The discovery rule would appear to balance the necessity of avoiding uncertain litigation against the injustice of depriving a patient of his cause of action before he knows it exists.

Judicial exceptions from other jurisdictions attempted to alleviate the traditional rule's harshness i.e. the "physician-patient relationship" and "continuous treatment" rules. The Kansas court has never expressly adopted either rule but has intimated that evidence stemming from either relationship, when relevant, would bear upon the issue of discovery.

The court in Hecht v. First National Bank and Trust Co., 208 K 84, states that summary judgment may be proper on the affirmative defense of the statute of limitations where there is no dispute or genuine issue at the time the statute commenced to run. But where evidence is in dispute as when substantial injury first appears or when it becomes reasonably ascertainable, the issue is for determination by the trier of fact.

Under K. S. A. 1974 Supp. 60-515 a person who is a minor or other incapacitated person at the time the cause of action accrued or at any time during the period the statute of limitations is running would be entitled to bring a malpractice action within one year after such disability is removed. However no such action could be maintained after twenty-two years from the time the cause of action shall have accrued.

Legislative Research Department

SUMMARY OF MALPRACTICE LEGISLATION ADOPTED

	JUA	Ad Damnum	Statute of Limitations		Discovery Period		Arbitration		Licensing Board Review	Limits Insureds' Liability	Limits Amount of Recovery
			Adults	Minors	Adults	Minors	Voluntary	Imposed			
ARKANSAS	X						X				
CALIFORNIA	X										
FLORIDA	X	X	X	X	X	X		X	X	X	
HAWAII	X										
INDIANA		X	X	X	X			X	X	X	X
IOWA	X	X	X	X	X	X					
MARYLAND	X		X		X						
MISSOURI											
NEVADA			X	X	X			X	X		
NEW YORK	X		X	X		X			X		
WISCONSIN	X										

Attachment 2

June 23, 1975

Informed Consent	Claims Reporting	Dicipline of Practitioners	Minimum Required Insurance	Requires Expert Testimony	Requires Continuing Education	Limits Contingency Fee	Doctor-Hospital Insurance Corporation	Injury Protection	Rate Approval
	X								
X		X	X				X	X	
		X	X			X			
X						X	X		
						X			
							X		
X		X		X					
X	X	X							X
	X								

Attachment G

Legislative Research Department June 10, 1975

ARKANSAS: SUMMARY OF 1975 MEDICAL MALPRACTICE LEGISLATION

The Seventieth General Assembly of Arkansas enacted three bills concerning medical malpractice. Act 306 of 1975 requires physicians to notify the Arkansas State Medical Board of a law suit against them charging malpractice.

Act 638 of 1975 establishes a professional medical malpractice insurance commission for the selection of arbitration panels to function in malpractice claims. The use of the panel is not required nor is the decision of the body binding upon either party in the claim. All proceedings, records, finding and deliberations of a hearing panel are confidential and may not be used in any other proceeding. The use of the arbitration panel does not limit a person's right to bring suit against the doctor.

Act 698 of 1975 creates a professional liability reinsurance exchange. The act requires all insurers writing general liability insurance in the state to become members of the professional liability reinsurance association. The association expires December 31, 1978.

A SUMMARY OF THE LEGISLATION RELATING TO MEDICAL MALPRACTICE CURRENTLY BEING CONSIDERED IN THE 1975-76 REGULAR AND SECOND EXTRAORDINARY SESSIONS

ASSEMBLY OFFICE OF RESEARCH

CALIFORNIA LEGISLATURE

SACRAMENTO

JUNE 1975

11 June 1975

Dear Member:

Attached is a list of the bills relating to medical malpractice now being considered in the 1975-76 Regular and Second Extraordinary Sessions. A short analysis and status as of 6 June 1975 of each measure is included.

We hope this information will be of service to you. Please let us know if we may be of further assistance.

Sincerely,

JIM HURST
Director

Richard B. Weisberg

by Richard B. Weisberg
Associate Consultant

RBW/sg/py

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1975-76 Regular Session

1) AB 36 (Berman)

AB 36 would require insurance carriers issuing specified malpractice insurance to file annual reports with the Insurance Commissioner not later than July 1st of each calendar year, including 1975 (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 19 February 1975).

2) AB 818 (McAlister)

AB 818 would create the California Medical Malpractice Underwriting Association, an insurance pool, composed of all carriers transacting liability insurance in California. The association would, with specified exceptions, be the exclusive source of medical malpractice insurance to physicians and health care providers in the state. The maximum amount written would be $1,000,000 per claimant per year not to exceed $3,000,000 for all claimants under a policy for a given year.

The association would be governed by a board of directors composed of six insurer representatives, three physicians, and two public representatives (Status: Vetoed by the Governor on 17 May 1975).

3) AB 875 (Deddeh)

AB 875 would require a 60-day notice to the defendant of an intention to commence a civil action based upon the defendant's professional negligence. The notice would be required to state the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered (Status: Re-referred to the Assembly Committee on Judiciary on 21 May 1975).

4) AB 878 (Murphy)

AB 878 would commence the statute of limitations in malpractice actions to run within three years from the date of the alleged wrongful act, except where the physician and surgeon were guilty of fraud, intentional concealment, or where there was a foreign object in the body of the injured plaintiff (Status: Referred to the Senate Committee on Judiciary on 30 April 1975).

5) AB 926 (Keene)

AB 926 would create the California Arbitration Commission on Medical Injury Compenstion which would be empowered to arbitrate medical malpractice cases. The bill would provide a system whereby the provider can contract with patients to agree to arbitrate malpractice claims with the commission. The bill also contains changes in the tort medical malpractice liability system in the following areas: statute of limitations, abolition of the collateral source rule, limitations on non-economic losses, and restrictions on attorney fees. AB 926 also deals with the regulations affecting medical quality assurances by reorganizing the Board of Medical Examiners (Status: Re-referred to the Assembly Committee on Ways and Means 27 May 1975).

6) AB 928 (McLennan)

AB 928 would make various technical changes in SB 491 (Behr) if the Governor signs the bill. SB 491 was enacted as Chapter 93 and became effective on 23 May 1975 (Status: Re-referred to the Senate Committee on Insurance and Financial Institutions on 28 May 1975).

7) AB 1021 (Duffy)

AB 1021 would allow the court to disallow contingency fees it deems unreasonable based on usual, customary, or reasonable fee standards (Status: Referred to the Assembly Committee on Judiciary on 5 March 1975).

8) AB 1106 (McLennan)

AB 1106 would create the position of California Medical Injury Commissioner in the Department of Consumer Affairs. The commissioner would be appointed by the Director of the Department of Consumer Affairs from a pool of physicians and surgeons practicing in California. The commissioner would review all malpractice claims and if reasonable cause exists to believe a compensable injury occurred, he would assign the claim for hearing to a panel of three physicians. The panel would issue a finding regarding the merit of the claim which would be admissible as evidence in court.

The bill also provides for courts to establish trust funds for the future care of patients awarded medical judgments (Status: Re-referred to the Assembly Committee on Juciciary on 21 May 1975).

ASSEMBLY OFFICE OF RESEARCH

9) AB 1168 (Antonovich)

Currently, the statute of limitations in medical malpractice cases commences to run from four years after the date of injury or one year after the date of discovery. AB 1168 would delete the provision which authorizes the plaintiff to bring an action within one year from the date of discovery (Status: Referred to the Assembly Committee on Judiciary on 17 March 1975).

10) AB 1652 (Campbell)

AB 1652 would limit attorney's contingency fees to 10 percent of the plaintiff's award after the first $1,667 (Status: Re-referred to the Assembly Committee on Judiciary on 22 May 1975).

11) AB 1941 (Boatwright)

AB 1941 would provide that an attorney is prohibited from contracting for or collecting a contingency fee for handling a personal injury tort claim in excess of specified amounts. The bill also permits the court to set the attorney's fee upon finding that the agreed fee is either excessive or inadequate (Status: Referred to the Assembly Committee on Judiciary on 17 April 1975).

12) AB 1942 (Hart)

AB 1942 would permit a superior court to enter a judgment ordering that money damages, or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump sum payment (Status: Re-referred to the Assembly Committee on Judiciary on 19 May 1975).

13) AB 1943 (McAlister)

AB 1943 would require damages in medical malpractice cases to be paid net of any benefit payable under the Social Security Act or any state or federal income disability or workmen's compensation act (Status: Referred to the Assembly Committee on Judiciary on 17 April 1975).

14) AB 1944 (Deddeh)

AB 1944 would prohibit after 1 January 1976, the issuing or renewing of professional liability policies with so-called "claims-made" clauses unless they contain specified provisions granting the right of renewal, and the physician continues to meet underwriting standards (Status: Passed by the Assembly Committee on Ways and Means on 3 June 1975).

15) AB 1945 (Hart)

AB 1945 would establish hearing panels in each county for all medical malpractice claims. Each panel would consist of a doctor, a lawyer, and a judge. The panel would issue a recommendation on each case which would be admissible in court unless there was an objection from either party (Status: Held without recommendation in the Assembly Committee on Judiciary on 15 May 1975).

16) AB 1946 (Duffy)

AB 1946 would require liability carriers to report awards of over $3,000 to the Board of Medical Examiners; hospitals to report removal of medical staff privileges to the board; and would provide a channel for public complaints against physicians (Status: Held without recommendation in the Assembly Committee on Judiciary on 15 May 1975).

17) AB 1947 (McVittie)

AB 1947 would allow doctors and patients to enter into voluntary but binding agreements to resolve disputes about medical care by arbitration (Status: Referred to the Assembly Committee on Judiciary on 17 April 1975).

18) AB 2255 (Dixon)

AB 2255 would:

a. Under specified circumstances limit the liability of physicians to specified amounts.

b. Exempt physicians from liability for breach of contract for results to be obtained from any procedure undertaken in the course of health care.

c. Run the statute of limitations for medical malpractice cases for two years from the date of the alleged injury.

d. Establish a Patients' Compensation Fund to which all health care providers would have to contribute in an amount determined by the Insurance Commissioner. Medical malpractice settlements of over $100,000 would be paid out of the fund.

e. Limit attorney's contingency fees for medical malpractice cases to 15 percent of the patient's recovery.

f. Establish the Residual Malpractice Insurance Authority in the Department of Insurance which would be empowered to issue policies to providers otherwise unable to obtain insurance at the option of the department.

g. Require medical review panels composed of one attorney and three physicians to review every claim and issue a recommendation admissible in court.

h. Establish the Medical Malpractice Study Commission to report and recommend further changes in the medical tort liability system to the Governor and the Legislature. (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 1 May 1975).

19) AB 2273 (Maddy)

AB 2273 would prohibit carriers writing medical malpractice insurance policies in effect on 1 January 1975 from either raising the rate of the policies to an amount higher than that charged on 1 January 1975 or cancelling the policy without first petitioning the Department of Insurance to make such a change. The bill would also empower the Department of Insurance to regulate medical malpractice insurance rates (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 5 May 1975).

20) AB 2287 (Maddy)

AB 2287 would require compulsory arbitration in medical malpractice cases. If the plaintiff disagrees with the result of arbitration, the bill would provide that the person may institute a civil action for damages on account of medical malpractice (Status: Referred to the Assembly Committee on Judiciary on 7 May 1975).

21) AB 2300 (Goggin)

AB 2300 would create an Office of Health Services Quality Assurance which would evaluate all health care providers. The office would then advise the appropriate licensing board of any restrictions to be placed on the practice of a particular provider. The bill would provide that before a provider could obtain malpractice insurance, he would have to be certified by the office as competent in the areas of practice for which the insurance is issued (Status: Re-referred to the Assembly Committee on Health on 19 May 1975).

22) AB 2316 (Campbell)

AB 2316 would prohibit carriers from canceling medical malpractice insurance issued to health care facilities after the effective date of the bill on the sole ground that one or more persons on the staff of the facility does not have malpractice coverage (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 13 May 1975).

23) AB 2317 (Campbell)

AB 2317 would limit to $500,000 the amount of damages that could be awarded in medical malpractice actions except for injury or death proximately caused by willful or wanton misconduct (Status: Referred to the Assembly Committee on Judiciary on 13 May 1975).

24) AB 2369 (Robinson)

AB 2369 would:

a. Require health care providers to report to the Board of Medical Examiners every occurrence of medical malpractice that the provider sees.

b. Require graduates of state supported medical schools to agree to practice for one year in an area of the state deficient in physicians' services.

c. Reduce the amount of damages the defendant must pay in a medical malpractice action by the amount of the collateral sources available to the plaintiff.

d. Run the statute of limitations in medical malpractice actions from three years of the injury or three years from the plaintiff's last professional visit to the provider, whichever is longer (Status: Referred to the Assembly Committee on Judiciary on 30 May 1975).

25) SB 397 (Carpenter)

SB 397 would create a Patients' Compensation Board to determine payment in event of medical injury within stated limits. The bill would bind all health care providers and the carriers to accept the decision of the board, although the claimant could reject the settlement under specified circumstances. The board would be required to notify the licensing agency of a provider if the board determines that an injury was caused by the provider's willful and wanton misconduct. The bill would also

authorize the Insurance Commissioner to form a joint underwriting pool to assure providers medical malpractice coverage (Status: Passed by the Senate Committee on Finance on 2 June 1975).

26) SB 398 (Carpenter)

SB 398 would create a joint underwriting pool under the jurisdiction of the State Insurance Commissioner to insure access to occurrence-based insurance for physicians unable to secure liability coverage (Status: Vetoed by the Governor on 23 May 1975).

27) SB 407 (Russell)

SB 407 would provide for attorney contingency fees in medical malpractice cases to be paid according to a sliding scale (Status: Failed passage in the Senate Committee on Judiciary on 3 June 1975).

28) SB 491 (Behr - Ch. 93, 1975 Statutes)

SB 491 would provide for a joint underwriting association composed of all carriers writing liability insurance in California. The association would offer insurance to providers in counties where coverage is not available or the rates are excessively high (Status: Effective 23 May 1975).

29) SB 521 (Robbins)

SB 521 would create a board within the Deparment of Insurance that would be the sole recourse for patients seeking compensation for medical injuries, and awards would be limited to loss of wages, medical expenses, and loss of bodily function. The bill would also require providers to carry professional liability insurance or deposit a self-insurance surety (Status: Re-referred to the Senate Committee on Insurance and Financial Institutions on 21 April 1975).

30) SB 661 (Song)

SB 661 would commence the statute of limitations running in medical malpractice cases for three years from the date of the injury or one year after the date of discovery, whichever comes first. The time limitation would be tolled for no longer than five years from the date of the injury for failure by the provider to disclose any act upon which the malpractice action is based and which is known or should have been known by the provider. The bill would also toll the time limitation during any period in which the plaintiff is under eight years of age. "To toll the statute of limitations means to show facts which remove its bar

of the action," Black's Law Dictionary, Fourth Edition, 1968 (Status: Re-referred to the Senate Committee on Judiciary on 29 May 1975).

31) SB 674 (Marks)

SB 674 would prohibit carriers which had medical malpractice insurance policies in effect on 1 January 1975 from canceling or refusing to renew the policies until 1 January 1976. The bill would also empower the Department of Insurance to regulate medical malpractice rates (Status: Failed passage in the Senate Committee on Insurance and Financial Institutions on 16 April 1975).

32) SB 697 (Grunsky)

SB 697 would provide that the damages which the defendant in a medical malpractice case is obligated to pay would be reduced by the amount of specified types of direct benefits payable to the plaintiff from collateral sources after first deducting certain costs of such benefits incurred by the plaintiff (Status: Passed by the Senate Committee on Finance on 3 June 1975).

33) SB 864 (Behr)

SB 864 would:

a. Create a joint underwriting association to issue policies on a claims made basis.

b. Start to run the statute of limitations in medical malpractice cases for two years from the date of injury or six years if a foreign object were left in the patient's body. The time limitation would apply only to adults.

c. Impose specified maximum attorney's fees based on a percentage of the recovery.

d. Limit maximum damages recoverable to $208,000. The recovery could be reduced by benefits received by the plaintiff from collateral sources.

e. Require the claimant in a medical malpractice action where the total judgment exceeds $25,000 to submit to annual medical examinations to determine if the continuation of the award is merited.

f. Provide that any guaranty by a provider to cure a patient would be void unless in writing and signed by the provider (Status: Reconsideration granted in the Senate Committee on Finance on 2 June 1975).

34) SB 889 (Carpenter)

SB 889 would:

a. Presume written statements of informed consent to be valid in the absence of clear proof of fraud or misrepresentation.

b. Admit evidence of collateral sources in court to mitigate the plaintiff's damages.

c. Begin to run the statute of limitations in medical malpractice cases from one year of the date of discovery or one year from the date of the alleged negligent act, but with certain exceptions, in no event longer than four years after the date of the act.

d. Require persons bringing medical malpractice actions to provide the defendant with 60 days notice prior to the commencement of the action.

e. Form an insurance pool to insure the availability of medical malpractice coverage (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 30 April 1975).

35) SB 1180 (Marks)

SB 1180 would establish an Insurance Rate Commission in the Department of Insurance vested with the authority to regulate the rates of all insurance sold in California with the exception of workmen's compensation carriers (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 8 May 1975).

1975-76 Second Extraordinary Session

1) AB 1 (Keene)

AB 1 is essentially the same bill as AB 926 (Keene) introduced in the 1975-76 Regular Session (Status: Re-referred to the Assembly Committee on Judiciary on 3 June 1975). Passed by the Assembly Committee on Ways and Means on 17 June 1975.

2) AB 2 (Keene)

AB 2 would repeal existing statutory provisions on comprehensive state health planning and add new provisions with the intent of better planning for the health care needs of the areas in the state. This would include vesting the authority for health facility modification in a State Planning Development Agency (Status: Re-referred to the Assembly Committee on Health on 27 May 1975).

3) AB 3 (Bane)

AB 3 would create a State Medical Malpractice Insurance Fund in the Department of Health which would be used to transact medical malpractice insurance to health care providers (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 20 May 1975).

4) AB 4 (Goggin)

AB 4 is essentially the same bill as AB 2300 (Goggin) introduced in the 1975-76 Regular Session (Status: Referred to the Assembly Committee on Health on 19 May 1975).

5) AB 5 (Duffy)

AB 5 would:

a. Require that specified healing arts boards record the convictions and judgments rendered against their licensees and the removal of their staff privileges.

b. Increase the membership of the Board of Medical Examiners to 17 members and restructure the board into three divisions with specified duties.

c. Provide for the establishment of medical quality review committees under the jurisdiction of the board whose duties would be to review the quality of medical practice, investigate complaints, and undertake disciplinary actions. These committees would also have the authority, as do other

licensing boards in the Department of Consumer Affairs, to petition the courts for an injunction to restrain a person engaging in an act which might be in violation of a provision enforced by the committee (Status: Referred to the Assembly Committee on Health on 22 May 1975).

6) AB 6 (Goggin)

AB 6 would require graduate medical students who receive state scholarship funds to devote 5 years of practice in needy areas designated by the Director of Health. The bill would also provide for $20,000 annual compensation and increased medical enrollment in the University of California until 1 January 1982 (Status: Referred to the Assembly Committee on Health on 22 May 1975).

7) AB 7 (Z'berg)

AB 7 would require court approval of any contract for attorney's fees in medical malpractice cases. In cases where no contract is approved and a judgment recovered, attorney's fees would be fixed by the court rendering the judgment (Status: Referred to the Assembly Committee on Judiciary on 23 May 1975).

8) AB 8 (Carpenter)

AB 8 would create a State Medical Malpractice Insurance Fund in the Department of Insurance which would be used to transact medical malpractice insurance to health care providers (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 23 May 1975).

9) AB 9 (McLennan)

AB 9 would:

a. Require damages in medical malpractice cases to be paid net of any benefit payable under the Social Security Act or any state of federal income disability or Workmen's Compensation act.

b. Require that money damages claimed for future expenses be deposited in court and disbursed as needed. The remaining funds would be returned to the defendant upon the termination of the future needs of the plaintiff.

c. Subject the entire amount of any judgment obtained to the full claim of the Director of the Department of Benefit

Payments for reimbursement of the value of the benefits provided under Medi-Cal and any lien filed pursuant to Welfare and Institutions Code, Section 14117 re: the state or a county recovering from a tortfeasor for the cost of medical care furnished to a welfare recipient.

d. Create the position of California Medical Injury Commissioner in the Department of Consumer Affairs. The commissioner would be appointed by the Director of the Department of Consumer Affairs from a pool of physicians and surgeons practicing in California. The commissioner would review all malpractice claims and if reasonable cause exists to believe a compensable injury occurred, he would assign the claim for hearing to a panel of three physicians. The panel would issue a finding regarding the merit of the claim which would be admissible as evidence in court (Status: Referred to the Assembly Committee on Judiciary on 23 May 1975).

10) AB 10 (Goggin)

AB 10 would provide for financial assistance to and provide state operation of bankrupt hospitals (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 23 May 1975).

11) AB 11 (Montoya)

AB 11 would:

a. Permit the State Compensation Insurance Fund to transact specified medical liability insurance.

b. Require that every medical malpractice insurance policy contain a clause which makes the carrier directly liable to potential claimants for the insured's negligence.

c. Require carriers of medical malpractice insurance to maintain on file in the Department of Insurance a bond in favor of the Insurance Commissioner as trustee for the beneficiaries of awards.

d. Authorize the Insurance Commissioner to regulate the rates of medical malpractice insurance.

e. Abolish the rights of persons to sue health care providers for alleged medical malpractice and substitute county arbitration panels.

f. Require all providers to be insured or self insured against medical malpractice claims (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 30 May 1975).

12) AB 12 (Bane)

AB 12 would permit the State Compensation Insurance Fund to transact specified medical liability insurance (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 30 May 1975).

13) AB 13 (Campbell)

AB 13 would increase the membership of the district review committees of the Board of Medical Examiners by adding both public members and physicians and surgeons (Status: Referred to the Assembly Committee on Health on 30 May 1975).

14) AB 14 (Campbell)

AB 14 would limit contingency fees in medical malpractice cases (Status: Referred to the Assembly Committee on Judiciary on 30 May 1975).

15) AB 15 (Campbell)

AB 15 would create a compulsory arbitration system for medical malpractice cases except in suits where punitive damages are sought (Status: Referred to the Assembly Committee on Judiciary on 30 May 1975).

16) AB 16 (Campbell)

AB 16 would create a Bureau of Medical Statistics in the Department of Insurance (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 30 May 1975).

17) AB 17 (Campbell)

AB 17 would limit to $500,000 the amount of damages that could be awarded in specified medical malpractice actions (Status: Referred to the Assembly Committee on Judiciary on 30 May 1975).

18) AB 18 (Campbell)

AB 18 would require a 60-day notice prior to filing a malpractice action (Status: Re-referred to the Assembly Committee on Judiciary on 5 June 1975).

19) AB 19 (Campbell)

AB 19 would commence the statute of limitations in medical malpractice actions to run from one year of the alleged injury or

or from one year of discovery, but in no event to exceed three years from the date of the alleged injury (Status: Referred to the Assembly Committee on Judiciary on 30 May 1975).

20) AB 20 (Campbell)

AB 20 would prohibit an insurer from cancelling hospital malpractice insurance on the grounds that one or more staff members are uninsured (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 30 May 1975).

21) AB 21 (Campbell)

AB 21 would reduce the plaintiff's recovery in a medical malpractice action by the amount of his collateral sources (Status: Referred to the Assembly Committee on Judiciary on 30 May 1975).

22) AB 22 (Robinson)

AB 22 would:

a. Require physicians to report observed acts of medical malpractice to the Board of Medical Examiners.

b. Revise the definition of unprofessional conduct as it applies to physicians by providing that negligence rather than gross negligence shall institute unprofessional conduct.

c. Require one year's public service by graduates of state funded medical schools.

d. Reduce the defendant's liability in medical malpractice cases by the amount of collateral benefits available to the plaintiff.

e. Commence the statute of limitations in medical malpractice actions to run from three years of the date of the alleged injury or three years from the date of the plaintiff's last professional visit to the provider, whichever is longer. The statute of limitations would be tolled when a health care provider has failed through fraud or concealment to disclose any such act, omission, or failure complained of and upon which such action is based.

f. Create a system of compulsory arbitration for all medical malpractice actions. The decision of the arbitration panel would not be binding unless all parties to the action agree to abide by the result. If there is not agreement, the aggrieved party

could institute a civil action and the decision of the arbitration panel would be admissible as evidence. Decisions of the arbitration panels against health care providers would be required to be reported to the appropriate licensing board and Professional Standards Review Organization (PSRO).

g. Authorize the Insurance Commissioner to regulate medical malpractice insurance rates and tie increases in premium rates to the Consumer Price Index (Status: Re-referred to the Assembly Committee on Judiciary on 5 June 1975).

23) AB 23 (Siegler)

AB 23 would require health care providers to report observed acts of medical malpractice (Status: Re-referred to the Assembly Committee on Judiciary on 5 June 1975).

24) AB 24 (Dixon)

AB 24 would:

a. Exempt any health care provider from liability for breach of contract for results to be obtained from any procedure undertaken in the course of health care, unless the contract is in writing and signed by the provider.

b. Limit liability in medical malpractice actions to specified amounts.

c. Impose a two year statute of limitations on medical malpractice actions with specified exceptions.

d. Create a Patients' Compensation Fund in the State Treasury to pay out medical malpractice claims made under the act.

e. Impose a 15% limitation on claimant attorney's fees in medical malpractice cases.

f. Authorize the Department of Insurance to issue medical malpractice insurance.

g. Establish medical review panels to process all medical malpractice claims and issue opinions admissible in court.

h. Create a Medical Malpractice Study Commission (Status: Referred to the Assembly Committee on Judiciary on 2 June 1975).

25) AB 25 (Hart)

AB 25 would establish hearing panels to screen medical malpractice claims voluntarily submitted for review prior to the commencement of litigation. The reports of the panels would be admissible as evidence in court (Status: Referred to the Assembly Committee on Judiciary on 2 June 1975).

26) AB 26 (Hart)

AB 26 would provide for periodic payment of future damages on personal injury actions (Status: Referred to the Assembly Committee on Judiciary on 2 June 1975).

27) AB 27 (McAlister)

AB 27 would permit personal injury awards to be reduced by the amount of collateral source payments made to the plaintiff (Status: Referred to the Assembly Committee on Judiciary on 2 June 1975).

28) AB 28 (Maddy)

AB 28 would prohibit insurers from changing medical malpractice premium insurance rates or for ceasing the sale of such insurance without the prior consent, after public hearing, of the Insurance Commissioner (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 2 June 1975).

29) AB 29 (Robinson)

AB 29 would require that the Board of Governors of the State Bar adopt rules to permit certification of attorneys as medical malpractice specialists (Status: Referred to the Assembly Committee on Judiciary on 2 June 1975).

30) AB 30 (Z'berg)

AB 30 would create a State Medical Malpractice Insurance fund to be administered by the Board of Directors of the State Compensation Insurance Fund for the purpose of transacting medical malpractice insurance (Status: Referred to the Assembly Committee on Finance, Insurance, and Commerce on 4 June 1975).

31) AB 31 (Kapiloff)

AB 31 would:

a. Abolish the healing arts boards in the Department of Consumer Affairs and replace them with a single State Healing Arts

Association as a public corporation governed by a 19 member board of governors with the authority to enforce rules of professional conduct and the powers of revocation and suspension presently held by the various boards. Fifteen members of the board would be elected by the healing arts professionals and the other four members would be the Director of the Department of Consumer Affairs, the Director of the Department of Health, the President Pro Tempore of the Senate, and the Speaker of the Assembly.

b. Require the association to designate the professional society in each healing art which represents the greatest number of members of that profession as the certified association. All persons desiring to practice in a healing arts profession would then be required to join the certified association for that particular area. Each certified association would be required to recommend rules of professional conduct for adoption by the board of governors and would be empowered to recommend disciplinary action to the board.

c. Create the State Medical Malpractice Commission consisting of 15 persons, appointed by the Governor, seven of whom would be health care providers and the remaining eight could not be health care providers. The commission would arbitrate all medical malpractice claims except for injuries resulting from gross negligence. Decisions of the commission could be appealed to the Supreme Court or the court of appeal for judicial review on questions of law not questions of fact. Claims would be paid out of a State Medical Malpractice Fund. Healing arts professionals would pay an unspecified amount per month into the fund. Also, each family in the state, including individuals not members of a family, would be taxed one dollar per month for support of the fund.

d. Establish a comprehensive statewide health benefit program, consisting of basic and major medical benefits. Enrollment in the major medical program would be compulsory, and enrollment in the basic health plan would be voluntary. A 16 member California Medical Commission would administer the plan. The commission and the Board of Governors of the State Medical Association would establish rates of payment or premiums to providers of medical care under the plan (Status: Referred to the Assembly Committee on Health on 5 June 1975).

32) AB 32 (McVittie)

AB 32 would permit health care providers to enter into contracts with patients providing that malpractice claims shall be

submitted to arbitration (Status: Referred to the Assembly Committee on Judiciary on 5 June 1975).

33) AB 33 (Boatwright)

AB 33 would provide for attorney contingency fees in medical malpractice cases to be paid according to a sliding scale (Status: Referred to the Assembly Committee on Judiciary on 5 June 1975).

34) SB 1 (Carpenter)

SB 1 would:

a. Provide that written consent to medical procedures containing specified matters be conclusively presumed to be valid and effective in the absence of clear proof that the execution of the consent was maliced by fraud or misrepresentation.

b. Permit malpractice awards to be reduced by the amount of collateral source payments made to the plaintiff.

c. Allow the court to enter judgments for periodic payment of damages.

d. Eliminate the inflation factor in the computing of damages.

e. Require expert medical testimony at trials for alleged medical malpractice.

f. Commence the statute of limitations in medical malpractice to run for one year from the date of the alleged injury or one year from the date of discovery, but, with certain exceptions, in no event longer than four years from the date of the alleged injury.

g. Require a 60-day notice prior to filing a malpractice action.

h. Create a medical malpractice insurance pool (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 22 May 1975).

35) SB 2 (Carpenter)

SB 2 would:

a. Create a Patient's Compensation Board which would be empowered to arbitrate medical malpractice cases with maximum levels of compensation.

b. Require the board to report cases of willful or wanton misconduct to the appropriate healing arts licensing board.

c. Require all health care providers to either carry medical malpractice insurance or furnish a bond.

d. Provide for attorney contingency fees in medical malpractice cases to be paid according to a sliding scale.

e. Provide for a medical malpractice pool (Status: Re-referred to the Senate Committee on Finance on 29 May 1975).

36) SB 3 (Marks)

SB 3 would prohibit carriers which had medical malpractice insurance policies in effect on 1 January 1975 from cancelling or refusing to renew such policies until 1 July 1976. Policies which were cancelled or not renewed between 1 January 1975 and the bill's effective date would be required, upon request by the insured after notice to the carrier to be reissued with identical terms and coverages. The bill would also require prior approval by the Insurance Commissioner before rates for medical malpractice insurance could be increased (Status: Re-referred to the Senate Committee on Insurance and Financial Institutions on 2 June 1975).

37) SB 4 (Marks)

SB 4 would require prior approval by the Insurance Commissioner before rates for medical malpractice insurance would be increased (Status: Re-referred to the Senate Committee on Finance on 6 June 1975).

38) SB 5 (Behr)

SB 5 would:

a. Create a Joint Underwriting Association composed of all carriers writing liability insurance in California for the purposes of creating a medical malpractice insurance pool.

b. Commence the statute of limitations to run for three years from the date of the alleged injury, unless fraud or intentional concealment is shown or a foreign body was left in the patient in which case the statute of limitations would be tolled. Minors under six years of age would have three years or until their eighth birthday in which to bring an action whichever provides a longer period.

c. Provide for attorney contingency fees in medical malpractice cases to be paid according to a sliding scale.

d. Set a maximum recovery in medical malpractice actions of $208,000 payable in periodic installments. Also, the recovery would be reduced by whatever collateral sources of benefits the patient may have.

e. Require the plaintiff in a medical malpractice action where the judgment exceeds $25,000, to submit to annual medical examination to determine if the continuation of the awards is merited.

f. Provide that any warranty by a health care provider to affect a cure would be void and unenforceable unless in writing and signed by the provider (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 4 June 1975).

39) SB 6 (Song)

SB 6 would prohibit a carrier from increasing an insured's medical malpractice insurance premiums on the sole basis that an action was commenced against the provider if the action was either dismissed or the court held for the insured (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 4 June 1975).

40) SB 7 (Rains)

SB 7 would:

a. Provide that recovery to the plaintiff in a medical malpractice action for noneconomic loss would be limited to $800 per month except under specified circumstances, and would be prohibited where recovery for lost earnings exceeds $1,500 per month.

b. Reduce damages paid to the plaintiff by benefits received from collateral sources.

c. Require upon motion of either party in a medical malpractice suit, a superior court to provide in the judgment for periodic payment of future damages.

d. Provide for attorney contingency fees in medical malpractice cases to be paid according to a sliding scale.

e. Require that specified healing arts boards keep certain records regarding convictions and judgments against their licensees. The bill would also provide for forms for public

complaints against licensees and reports from courts concerning judgments against health care providers.

d. Abolish the Board of Medical Examiners and replace it with the Board of Medical Quality Assurance. The new board would have 17 members and be divided into three areas of responsibility.

e. Abolish district review committees within the Board of Medical Examiners and replace them with medical quality review committees under the jurisdiction of the new board whose duties would be to review the quality of medical practice, investigate complaints, and undertake disciplinary actions.

f. Create a Bureau of Medical Statistics under the Board of Medical Quality Assurance, to which any state agency or health care provider would be required to submit information pertaining to health care services.

g. Commence the statute of limitations to run from three years from the date of the alleged malpractice, except upon proof of fraud or intentional concealment or where there was a foreign body left in the plaintiff's body.

h. Authorize the Insurance Commissioner to exercise greater authority over medical malpractice insurance rates (Status: Re-referred to the Senate Committee on Insurance and Financial Institutions on 6 June 1975).

41) SB 8 (Mills)

SB 8 would limit the permissible investments of medical malpractice premium reserves to specified public obligations, securities, and bonds (Status: Referred to the Senate Committee on Insurance and Financial Institutions on 5 June 1975).

42) SB 9 (Song)

SB 9 would require the Board of Medical Examiner's district review committees to conduct investigations of the professional performance of physicians and surgeons within its district. The bill also provides that a provider could communicate to a district review committee regarding the performance of any other provider. These communications would be confidential (Status: Referred to the Senate Committee on Business and Professions on 5 June 1975).

ASSEMBLY OFFICE OF RESEARCH

43) SB 10 (Song)

SB 10 would:

a. Require that four members of the 11 member Board of Medical Examiners be public members.

b. Authorize the board to develop a health care system which would minimize any medical maldistribution of health care in the state.

c. Authorize the board to require two concurring opinions by licensees before any elective surgery may be performed by another licensee.

d. Authorize the board to require providers to submit proof of the completion of specified courses in continuing education as a condition of the renewal of a provider's license to practice medicine (Status: Referred to the Senate Committee on Business and Professions on 5 June 1975).

Attachment I

Legislative Research Department June 3, 1975

Florida: Summary of 1975 Medical Malpractice Legislation

Chapter 75-9, Laws of Florida, represents 1975 legislation designed to alleviate the problem of medical malpractice insurance in Florida. H.B. 1267 as passed by the legislature and signed by the governor makes the following provisions:

1). Creates a medical liability insurance study commission. The goal of the commission is to recommend a medical liability insurance system which can be operated at reasonable cost for the purpose of providing prompt, equitable compensation to those sustaining medical injury. Deadline for the report is January 1, 1976.

2). Requires that every hospital having in excess of 300 beds, establish an internal risk management program. The program includes: the investigation and analysis of the frequency and causes of adverse incidents causing patient injury; development of measures to minimize the risk of those injuries; and the analysis of patient grievances which relate to patient care and the quality of medical services.

3). Authorizes any group or association of physicians or health care facilities to self-insure against claims of medical malpractice.

4). Requires that the chief judge of each judicial circuit prepare a list of persons to serve on medical liability mediation panels. The purpose of the panels is to hear and facilitate the disposition of all medical malpractice actions. The panel will be composed of three members -- a judicial referee, a licensed physician and an attorney. All malpractice claims must be submitted to a panel before that claim can be filed in any court. Within 30 days of completing hearings, the panel must decide the issue of liability and state its conclusions of all parties involved accept the decision of the panel, that panel may continue mediation toward a claim settlement. If any party rejects the decision, litigation based upon the claim can be undertaken. In any civil action, no member of the panel may participate, as judge, legal counsel or witness. The conclusions of the panel, however, may be admitted into evidence.

5). Stipulates that an action for medical malpractice must be commenced within two years from the time the incident occurred, or within two years from the time the incident is or should have been discovered. Under all circumstances four years is the maximum limit.

6). Denies any statement for the amount of damages sought in a complaint.

7). Promulgates the Florida Medical Consent Law. Accordingly, no recovery for malpractice will be allowed if:

a. The action of the physician, etc., in obtaining the consent of the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community;

b. a reasonable individual from the information provided by the physician, etc., under the circumstances, would have a general understanding of the procedure and medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other physicians, etc., in the same or similar community who perform similar treatments or procedures; or

c. the patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician, etc., in accordance with the provisions of paragraphs (a) and (b) of this section.

A consent which is evidenced in writing, is, if validly signed by the patient or another authorized person, conclusively presumed to be valid consent.

8). Grants to the State Board of Medical Examiners certain disciplinary powers against physicians, etc., found guilty of incompetence, negligence, or willful misconduct.

9). Gives to the medical staff of any licensed hospital authorization to use certain disciplinary powers against staff members.

10). Adopts for the state an insurance risk apportionment plan -- a Joint Underwriting Association (JUA). The association will function no more than three years.

11). Limits the liability of all hospitals and physicians, etc., to $100,000 if at the time of the incident financial responsibility had been provided in the amount of $100,000 to the satisfaction of the insurance commissioner.

There is created a patients' compensation fund, from which any claim in excess of $100,000 will be paid. Annually each licensed hospital and physician, etc., will pay a fee -- $1,000 per individual and $300 per bed for a hospital the first year. In the second year the fee charged will be $500 per individual and $300 per hospital bed, plus additional fees and assessments if necessary. The patients compensation fund is administered by the joint underwriting association.

Attachment J

Legislative Research Department June 3, 1975

Indiana: Summary of 1975 Medical Malpractice Legislation

House Enrolled Act No. 1460 amends the Indiana Code 1971, Title 16 by adding a new article concerning medical malpractice. Beyond the definitions of necessary terms and general applications, the Act makes the following provisions:

Chapter 1: provides that a patient or his representative having a claim for bodily injury or death on account of malpractice, may file a complaint in any court of law with requisite jurisdiction and demand a trial by jury. No dollar amount or figure, however, shall be included in the demand in any malpractice complaint.

Prior to the application of Chapter 1, all malpractice claims must be reviewed by a medical review panel as outlined in Chapter 9. The panel consists of one attorney and three physicians selected in a prescribed manner. From a pool comprised of all physicians engaged in active practice of medicine in the state, each party to the complaint selects one physician, who is required to serve. The two physicians thus selected name the third physician panelist. The attorney member of the panel can be agreed upon by the parties, or in the absence of agreement, the attorney member will be drawn by lot from the list of attorneys qualified to practice and on the rolls of the Supreme Court of the state. The attorney acts as legal advisor and chairman for the panel.

Upon the creation of the medical review panel, the parties to the complaint submit their evidence, in writing only, to the panel. The panel may also request information and consult with medical authorities. The sole duty of the panel is to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant(s) acted or failed to act within the appropriate standards of care as charged in the complaint.

The report of the panel is admissible as evidence in any action subsequently brought by the claimant in a court of law. The report is not conclusive, however, and either party has the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness is required to appear and testify.

Chapter 2: places monetary limitations on recovery if the health care provider has met certain requirements. Particularly, the health care provider must file with the commissioner of insurance proof of financial responsibility or a policy of

malpractice liability insurance in the amount of $100,000 or more; and pay the surcharge assessed on all health care providers to the patient's compensation fund (see chapter 4). A health care provider qualified under this chapter is not liable for an amount in excess of $100,000 for a claim of malpractice. The total amount recoverable for any injury or death of a patient is also limited and may not exceed $500,000. The amount due from a judgement or settlement which is in excess of the total liability of the health care providers will be paid from the patients' compensation fund.

In the event of an advance payment from the health care provider or his insurer to the plaintiff, such payment may not be construed as an admission of liability. Upon a judgement favorable to the plaintiff, the court will reduce the judgement to the extent of the advance payment.

Chapter 3: reduces the statute of limitations in malpractice cases. No claim against a health care provider can be brought unless filed within two years from the date of the alleged act, omission or neglect. Minors under six years will have until the eighth birthday in which to file.

Chapter 4: creates the patient's compensation fund to be collected and received by the commissioner. The fund is created by an annual surcharge levied on all health care providers in the state. The insurance commissioner determines the amount of the surcharge, but the amount cannot exceed 10% of the cost to each health care provider for maintenance of financial responsibility.

If the fund exceeds $15,000,000 at the end of any calendar year after payment of all claims and expenses, the commissioner reduces the surcharge in order to maintain the fund at an approximate level of $15,000,000.

On December 31 of each year, the auditor of the state issues a warrant in the amount of each claim submitted to him against the fund.

Chapter 5: establishes that when a plaintiff is represented by an attorney in the prosecution of his claim, the plaintiff's attorney fees from any award made from the patient's compensation fund may not exceed 15% of any recovery from the fund. Also, the patient has the right to pay for the attorney's services on a mutually satisfactory per diem basis.

Chapter 6: provides for the reporting and review of claims. All malpractice claims settled or adjudicated to final judgement against a health care provider must be reported to the commissioner of insurance. The commissioner then forwards the name of the health care provider against whom a settlement or judgement is made to the appropriate board of professional registration and examination for review of the fitness of the health care provider. The board, in appropriate cases, has the power to take disciplinary action.

Chapter 7: makes several provisions regarding the described malpractice coverage.

a) Only while malpractice liability insurance remains in force are health care providers and insurers liable to a patient, or his representative, for malpractice to the extent and in the manner specified,

b) no policy may limit or modify the liability of the insurer contrary to the act,

c) insurers assume all obligations to pay an award.

Chapter 8: creates the Residual Malpractice Insurance Authority. In general, the risk manager for the authority is responsible for making malpractice liability insurance available to risks.

Attachment X

Legislative Research Department June 3, 1

Maryland: A Summary of 1975 Medical Malpractice Legislation

In the 1975 Legislative Session, Maryland legislators passed and the Governor of the state signed three bills dealing with medical malpractice.

Senate Bill No. 816 creates the Medical Mutual Liability Insurance Society of Maryland. The purposes of the non-stock corporation is to provide insurance against liability of physicians, any person for whose acts or omissions a physician is responsible, and for injury by persons employed in, by property used in, or by activities incidental to the practice of medicine by the insured.

Every licensed physician in the state pays a one-time tax in the amount of $300. Upon payment of the fee the physician may be insured by the Society for any and all hazards insured by the Society. In addition, each policyholder member pays a stabilization reserve fund charge until such time as the net balance of the fund is not less than the projected sum of premiums to be written in the year following the valuation date.

Senate Bill No. 1055 provides a statute of limitations for actions based on malpractice by physicians. Any action for damages must be filed within five years of the time the injury was committed or within three years of the date when the injury was discovered, whichever is the shorter. In no event is the time to run against a minor until he has attained majority.

Senate Bill No. 1072 creates a professional liability pool to provide malpractice insurance (not limited to the medical professions) at standard rates for risks unable to secure coverage through the regular market. The act specifies which insurance carriers are to be members of the pool. The pool is to operate from July 1, 1975 and terminate on July 1, 1977.

Attachment 1

Legislative Research Department

June 10, 1975

NEVADA: SUMMARY OF 1975 MEDICAL MALPRACTICE LEGISLATION

Early in the 1975 Session, a select committee on medical liability insurance was appointed from both houses of the Nevada Legislature. The committee held two public hearings, taking testimony from concerned parties. The following bills are a result of the sessions.

Senate Bill No. 401 eliminates malpractice insurance as a separate form of casualty insurance and incorporates "liability resulting from negligence in rendering expert fiduciary or professional services . . ." into the general definition of liability insurance. Apparently the insurance commissioner for Nevada has statutory authority to develop regulations which provide insurance coverage to risks unable to obtain coverage. Senate Bill No. 401, however, expands that authority to develop plans which may include any kind of reinsurance that is unavailable and which would make essential coverage available where it would otherwise not be offered.

Senate Bill No. 403 requires the amount of judgment for damages in personal injury actions against providers of medical care or services, to be reduced by the amount paid prior to judgment by the defendant for medical, hospital or similar expenses occasioned by an injury.

Senate Bill No. 405 requires the introduction of expert medical testimony in any malpractice suit. Certain obvious circumstances, however, are excluded from the requirement.

Senate Bill No. 406 establishes that an action against a health care provider cannot be commenced more than four years after the injury, or two years after the plaintiff discovers or should have discovered the injury. In the case of a minor child, an action could be brought against a health care provider until the child attains 10 years of age.

Senate Bill No. 408 provides guidelines for physicians in obtaining consent from a patient for a medical or surgical procedure. That is, the physician must obtain the signature of the patient to a statement containing an explanation of the procedure, alternative methods of treatment and risks involved.

Senate Bill No. 409 creates a medical-legal screening panel for malpractice claims. No course of action may be filed until the case has been submitted to a panel and a determination made on the complaint of negligence. The screening panel does not determine damages, but reports its conclusions to the state board of medical examiners, to the county medical society of the county in which the alleged malpractice occurred, and to the state attorney general.

Senate Bill No. 432 provides for judicial proceedings in cases where the conduct or fitness of a physician directly affects the public health. The act authorizes the state board of medical examiners, county medical societies, and the attorney general of the state to take action against physicians guilty of gross or repeated malpractice or professional incompetence.

Attachment M

New York

S6449 by Senator Lombardi, et al
A8433 by Assemblyman Silverman, et al

AN ACT to amend the public health law, the insurance law, the workmen's compensation law, the civil practice law and rules, the judiciary law, the education law and the business corporation law, in relation to medical malpractice

A. Tort Changes

1. Informed Consent - The doctrine of informed consent is limited to non-emergency treatment, procedure or surgery or diagnostic procedures which involve invasion or disruption of the integrity of the body. Lack of informed consent is defined to mean the failure of the person providing the professional treatment or diagnosis to disclose alternatives to the patient as well as reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed. No action may exist unless it is established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed.

2. Reporting of Malpractice Claims - All insurers writing professional liability coverage would be required to submit detailed reports on each claim to the Superintendent of Insurance and the Commissioner of Health on a semi-annual basis.

3. Statute of Limitations - The Statute of Limitations is reduced to two and one-half years. If an action is based upon discovery of a foreign object, that action may be commenced within one year after discovery. Also, in cases where there is continuous treatment for the same illness, an action may be brought within one year after the treatment ceases. With respect to infants, the statute would be limited to 10 years after the cause of action accrues.

4. Motion for Judgment - Motion must be granted as to any cause of medical malpractice based solely on lack of informed consent if the plaintiff has failed to adduce expert medical testimony in support of the alleged qualitative insufficiency of the consent.

5. Collateral Source - Evidence is permitted to be adduced before a jury in a medical malpractice case that claims of economic loss by a plaintiff are offset by payments to the plaintiff from collateral sources such as insurance, social security, workmen's compensation or other employee benefits. Those collateral sources secured by liens are excepted.

6. Judicial Panel Recommendations - If the three members of the panel concur as to the question of liability, the panel's recommendation concerning liability may be admissible as evidence at any subsequent trial. The panel recommendation shall not be binding on the jury or court, but shall be granted such weight as the jury or court chooses to ascribe to it.

If the recommendation is read to the court or jury, the doctor or attorney member of the panel may be called as a witness only with reference to the panel's recommendation.

The panel may request an additional doctor, with expertise in the specialty involved, to assist it in the determination of the claim. This doctor may also be called at a subsequent trial as a witness by any party.

Prior to the panel's hearing, any party may file a written objection to the designation of the doctor or attorney. This objection is to be decided by the justice member of the panel.

B. Insurance Provisions

1. A medical malpractice insurance association, composed of all insurers writing personal injury liability insurance in New York State, is created. This would be a non-profit association required to provide a market for medical malpractice insurance for a period not to exceed six years. In order for the association to begin operations, the Superintendent of Insurance after consultation with the Commissioner of Health must determine that medical malpractice insurance for physicians and/or hospitals is not readily available in the voluntary market. The Superintendent of Insurance must approve or promulgate the association's plan of operation. The Superintendent of Insurance may start up or suspend the association's operations depending upon his determination of whether or not coverage is readily available in the open market. Policies up to $1,000,000 for each claimant under one policy, and $3,000,000 for all claimants under one policy in any one year may be issued. Reinsurance may be assumed.

2. The Superintendent must approve all policy forms. Rates, rating plans and rules and classifications are to be calculated to be self-supporting and based upon reasonable standards. Consideration may be given to experience of the insured, geographical areas and specialties of practice. Premiums must be fixed at lowest possible rates. Premium discounts may be granted for physicians commencing practice and those conducting a limited practice. Policies may provide for deductibles and co-insurance. Claims may be settled without the consent of the insured if the policy is issued without deductibles or co-insurance.

3. Brokers or agents may receive a service fee but not a commission.

4. Association members are to share in operations on a pro rata basis determined by the net direct premiums written by each member in New York State. The Board of Directors may require members to temporarily contribute to the association for the payment of losses and expenses pending the recoupment from the stabilization reserve fund.

5. The association would be governed by a twelve-member board of directors; eight to be elected by the members of the association and four to be appointed by the Superintendent as representatives of physicians and hospitals. Directors will serve without pay, but will be allowed reimbursement for expenses.

6. A stabilization reserve fund would be established for the payment of deficits. Until the net value of this fund exceeds $50,000,000, each physician and hospital policyholder shall pay an annual charge equal to 20% of the annual premium; thereafter charges shall be made only when the net value of this fund is less than $25,000,000 and shall continue until it again exceeds $50,000,000. When the association is terminated and discharged of its liabilities, excess funds shall be distributed to the policyholders.

7. Applicant, insured or insurer may appeal to the Superintendent on any ruling, action or decision of the association. Provision is made for judicial review of the Superintendent's orders.

C. State Fund

1. The State Insurance Fund, through the creation of a medical and hospital malpractice fund, is to be used as a "backup vehicle" in the event that the Association ceases operation due to either a judicial determination or the exhaustion of its assets and reserve fund. In the event the State Fund must become operative, it shall write malpractice coverage only until June 30, 1981.

2. The Commissioner of Health is added as a Commissioner of the State Insurance Fund. The State Insurance Fund must set aside a catastrophe surplus. Adequate reserves must be established to meet anticipated losses. Such reserves must be approved by the Superintendent.

3. The medical and hospital malpractice fund must contribute to the administrative expenses of the State Insurance Fund -- contribution not to exceed 25% of the premiums earned by such fund.

4. The Superintendent must grant prior approval to all rates, rating plans, rules, manuals and classifications; basis of exposure; limits of coverage; and policy forms. Premiums must be set at the lowest possible rate based upon estimated exposures of insured with an adjustment to be made according to actual exposures at the end of the period of coverage.

5. Every insured must keep accurate records of exposures and must furnish, on demand, a sworn statement of same.

6. The Fund would be the exclusive carrier for doctors and hospitals. Self-insurance would be prohibited, except for excess coverage not available from the fund.

7. Each policyholder would be required to make a onetime special contribution not to exceed 3% of the first year's premium to be held as paid-in surplus.

8. There would be co-insurance of 25% or a maximum of $3,000 for each doctor and a maximum of $6,000 for each hospital on any one claim.

D. Professional Misconduct Proceedings

A State Board for Professional Medical Conduct, consisting of not less than eighteen physicians, two of whom shall be doctors of osteopathy, and not less than seven lay members, is created in the Department of Health. Physicians are to be appointed by the Commissioner on recommendations made by organized medical groups and lay members by the Commissioner with approval by the Governor. Board members' terms are to be three years. Two or more committees on professional conduct, consisting of four physicians and one lay member each, are to be appointed from among members of the Board. A committee shall investigate each complaint received regardless of the source, and also conduct self-initiated investigations of suspected misconduct.

If the committee conducting the investigation determines a hearing is warranted, the hearing shall be conducted by a different committee than the one which directed the preparation of the charges.

The evidence in support of the charges is to be presented by the Attorney General. Four committee members must vote for a determination when a conclusion is made sustaining a charge. Upon completion of the investigation and hearing, the committee's recommendations shall be transmitted to the Commissioner of Health who shall make recommendation as to the committee's findings, conclusions and recommendation. The Commissioner shall then transfer the entire record to the Board of Regents for final decision. A copy of the Commissioner's recommention shall go to the licensee.

Within sixty days after the transfer of a case, the Regents must make its final decision, which requires the affirmative vote of a majority of the members of the Board of Regents.

The decisions of the Board of Regents are reviewable in accordance with Article 78 of the CPLR.

The State Board of Medicine in the Department of Education shall, in accordance with this bill, be responsible only on matters of professional licensing and shall no longer have responsibility with regard to discipline.

TIMETABLE:

A. If the investigating committee determines that a hearing is warranted, it shall notify the Board within 5 days and charges must be prepared within 15 days.

B. Hearing must be set not later than 35 days from the date charges were served.

C. Notice of hearing must be served personally on the licensee at least 20 days prior to the hearing date. If personal service cannot be made, notice must be mailed (registered or certified) at least 15 days prior to the hearing.

D. The Hearing Committee shall, within 30 days, make findings of fact, conclusions concerning the charges, and a recommendation concerning a penalty or sanction, if any.

E. Within 30 days after receiving the matter, the Commissioner shall make his recommendation as to the Committee's findings, conclusions and recommendations.

F. Within 5 days of making his recommendation, the Commissioner shall transfer the entire record to the Board of Regents.

G. Within 60 days after receipt of the records, the Regents shall make its determination.

Attachment N

Wisconsin: Summary of 1975 Medical Malpractice Legislation

Assembly Bill 58, Medical Liability Insurance Risk-Sharing Plans

Assembly Bill 58 amends s. 619.01, Wis. Stats., to allow the Commissioner of Insurance to create mandatory risk-sharing plans to provide liability insurance for physicians and other health professionals, if such insurance is not readily available in the voluntary market.

Assembly Bill 58 also requires that the premiums charged to the persons insured under the plan shall be adequate, to the extent possible, to make the plan self-sufficient. The minimum amount of insurance provided in each policy issued under such plans must be $100,000 per incident and $300,000 per year.

Under the present law, s. 619.01, Wis. Stats., the Commissioner has authority to create mandatory risk-sharing plans for automobile, property and workmen's compensation insurance.

Since malpractice insurance for health care providers is becoming increasingly difficult to obtain in the voluntary market, certain categories of health professionals such as physicians and osteopaths may in the future be unable to obtain liability insurance. Granting the Commissioner the authority to create risk-sharing plans for health professional liability insurance, which require all liability insurers to participate, will avoid this situation. Since the purpose of creating such plans is to alleviate the problems of lack of availability of malpractice insurance, not to require insurers to assume the costs of malpractice suits and administrative expenses, the premiums charged to the policyholder are to be adequate, to the extent possible, to ensure that the plan is self-supporting.

Assembly Bill 59, Reports to the Insurance Commissioner

Assembly Bill 59 creates s. 625.35, Wis. Stats., to require all insurers doing business in this state in liability insurance for health professionals to file an annual report with the Commissioner of Insurance. This report must be filed for each year by March 1 of the next year. The information required for each year includes, for each rating class:

1. The number of insureds;

2. The total premiums paid;

3. The total number of claims made, the years in which the incidents giving rise to the claims occurred, and the total number of those claims outstanding at the end of the year;

4. The total amount of claims paid, the years in which the incidents giving rise to the claims occurred and the amount of the costs which can be identified with these claims for investigation, processing and defense of these claims; and

5. The number of lawsuits filed.

Under present s. 625.34, Wis. Stats., the Commissioner of Insurance is required to develop rules relating to reports by insurers of loss and expense experience. However, the information required under present rules of the Commissioner of Insurance do not include the detailed information specified in A.B. 59. The purpose of this proposal is to enable an accurate assessment to be made of the malpractice claims situation in Wisconsin.

Attachment O

PROPOSED FEDERAL LEGISLATION REGARDING MEDICAL MALPRACTICE

Legislative Research Department
June 24, 1975

HR 1600, MEDICAL MALPRACTICE CLAIMS SETTLEMENT ASSISTANCE ACT - Congressman Hastings, et. al.

The basis of the Hastings bill, which reflects primarily the input of the American Group Practice Association, is to provide reinsurance for all claims over $200,000 if the individual state and the providers therein wish to meet the requirements of the Act to become eligible.

Secretary of HEW: HR 1600 would authorize the Secretary of HEW to take such actions as are necessary to make reinsurance available to medical malpractice insurers within a qualified state for the part of medical malpractice claims which exceed $200,000. The Secretary would be required to establish methods by which claims would be adjusted and paid and would be authorized to call on insurers and others to carry out the act. The Secretary would also be required to carry out certain studies related to medical malpractice.

State Programs: Under HR 1600 the states would have to meet certain conditions to qualify for the federal assistance in the form of reinsurance. The requirements which the state would have to meet are summarized below:

1. The state would have to establish arbitration programs. Although all medical malpractice claims would be required to be arbitrated before judicial proceedings were undertaken, the arbitration would be non-binding. However, the decision of the arbitration panel would be admissable in evidence in a judicial proceeding.

2. The state would have to establish a schedule of maximum contingent fee rates for attorneys in connection with claims for damages on account of alleged medical malpractice. The fee schedule could be established by court rule or by statute.

3. The state would be required to limit the statute of limitations to two years from the time the alleged medical malpractice occurred for an adult. For minors less than six years of age, an action could be brought until the minor reached the age of eight.

4. The state would be required to establish statewide patient grievance mechanisms applicable to health care entities and individual practitioners. Consumers could register their concerns relating to their medical care through such mechanisms. The statistical data on such incidents would have to be reported quarterly to HEW.

5. The state would be required to provide by statute that an award for damages in a civil action for medical malpractice may include actual economic losses suffered by the plaintiff, including the cost of reasonable and necessary medical care, loss of services, and loss of earned income but only to the extent that such costs are not paid or replaced by insurance or other sources.

6. The state would be required to establish rules which would require that arbitration panels would, where appropriate, award periodic rather than lump-sum payments on behalf of injured patients.

7. All health care institutions that receive medical assistance payments from the state would be required to establish risk control programs to directly intercede in actual or potential malpractice situations and to undertake education for staff and patients. Statistical data on medical injury incidents would have to be reported to HEW quarterly.

S 215, NATIONAL MEDICAL INJURY COMPENSATION INSURANCE - Senators Inouye and Kennedy

In general the Inouye-Kennedy bill would establish a federal system of compensation for injuries received as the result of medical treatment. Under the terms of the bill, any person who received an injury would automatically be compensated by the government without first having to prove that his doctor had been negligent or bringing a malpractice suit or a so-called "no-fault" system of compensation similar to workmen's compensation.

Secretary of HEW: Under the provisions of S 215, the Secretary of HEW would enter into contracts with health care providers, both professionals and institutions, who choose to participate in the program. The providers who chose to participate would pay an annual premium to the Medical Injury Compensation Fund and would in turn receive no-fault coverage for their patients and medical malpractice insurance for themselves.

Providers: As a condition of participation, providers would be required: (1) to comply with standards of licensure and relicensure established by the Secretary; (2) to agree to accept review of their services by PSRO's (Professional Standards Review Organizations); (3) to accept the level of reimbursement assigned by the federal government as full payment in medicare cases; (4) to obtain concurring opinions from specialists prior to the performance of surgical procedures.

Patients: For the duration of a provider's participation in the program, any of his patients who sustain an injury as a result of the provider's health service would be entitled to file a claim (within a prescribed time limit) with the Medical Injury Compensation Insurance Administration which would be set up in HEW.

1. If the injury were found to result from treatment, he would be compensated, within certain limits, for medical expenses, injury-related income loss, and pain or inconvenience.

2. Any benefits received from health insurance, workmen's compensation or other sources would be deducted from benefits due.

3. Determinations would be made by the Secretary who would be authorized to subpoena witnesses or records.

4. The patient could appeal the Secretary's determination to an administrative hearing.

The patient could choose to file a malpractice action as an alternative to filing a claim under the Act but once he starts one or the other procedure, he would be barred from the alternate course.

S 482, MEDICAL MALPRACTICE INSURANCE AND ARBITRATION ACT OF 1975 - Senators Kennedy and Inouye

In general, S 482 would authorize provider participation in and federal medical malpractice insurance coverage if the provider were from a state which passed legislation enabling arbitration of medical malpractice disputes which met national standards. Basically, the responsibility for implementing the Act would rest primarily with the states.

Arbitration: In those states which passed legislation consistent with the provisions of S 482, arbitration of medical malpractice disputes would be mandatory. The decision of the arbitration panel would not be binding on either party; however, the decision would be admissable as evidence in any court proceeding, subject to review by the court before admission. The claimant, if dissatisfied by the decision of the arbitration panel, could initiate a court action.

Secretary: The Secretary of HEW would be authorized to contract with providers to provide medical malpractice insurance if the provider is eligible. The Secretary would also be required to set minimum standards for provider licensure and relicensure and would be authorized to investigate the provider's performance in cases where unusual losses were accumulated. The Secretary would also set a schedule of contingent fees for plaintiff attorneys.

Providers: Under S 482 the Secretary of HEW would contract with providers of health care who choose to participate. The provider would pay an annual premium to a medical malpractice insurance fund and receive federal medical malpractice insurance coverage. In return for participation, providers would be required:

1. to comply with state licensure and relicensure requirements which meet or exceed those set by the Secretary;

2. to agree to accept review by PSRO's;

3. to accept the level of payment for Medicare cases set up by the federal government as payment in full;

4. to obtain concurring opinions from specialists prior to the performance of surgical procedures.

Findings of arbitration would be required to be reported to the state licensing agency and the appropriate PSRO.

Attachment P

Remarks By

FLETCHER BELL

COMMISSIONER OF INSURANCE

Before The

Special Committee on Medical Malpractice

Topeka, Kansas
June 25, 1975

(Relayed from Commissioner's copy delivered, June 25, 1975)

REMARKS BY FLETCHER BELL, COMMISSIONER OF INSURANCE BEFORE THE SPECIAL COMMITTEE ON MEDICAL MALPRACTICE - JUNE 25, 1975

The very existence of this committee and the fact that you have already begun your deliberations is clear evidence that liability insurance for physicians, surgeons, hospitals and other providers of health care has become an extremely serious problem. Until very recently, we have been most fortunate in Kansas that this problem has not yet reached a crisis point in our area but, quite frankly, there are some disturbing indications that this period of relative tranquility is coming to an end. We are currently faced with a potentially serious problem of considerable magnitude in Hutchinson and one of the clinics in Wichita is also cause for concern. But, even if we alleviate these problems -- and I can assure you we are trying very hard to do so -- I want to emphasize that this means only that we have been blessed with some additional time to seek solutions and make repairs -- it does not mean that we are immune from the disease.

In my opinion, the medical malpractice problem is not difficult to define because it is really -- and simply -- a problem of excessiveness. We have too many medical injuries -- we have a legal system that perhaps is too expensive -- we have too many insurance companies that do not write malpractice coverage -- we have too many physicians that have lost, or failed to establish, a personal relationship with their patients -- we have too many people that expect too much from an imperfect and unpredictable medical science -- we have too many people too willing to sue for frivolous reasons or for medical injuries that do not result from malpractice and too many attorneys who are willing to help them -- and, unfortunately, we probably have too many providers that are not competent or, at least, not competent to perform some of the procedures they undertake. Obviously, this list could go on and on but the point I want to make is that some of the responsibility for the malpractice situation rests on everyone -- everyone must share in the responsibility and everyone must be willing to contribute and perhaps even sacrifice a portion of the advantages they now have if we are to avoid some of the difficulties experienced in other localities. This is no time to be timid if we are to significantly improve the cost, availability and quality of health care in this state.

All too often, I think there is a tendency for us to think of the malpractice insurance problem as being little more than a self-serving struggle between doctors, lawyers and insurance companies. To, at least, a slight degree I suppose this might be true but the public as a whole must recognize that they have the biggest stake of all in the outcome. If nothing else the thankfully short-lived strikes by physicians in California and New York might have been helpful in this regard because they should have dramatically impressed upon our citizens just how serious the problem is capable of becoming and how they can be personally and directly effected if solutions are not found.

In all honesty, however, the fact that I can describe the problem -- as I have tried to do in a perhaps over-simplified fashion -- and the fact that I can emphasize its virtually universal effect -- as I have similarly attempted -- does not confront the real and all important issue of what can and needs to be done.

If I knew the answer to this question none of us would be here today -- or at least we wouldn't be considering medical malpractice -- because presumably we wouldn't have a problem. Since this isn't the case, however, I want to relate to you -- or bring you up-to-date -- on some of the things we in the insurance department have been trying to do and some of the things that are in process. First, we have tried to maintain a viable malpractice insurance market in Kansas because the lack of adequate coverage for health care providers is the one factor that would most quickly disrupt our entire health care delivery system. This effort has involved a number of activities including -- the use of our facilities to actually search the insurance markets and arrange for coverage to be provided physicians, hospitals and other providers on an individual case basis -- obtaining commitments from insurance companies to provide coverage for new physicians and to cancel or refuse to renew existing policyholders only when their individual loss experience clearly indicates that such action is warranted -- the approval of necessary rate increases but, I hasten to add that even with the increases the rates in Kansas are still well within the realm of reason particularly when viewed in relation to other states -- the acceptance of the "claims made" policy advocated by one of the most prominent medical malpractice insurers in Kansas -- and attempting to keep health care providers, the insurance industry -- the legislature -- and the public informed of our action. All of these activities are designed to alleviate immediate and individual difficulties but, equally important, they are an attempt to provide sufficient stability to permit an orderly and reasoned search for equitable and lasting solutions.

Thus far we have been reasonably successful although as I stated we are currently faced with some unresolved problems in Wichita and Hutchinson and in Wichita the difficulty arises from the fact that Lloyd's of London is apparently cancelling or refusing to renew all or a substantial portion of their medical malpractice policies. Since this is a non-admitted entity there is little I can do to prevent this action although I am attempting to persuade them to delay this action so we can seek replacement coverage. Equally important, I don't know how many Kansas policy holders may be involved with the Lloyd's market and I therefore don't know just how much of a problem we have.

In any event, our success to date has, in turn, enabled us to move forward in our efforts to develop -- and assist you in developing -- positive and constructive recommendations for necessary changes in our health care delivery and legal systems. We initiated our activities on this point by holding a series of meetings with the medical, legal and insurance communities -- first by meeting with them separately -- then collectively.

Basically, what we have developed at this point in time can, in my opinion, be segregated into two categories consisting of those things that might be established or improved to reduce the incidence of medical injuries and those things that might permit a more rapid and economical,but equitable, compensation for a medical injury that is sustained. For simplicity, I suppose we could describe these two general areas as being loss prevention activities and loss processing activities.

In the first category we have such things as re-licensure, re-certification and continuing education requirements for physicians and other appropriate health care providers. As the description implies research and possible changes in this area would be intended to better assure the competence of those delivering health care services is maintained at the highest possible level -- peer review is another area which seems to hold forth some prospects of reducing medical injuries in that it would permit a provider's peers to review his or her techniques, procedures and course of treatment when a medical injury occurs, and, from such a review, make suggestions which would improve the subject provider's technical competency or even make appropriate recommendations to the licensing authority --(specifically the Board of Healing Arts.) In addition, it appears that much more could be done in the precise area of loss prevention, particularly by insurance companies. In workmen's compensation insurance for example, insurance companies have developed considerable expertise in safety engineering and this expertise has been of significant to their policyholders by reducing injuries sustained by employees. While it would, of course, have to take a different form, the establishment of a similar program in the area of medical liability (and legal liability is, in my opinion, worthy of exploration. -- The possible establishment of a formalized grievance procedure is another area we want to consider. I am convinced that many people are virtually forced into the judicial process simply because they have no other objective body to turn to when they believe they have suffered a medical injury or are otherwise dissatistied with the treatment they received. A grievance procedure would fill this void -- provide the patient with the opportunity to better understand what happened, why it happened and who, if anyone, was responsible. Quite frankly, I believe the medical community needs a process like this even if the possibility exists that it will not have a significant impact on the malpractice situation -- and finally in the category of loss prevention, the medical profession must re-establish the personal relationship that used to exist between doctors and their patients. Perhaps our medical technology has advanced to the point that we cannot eliminate the assembly line approach to treatment but, even so, patients are also humans and they must be treated as such.

In the category of loss processing, we must, in my opinion, give careful consideration to arbitration as a possible means of resolving conflicts between health care providers and their patients. Some form of effective arbitration would seem to offer as primary

advantages simplicity, economy and rapidity without any sacrifice of equity. -- A claims review procedure is another possible improvement if such a procedure was and could be a deterrent to frivolous law suits or other claims whose merits would not seem to warrant extensive and expensive litigation. -- The ad damnum clause should be reviewed to ascertain whether the amount of damages contained in a petition should really need to be stated or become a public record when many times such amounts bear little relationship to the realistic expectations of actual recovery. -- While few, if any, persons will deny that the contingency fee system provides a means of acquiring legal representation by many people who could not otherwise afford it, it is equally true that no system is beyond improvement. Thus, we need to review the contingency fee system to determine if some limitations or other changes in regards to that system would benefit the public interest -- The doctrine of informed consent has also been described as a problem area as has the current discovery period and statute of limitations and these issues certainly must be evaluated to determine what changes, if any, would be helpful.

While I realize, I haven't segregated them very clearly, each of these various items I have just mentioned will be studied by separate task forces I am in the process of establishing. I suggested this approach at a June 2, 1975 public meeting on the malpractice situation and was given assurances at that time that the medical and legal professions as well as the insurance industry would cooperate in this endeavor. Since then I have obtained a number of influential and respected members of the public who have consented to give their time and efforts on these task forces. Therefore, it is anticipated that each task force will consist of at least one -- and in some cases several representatives from the legal profession, the medical profession, the insurance industry and the general public. The date of July 17 has been established as the time these task forces are to provide me their initial report and any information and recommendations they have developed in their respective areas of responsibility. To be perfectly honest, I am not overly optimistic that their studies and results will be totally complete at that time but I'm sure they will give it their best effort and this is about all we can ask.

In any event, once these task force reports are completed, we will hopfully have a better idea of the more precise actions which are needed to implement necessary changes. And, equally important, we should be able to provide this committee some concrete and hopefully unified views of what must be done the correct the malpractice problems.

I want to emphasize that these efforts are by no means intended to intrude upon the affairs and responsibilities of this committee. Rather, I would hope that these activities will assist you in your work by sparing you the time it often takes to really get at the heart of particular issues and thereby allow you to concentrate your attention on the matters of substance that hopefully will emerge from these discussions.

To further assist you, we have prepared the packet of information and material which you now have before you. In essence, this information and material is a supplement to the report on medical malpractice that we presented during the legislative session. It generally up-dates the original information and includes a summary of the action taken by other states to the extent we have been able to obtain it. Also, attached to the supplement you will find a speciman of the "claims made" policy which has been approved for one of the major medical malpractice insurance carriers as well as a speciman of the traditional "occurrence" based form -- a sample rate filing which, though technical in nature, will hopefully give you some idea of the rate making procedures used in the malpractice insurance arena -- an exhibit showing the "normal" manner in which medical care providers are classified for insurance purposes -- and a copy of the "medical professional liability insurance uniform claims report" adopted by the National Association of Insurance Commissioners which, beginning July 1, will be used to develop necessary and more refined information regarding this kind of coverage than has heretofore been available.

Mr. Chairman that concludes my presentation but -- as I'm sure you already know -- I or members of my staff stand ready to help you in any way we can as you proveeed with your difficult assignment and at this time we would be happy to attempt to answer any questions you or the members of your committee might have.

Attachment B

SUPPLEMENTARY REPORT

MEDICAL MALPRACTICE

AND

PROFESSIONAL LIABILITY

INSURANCE IN THE STATE

OF

KANSAS

FLETCHER BELL

COMMISSIONER OF INSURANCE

STATE OF KANSAS

JUNE 25, 1975

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INTRODUCTION

This report supplements the March 14, 1975 report on medical malpractice and professional liability insurance in the state of Kansas. This report is intended to provide a summarized update of the current Kansas medical malpractice scene and provides additional information which may permit the establishment of objective standards for judging the past, current and future medical malpractice insurance markets.

I. CURRENT MEDICAL MALPRACTICE INSURANCE MARKET

A. Malpractice Insurance Costs: Since the last round of insurance rate increases in December and January, there has been little activity in the area of increasing premium costs for physicians' and surgeons' professional liability insurance. Most of the activity has been isolated to two companies which have requested significant rate increases in the amount of 200 percent or more. One of these companies, the USF&G, was granted a 200 percent rate increase during the first quarter of this year. The second company, Liberty Mutual Insurance Company, which currently has outstanding approximately 14 malpractice policies in the state of Kansas, is desiring a 274 percent rate increase. This Department has not yet taken any action other than investigatory on the Liberty Mutual filing. It is anticipated, however, that the 274 percent rate increase (or a downward modification) may be approved in order to keep the company in the current Kansas market.

It is imperative to note that to date, this Department has received the assurance of Liberty Mutual that they will extend all existing policies until January 1, 1976, and permit this Department to conduct further investigation of their indicated desire to withdraw from the state of Kansas; that is, the entire matter remains under this Department's consideration.

It should also be noted that the Liberty Mutual and United States Fidelity and Guaranty Insurance Company write only approximately 5 percent of the total Kansas physicians' and surgeons' professional liability market. The remaining 95 percent of the market appears to be experiencing a temporary period of rate stability, but the situation is so volatile that this could change rather quickly.

B. Availability of Adequate Coverage for New Physicians and Surgeons Establishing a Practice in Kansas: To the best of our knowledge, all new physicians and surgeons desiring to enter the Kansas health care market have been able to obtain adequate professional liability insurance through the traditional malpractice insurance companies. It is, however, common for new physicians and surgeons to request this Department's assistance in locating adequate coverage, and without the direct assistance of this Department, the desired professional liability insurance coverages appear to be difficult to obtain in Kansas.

Currently this Department is in the process of directly assisting several physicians in finding the insurance coverages they desire; although these physicians and surgeons have not yet been placed with one specific company, unfavorable results for these individuals are not anticipated.

C. Market Availability and Stability for Existing Medical Practitioners: Physicians and surgeons currently insured in the admitted insurance market appear to be experiencing a general stability of coverage; that is, to date this Department is not aware of any major changes in this market. The only real documented problem is one currently confronting approximately 14 policyholders of Liberty Mutual Insurance Company which desires to withdraw from the Kansas Medical Malpractice Insurance Market; however, it is noted in item A above that the Department is currently negotiating with the company to prevent such withdrawal.

A significant change in the current and future non-admitted insurance market is just starting to surface inasmuch as the Lloyd's of London market is apparently moving toward a withdrawal of its medical malpractice insurance facility both in Kansas and countrywide. This Department has been advised through informal channels that the Lloyd's market will cease to be a market for any medical malpractice insurance effective July 1, 1975. The effects of this change in the non-admitted market cannot be evaluated at this date since the Lloyd's of London facility is not regulated by this Department.

D. Physicians and Surgeons Without Professional Liability Insurance Coverage: During the early months of 1975, this Department became aware of three individual medical practitioners with a history of past medical malpractice

claims and losses who were unable to locate any insurance company willing to provide coverage at any price; however, since the date of this Department's first report and with the assistance of this Department, two of these individuals were provided with an insurance quotation, although it is not certain whether those individuals accepted or rejected that proposal. The other remaining individual practitioner has not been able to locate any potential market willing to provide insurance for his professional risk. This is the only instance that this Department is aware of where an individual medical practitioner could not obtain a quotation or offer, for medical malpractice insurance.

E. The "Occurrence" and "Claims-made" Medical Malpractice Policies: After July 1, 1975, two principal bases will exist for medical malpractice policies, the traditional "occurrence" based policies and the "claims-made" based policies, the latter being the most recently approved type of policy.

For many years, the "occurrence" based policy[1] has been utilized exclusively by the insurance companies admitted and authorized to write medical malpractice insurance in Kansas. The "occurrence" based policy means coverage is afforded for any claim arising from an incident occurring or allegedly

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[1] See Exhibit I for specimen "Occurrence" based policies for physicians, surgeons, and dentists, and hospitals

occurring during the policy period, regardless of when the claim is made--subject to only the statutes of limitations. Under this occurrence-based policy, the insured is purchasing coverage for claims which may not be "made" for years to come. Even if the policy is terminated, claims that arise out of occurrences or incidents during the period the policy was in effect will be covered.

The "occurrence" based policy requires the insurance company to collect premium dollars today to pay for claims and claims expenses that may not be actually incurred for two decades under the existing statute of limitations. Although most claims are made and settled or disposed of within five years, the "occurrence" based policy has presented some insurance companies with what they believe to be a cumbersome and inaccurate rating procedure, which has resulted in their inability to properly price or rate the medical malpractice liability policy. As a possible solution to this rate making problem, one insurer, the St. Paul Fire and Marine Insurance Company, has proposed and this Department has approved the utilization of a "claims-made" insurance policy for physician's and surgeon's professional liability insurance.[2]

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[2]See Exhibit II for specimen "claims-made" policy

The St. Paul "claims-made" policy differs from the occurrence-based policy in that claims made during the policy period are covered, regardless of when the incident or alleged incident of malpractice occurred. Incidents occurring prior to the initial issuance or retroactive date are not covered by the claims-made policy, just as prior acts under the "occurrence" based policy are not covered. Utilization of the claims-made approach permits the insurance company to pay for current year claims settlement and claims expense costs out of current premium collection.

The physician (or insured) under the claims-made policy is purchasing coverage for claims made against him during the current policy period. Under the St. Paul Fire and Marine Insurance Company's claims-made policy, the doctor that retires or terminates his St. Paul coverage is guaranteed the option to buy an endorsement to take care of claims which may be made as a result of occurrences during the time the claims-made policy was purchased. After the physician (or insured) purchases the reporting endorsement for three annual periods, or as otherwise provided, the claims-made policy is, in effect, returned to an occurrence-based policy; that is, unlimited discovery and reporting privileges are afforded to the physician (or insured).

Adoption of the claims-made basis will not ultimately result in lower rates, although the initial rates are significantly

below the occurrence-based policy rates. The initial reduction in rates is due to the reduced exposure being insured and the rate will be adjusted during the first four to five years until the mature claims-made rate is calculated. It is important to note that the claims-made concept does nothing to prevent or reduce losses due to allegations of medical malpractice, but is simply an accounting solution to the company's difficulties in rating the exposure being assumed by the insurer.

II. RATE ESTABLISHMENT FOR MEDICAL MALPRACTICE INSURANCE IN THE STATE OF KANSAS

Providing an adequate and comprehensive explanation of the rate establishment procedures utilized by admitted insurance companies would be an impossible task in this presentation; therefore, included with this report is Exhibit 3, which contains a photocopy of a recent rate filing submitted by one of the major writers of Kansas physicians' and surgeons' professional liability insurance. In essence, it should be noted that the rate making calculations and procedures are the same standard approach utilized in other programs of liability insurance.

Medical malpractice insurance rates approved by this Department currently comply with the requirements of K.S.A. 40-1112 in that such rates are reasonable, adequate and not unfairly discriminatory. There can be

no assurance beyond today that this statement will remain true without adjustment to the currently filed rates because of the unsettled nature of the situation.

General information regarding Kansas medical malpractice loss and experience data utilized in the formulation of Kansas rates must be included in this discussion. First, it must be reiterated that there are only approximately fifteen insurance companies writing this type of insurance in the state of Kansas. In most instances, each company records its own premium and loss experience for medical malpractice insurance in the broader category of general liability insurance. Furthermore, with the exception of the two major writers of medical malpractice insurance, the individual company portion of the Kansas malpractice market is extremely small for the establishment of rates formulated on Kansas experience. Even the two major writers of malpractice insurance do not write enough premium volume to be utilized as a credible basis for rate formulation based only on Kansas experience. The lack of credible numbers and premium volumes can best be indicated by the fact that the largest writer of Kansas medical malpractice insurance provides coverage for about 1,000 Kansas physicians and surgeons and collected Kansas premiums of less than $1,000,000 during 1974--if the total business written by all companies were lumped into one total, there would be approximately 2,500 medical practitioners paying approximately 2 to 2.5 million dollars in premiums. Ten

insured losses of $200,000 each could produce a Kansas loss ratio of 80 percent to 100 percent, without consideration for the settlement and loss expense costs of day-to-day claims of alleged medical malpractice. One $1,000,000 judgement award could produce a 50 percent loss ratio.

In view of these potential loss problems, it is necessary to utilize the Kansas data for a basis of the rate filing and then modify such Kansas data with the countrywide experience indicators. This process is also permitted by the Kansas insurance rating laws as specified by K.S.A. 40-1112.

III. BASIC FEATURES OF MEDICAL MALPRACTICE POLICY

Medical malpractice insurance policies, more correctly titled professional liability insurance, affords coverage for the medical practitioner's legal obligation to pay damages because of injury arising out of the rendering of or failure to render professional services.[3] These policies of insurance also provide coverage for personal acts of the insured (if an individual). Also covered is liability which the insured incurs because of the error of an associate, assistant, nurse, technician, substitute, etc. Supplemental coverage is also afforded for (1) defense

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[3]See Exhibit I for specimen policy

costs, (2) bond premiums, (3) expenses for first aid to others, and (4) reasonable expenses incurred by the insured at the insurance companies request (not to exceed $25 per date). These are the common coverages afforded to medical practitioners. The coverage afforded to medical care institutions, such as hospitals, is inclusive of not only the medical malpractice coverages, but also often includes two other primary areas: General liability (such as premises and products liability) and workmen's compensation and employers liability.

Medical malpractice insurance policies are normally written with a dollar limit per occurrence and an aggregate limit of liability on all occurrences for the insured for the policy year. Basic limits of liability begin at $25,000 per occurrence and $75,000 aggregate and may be increased to limits exceeding one million dollars. Policies providing liability coverage from the first dollar up to the specified limit of liability are commonly referred to as primary coverage, and additional medical malpractice insurance policies providing higher limits are called excess insurance.

The excess insurance policy is an extension of the primary insurance policy and may provide limits of liability in amounts of one million, five million and higher. One of the most common methods to write the excess coverage is an "umbrella" policy covering several kinds of risk in one package. The excess insurance policy may be written

by the same company providing the primary policy or it may be written by a separate excess carrier.

Both primary insurance and excess insurance policies are considered to be vital components of the medical malpractice insurance market. While the primary policy can be purchased and maintained without an excess or umbrella policy, the excess or umbrella policy cannot usually exist without the primary insurance policy.

IV. OTHER FEATURES OF THE KANSAS MEDICAL MALPRACTICE MARKET

In addition to distinctions of the Kansas medical malpractice insurance market already considered--that is, the basic features of the primary and excess policies and occurrence and claims-made based policies--a distinction must also be drawn between the types of insurance companies providing these essential coverages. Most of the policies written in Kansas, both primary and excess or umbrella, are from a company which has been admitted and authorized to write insurance contracts of general and malpractice liability insurance. These companies have complied and met the requirements of Kansas insurance laws and regulations, are regulated by the Department and are commonly referred to as the "admitted" insurance companies.

Currently, there are approximately fifteen admitted insurance companies providing approximately 90 percent

of all Kansas medical malpractice insurance. Of these fifteen companies, five provide the greatest majority of the Kansas health care delivery system with malpractice insurance. These five companies are: The Medical Protective Company, The St. Paul Fire and Marine Insurance Company, Hartford Assurance and Indemnity Company, Aetna Casualty and Surety Insurance Company, and the United States Fidelity and Guaranty Insurance Company. Furthermore, two of the companies, the Medical Protective Company and the St. Paul Fire and Marine Insurance Company, provide approximately 86 percent of the coverage provided by the admitted insurance companies.

The remaining 10 percent of the Kansas medical malpractice insurance is written by carriers commonly referred to as surplus-excess lines market or the non-admitted insurance market.[4] This market provides an important role in the Kansas medical malpractice insurance system by providing those practitioners and health care facilities with unique characteristics or a history of malpractice losses with the essential professional liability insurance--usually at a higher than normal rate, or a modified contract of insurance providing a high deductable. The non-admitted market also provides a back-up insurance facility when the admitted companies are unwilling to provide additional coverage during periods of uncertainty. However, since malpractice crisis situations in states other than Kansas have occurred in previous years, the non-admitted market is also currently restricted to only a very few carriers.

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[4]As permitted by K.S.A. 40-246 (b), (c) and (d); K.A.R. 40-8-1 et.seq

Since these non-admitted carriers do not fall within the direct control of the Commissioner of Insurance, they are more or less free to modify the coverage and rates as they deem necessary. There are no standard rates and the coverage is usually provided under a claims-made policy which, unlike the St. Paul Fire and Marine Insurance Company's policy, cannot be endorsed to provide extended reporting privileges after termination. If the insured of a non-admitted insurance company which utilizes the non-admitted claims-made policy were to retire from practice or switch to an admitted insurance company, it would be necessary for the insured to continue to purchase the non-admitted insurance company's full policy until the Kansas statutes of limitation had expired.

The non-admitted market is composed of several insurance carriers, examples of which are Lloyd's of London, Guaranty National Insurance Company, and Jersey/International, Inc.

In general, the non-admitted insurance carrier does play a vital role in providing both primary and excess insurance policies for the Kansas medical practitioner and health care institution when the desired coverages are not available from the regular admitted insurance companies.

V. NEW STATISTICAL REPORTING REQUIREMENTS (Closed Claims File Review)

A. Significant action has been taken during 1975 in regard to statistical reporting requirements by insurers. The Insurance

Department, through its affiliation with the NAIC, will implement a comprehensive uniform Medical Professional Liability Insurance Claims Report Form effective July 1, 1975. A new program was adopted by the NAIC during its June, 1975 meeting, held in Seattle, Washington. A "closed claim" study on claims closed on and after July 1, 1975, will be implemented by all major insurers of medical malpractice.[5] This data which will be subject to audit during its preparation by the commissioners, will provide essential information which will be helpful for a number of purposes, including, for example,

(1) Determining the cause of injury

(2) To evaluate proper remedial legislation

(3) To provide a basis for alternative methods of dealing with medical malpractice in cases where abandonment of the existing system is being considered

(4) To provide information on claim frequency and severity

This new data is to be reported by companies to the NAIC and processed by its computer contractor. Newly created claims report forms are attached hereto for reference. The uniform NAIC form will exceed the statistical requirements of Senate Bill 353 of the 1975 legislative session in those areas. The NAIC form does not, however, include the following information which would be required for compliance with the provisions of Senate Bill 353:

(1) The insured's policy number

(2) The date of suit if filed

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[5]See Exhibit V for specimen copy of the NAIC reporting form to be utilized

(3) A separation and identification of the parties involved in the distribution of a judgment or settlement and the amount received by each party

(4) The reason for final disposition of a claim if there was no judgment or settlement

Pursuant to a motion adopted by the Executive Committee of the NAIC, any state may request detailed information supplementary to adopted NAIC Medical Malpractice Claims Form. Their motion provided that they may issue a call for the additional detail if (a) such a request would not unduly delay or burden the NAIC Claims Study and (b) the requesting state arranges to reimburse the NAIC expenses involved. (Initial expenses may require a filing fee of $5.00 for a claim report filed.)

B. Uniform Statistical Plan

Other action is also in process at the NAIC level in the area of statistical procedures. A new uniform statistical plan for rate making is planned to become effective January 1, 1976 and will be used by all insurers writing medical malpractice insurance. Final action will be taken at the December, 1975, meeting of the NAIC following the submission and recommendations by key members of the industry. The plan will provide detailed data on rating classifications, territories, exposures, premiums and losses. Companies will be required to report this information on a state-by-state basis and will be available to each state Insurance Commissioner in evaluating rate levels.

C. Annual and Quarterly State Forms

The insurance companies' annual statement forms (the prescribed document upon which an insurance company annually reports its

financial condition) was also modified by the NAIC at its June meeting in Seattle. The revised form will provide summary data on such items as premiums, losses, expenses, etc., on a country-wide basis, plus premiums and losses on a state-by-state basis. A statistical supplement for the company's quarterly statement was also adopted and the new form will provide information on exposures, premiums, losses paid, number of claims paid, losses incurred, losses unpaid and number of claims unpaid for each state and for each of four types of health care providers as follows:

(1) Physicians and Surgeons

(2) Hospitals

(3) Other Health Care Providers

(4) Other Health Care Facilities

VI. LEGISLATIVE ACTIONS TAKEN BY STATES OTHER THAN KANSAS

Attached to this supplementary report is Exhibit IV which provides an illustrative list of proposed solutions to the medical malpractice insurance problems (excerpted from the June 10, 1975, meeting of the National Association of Insurance Commissioners Professional Liability (D4) Subcommittee). This list provides a comprehensive summary of the various alternatives that have been either proposed or adopted throughout the United States.

(For policy issued by one company)

[BLANK INDEMNITY COMPANY

(A _____ insurance company, herein called the company)],

In consideration of the payment of the premium, in reliance upon the statements in the declarations made a part hereof and subject to all of the terms of this policy, agrees with the named insured as follows:

(For policy issued by two companies)

[BLANK INDEMNITY COMPANY
and
BLANK INSURANCE COMPANY

(Each a _____ insurance company, herein called the company)].

In consideration of the payment of the premium, in reliance upon the statements in the declarations made a part hereof and subject to all of the terms of this policy, severally agree with the named insured as follows, provided the Blank Indemnity Company shall be the insurer with respect to [Part]' _____ and no other and the Blank Insurance Company shall be the insurer with respect to [Part]' _____ and no other:

PHYSICIANS', SURGEONS' AND DENTISTS' PROFESSIONAL LIABILITY INSURANCE
(See Preceding Page)

(Insert or print here a Standard Coverage Part or Parts)

SUPPLEMENTARY PAYMENTS

The company will pay, in addition to the applicable limit of liability:

(a) all expenses incurred by the company, all costs taxed against the insured in any suit defended by the company and all interest on the entire amount of any judgment therein which accrues after entry of the judgment and before the company has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the company's liability thereon;

(b) premiums on appeal bonds required in any such suit, 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, and the cost of bail bonds required of the insured because of accident or traffic law violation arising out of the use of any vehicle to which this policy applies, not to exceed $250 per bail bond, but the company shall have no obligation to apply for or furnish any such bonds;

(c) expenses incurred by the insured for first aid to others at the time of an accident, for bodily injury to which this policy applies;

(d) reasonable expenses incurred by the insured at the company's request in assisting the company in the investigation or defense of any claim or suit, including actual loss of earnings not to exceed $25 per day.

DEFINITIONS

When used in this policy (including endorsements forming a part hereof):

"automobile" means a land motor vehicle, trailer or semitrailer designed for travel on public roads (including any machinery or apparatus attached thereto), but does not include mobile equipment;

"bodily injury" means bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom;

["collapse hazard" includes "structural property damage" as defined herein and property damage to any other property at any time resulting therefrom. "Structural property damage" means the collapse of or structural injury to any building or structure due to (1) grading of land, excavating, borrowing, filling, back-filling, tunnelling, pile driving, cofferdam work or caisson work or (2) moving, shoring, underpinning, raising or demolition of any building or structure or removal or rebuilding of any structural support thereof. The collapse hazard does not include property damage (1) arising out of operations performed for the named insured by independent contractors, or (2) included within the completed operations hazard or the underground property damage hazard, or (3) for which liability is assumed by the insured under an incidental contract;][5]

"completed operations hazard" includes bodily injury and property damage arising out of operations or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs after such operations have been completed or abandoned and occurs away from premises owned by or rented to the named insured. "Operations" include materials, parts or equipment furnished in connection therewith. Operations shall be deemed completed at the earliest of the following times:

(1) when all operations to be performed by or on behalf of the named insured under the contract have been completed,

(2) when all operations to be performed by or on behalf of the named insured at the site of the operations have been completed, or

(3) when the portion of the work out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

Operations which may require further service or maintenance work, or correction, repair or replacement because of any defect or deficiency, but which are otherwise complete, shall be deemed completed.

The completed operations hazard does not include bodily injury or property damage arising out of

(a) operations in connection with the transportation of property, unless the bodily injury or property damage arises out of a condition in or on a vehicle created by the loading or unloading thereof,

(b) the existence of tools, uninstalled equipment or abandoned or unused materials, or

(c) operations for which the classification stated in the policy or in the company's manual specifies "including completed operations";

"elevator" means any hoisting or lowering device to connect floors or landings, whether or not in service, and all appliances thereof including any car, platform, shaft, hoistway, stairway, runway, power equipment and machinery; but does not include an automobile servicing hoist, or a hoist without a platform outside a building if without mechanical power or if not

PSD-2
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[Part_____][1]

PHYSICIANS', SURGEONS' AND DENTISTS' PROFESSIONAL LIABILITY INSURANCE

I. COVERAGE AGREEMENTS

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of:

Coverage M—Individual Professional Liability

injury arising out of the rendering of or failure to render, during the policy period, professional services by the individual insured, or by any person for whose acts or omissions such insured is legally responsible, except as a member of a partnership, performed in the practice of the individual insured's profession described in the [declarations][3] including service by the individual insured as a member of a formal accreditation or similar professional board or committee of a hospital or professional society,

Coverage N—Partnership Liability

injury arising out of the rendering of or failure to render, during the policy period, professional services in the practice of the profession described in the [declarations][3] by any person for whose acts or omissions the partnership insured is legally responsible,

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

Exclusion

This [insurance][2] does not apply [under Part_____][1] to liability of the insured as a proprietor, superintendent or executive officer of any hospital, sanitarium, clinic with bed and board facilities, laboratory or business enterprise.

II. PERSONS INSURED

Each of the following is an insured under this [insurance][2] to the extent set forth below:

(a) under Individual Professional Liability, each individual named in the [declarations][3] as insured;

(b) under Partnership Liability, the partnership described in the [declarations][3] and any member thereof with respect to acts or omissions of others, provided that no member of a partnership shall be an insured under this paragraph (b) with respect to liability for his personal acts of a professional nature.

III. LIMITS OF LIABILITY

Coverage M—Individual Professional Liability—The limit of liability stated in the [declarations][3] as applicable to "each claim" is the limit of the company's liability for all damages because of each claim or suit covered hereby. The limit of liability stated in the [declarations][3] as "aggregate" is, subject to the above provision respecting "each claim", the total limit of the company's liability under this coverage for all damages. Such limits of liability shall apply separately to each insured.

Coverage N—Partnership Liability—Regardless of the number of insureds under this [insurance][2], the company's liability is limited as follows:

The limit of liability stated in the [declarations][3] as applicable to "each claim" is the limit of the company's liability for all damages because of each claim or suit covered hereby. The limit of liability stated in the [declarations][3] as "aggregate" is, subject to the above provision respecting "each claim", the total limit of the company's liability under this Coverage for all damages.

IV. AMENDED DEFINITION

When used in reference to this [insurance][2] "damages" means all damages, including damages for death, which are payable because of injury to which this [insurance][2] applies.

V. AMENDED CONDITIONS

A. With reference to this [insurance][2] the Conditions are amended as follows:

Condition 4 (a) Insured's Duties in the Event of Occurrence, Claim or Suit

(a) Upon the insured becoming aware of any alleged injury to which this [insurance][2] applies, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents as soon as practicable.

Condition 9 Assignment The interest hereunder of any insured is not assignable. If the insured shall die or be adjudged incompetent, this [insurance][2] shall thereupon terminate, but shall cover the insured's legal representative as the insured with respect to liability previously incurred and covered by this [insurance][2].

Pro rata return premium will be computed from the date of termination.

[**Condition 10 Three Year Policy** If this policy is issued for a period of three years:

(a) The policy period is comprised of three consecutive annual periods;

(b) The rates are subject to amendment for the second and third annual periods, in accordance with the company's rules and rating plans. Amended rates shall be stated by endorsement issued to form a part of this policy;

(c) The insured shall notify the company, as of the start of each annual period, of any change in the number of partners or employees as stated in the [declarations][3], and computation and adjustment of earned premium shall be made accordingly;

(d) The aggregate limit of liability shall apply separately to each annual period.]

B. The "Inspection and Audit" and the "Financial Responsibility Laws" Conditions do not apply to this [insurance][2].

VI. ADDITIONAL CONDITIONS

A. **First Aid Exclusion** The [insurance][2] shall not apply to expenses incurred by the insured for first aid at the time of an accident and the "Supplementary Payments" provision and the "Insured's Duties in the Event of Occurrence, Claim or Suit" Condition are amended accordingly.

[B. **Limitation of Coverage Under Any Other Liability Insurance** Except as stated in this [Part][4], the policy does not apply to injury arising out of the rendering of or failure to render professional services described in paragraph I above.][5]

Exhibit I, Part 1 of 4 parts

attached to building walls, or a hod or material hoist used in alteration, construction or demolition operations, or an inclined conveyor used exclusively for carrying property or a dumbwaiter used exclusively for carrying property and having a compartment height not exceeding four feet;

["explosion hazard" includes property damage arising out of blasting or explosion. The explosion hazard does not include property damage (1) arising out of the explosion of air or steam vessels, piping under pressure, prime movers, machinery or power transmitting equipment, or (2) arising out of operations performed for the named insured by independent contractors, or (3) included within the completed operations hazard or the underground property damage hazard, or (4) for which liability is assumed by the insured under an incidental contract;][8]

"incidental contract" means any written (1) lease of premises, (2) easement agreement, except in connection with construction or demolition operations on or adjacent to a railroad, (3) undertaking to indemnify a municipality required by municipal ordinance, except in connection with work for the municipality, (4) sidetrack agreement, or (5) elevator maintenance agreement;

"insured" means any person or organization qualifying as an insured in the "Persons Insured" provision of the applicable insurance coverage. The insurance afforded applies separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the company's liability;

"mobile equipment" means a land vehicle (including any machinery or apparatus attached thereto), whether or not self-propelled, (1) not subject to motor vehicle registration, or (2) maintained for use exclusively on premises owned by or rented to the named insured, including the ways immediately adjoining, or (3) designed for use principally off public roads, or (4) designed or maintained for the sole purpose of affording mobility to equipment of the following types forming an integral part of or permanently attached to such vehicle: power cranes, shovels, loaders, diggers and drills; concrete mixers (other than the mix-in-transit type); graders, scrapers, rollers and other road construction or repair equipment; air-compressors, pumps and generators, including spraying, welding and building cleaning equipment; and geophysical exploration and well servicing equipment;

"named insured" means the person or organization named in Item 1. of the declarations of this policy;

"named insured's products" means goods or products manufactured, sold, handled or distributed by the named insured or by others trading under his name, including any container thereof (other than a vehicle), but "named insured's products" shall not include a vending machine or any property other than such container, rented to or located for use of others but not sold;

"occurrence" means an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured;

"policy territory" means:

(1) the United States of America, its territories or possessions, or Canada, or

(2) international waters or air space, provided the bodily injury or property damage does not occur in the course of travel or transportation to or from any other country, state or nation, or

(3) anywhere in the world with respect to damages because of bodily injury or property damage arising out of a product which was sold for use or consumption within the territory described in paragraph (1) above, provided the original suit for such damages is brought within such territory;

"products hazard" includes bodily injury and property damage arising out of the named insured's products or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs away from premises owned by or rented to the named insured and after physical possession of such products has been relinquished to others;

"property damage" means (1) physical injury to or destruction of tangible property which occurs during the policy period, including the loss of use thereof at any time resulting therefrom, or (2) loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period;

["underground property damage hazard" includes underground property damage as defined herein and property damage to any other property at any time resulting therefrom. "Underground property damage" means property damage to wires, conduits, pipes, mains, sewers, tanks, tunnels, any similar property, and any apparatus in connection therewith, beneath the surface of the ground or water, caused by and occurring during the use of mechanical equipment for the purpose of grading land, paving, excavating, drilling, borrowing, filling, back-filling or pile driving. The underground property damage hazard does not include property damage (1) arising out of operations performed for the named insured by independent contractors, or (2) included within the completed operations hazard, or (3) for which liability is assumed by the insured under an incidental contract.][8]

CONDITIONS

1. Premium. All premiums for this policy shall be computed in accordance with the company's rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein.

Premium designated in this policy as "advance premium" is a deposit premium only which shall be credited to the amount of the earned premium due at the end of the policy period. At the close of each period (or part thereof terminating with the end of the policy period) designated in the declarations as the audit period the earned premium shall be computed for such period and, upon notice thereof to the named insured, shall become due and payable. If the total earned premium for the policy period is less than the premium previously paid, the company shall return to the named insured the unearned portion paid by the named insured.

The named insured shall maintain records of such information as is necessary for premium computation, and shall send copies of such records to the company at the end of the policy period and at such times during the policy period as the company may direct.

2. Inspection and Audit. The company shall be permitted but not obligated to inspect the named insured's property and operations at any time. Neither the company'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 property or operations are safe or healthful, or are in compliance with any law, rule or regulation.

The company 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.

3. Financial Responsibility Laws. When this policy is certified as proof of financial responsibility for the future under the provisions of any motor vehicle financial responsibility law, such insurance as is afforded by this policy for bodily injury liability or for property damage liability shall comply with the provisions of such law to the extent of the coverage and limits of liability required by such law. The insured agrees to reimburse the company for any payment made by the company which it would not have been obligated to make under the terms of this policy except for the agreement contained in this paragraph.

4. Insured's Duties in the Event of Occurrence, Claim or Suit.

(a) In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents as soon as practicable.

(b) If claim is made or suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons or other process received by him or his representative.

(c) The insured shall cooperate with the company and, upon the company's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of injury or damage with respect to which insurance is afforded under this policy, and the insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The 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.

5. Action Against Company. No action shall lie against the company 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 insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the company.

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 the company as a party to any action against the insured to determine the insured's liability, nor shall the company be impleaded by the insured or his legal representative. Bankruptcy or insolvency of the insured or of the insured's estate shall not relieve the company of any of its obligations hereunder.

6. Other Insurance. 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 insured has other insurance which is stated to be applicable to the loss on an excess or contingent basis, the amount of the company's liability under this policy shall not be reduced by the existence of such other insurance.

When both this insurance and other insurance apply to the loss on the same basis, whether primary, excess or contingent, the company shall not be liable under this policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(a) Contribution by Equal Shares. If all of such other valid and collectible insurance provides for contribution by equal shares, the company 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, with respect to any amount of loss not so paid the remaining insurers then 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.

(b) Contribution by Limits. If any of such other insurance does not provide for contribution by equal shares, the company 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.

7. Subrogation. In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights.

8. Changes. Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or estop the company 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 [, signed by _____

_____

(here insert titles of authorized company officials or representatives); provided, however, changes may be made in the written portion of the declarations by _____

_____ (here insert titles of authorized company representatives) when initialed by such _____

_____(here insert titles of authorized company representatives) or by endorsement issued to form a part of this policy signed by such _____

_____

(here insert titles of authorized company representatives)][1].

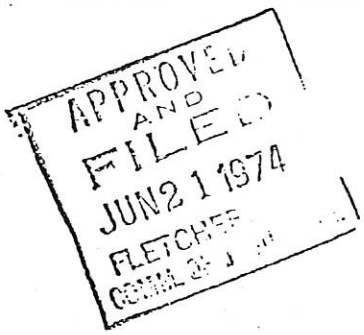
9. Assignment. Assignment of interest under this policy shall not bind the company until its consent is endorsed hereon; if, however, the named insured shall die, such insurance as is afforded by this policy shall apply (1) to the named insured's legal representative, as the named insured, but only while acting within the scope of his duties as such, and (2) with respect to the property of the named insured, to the person having proper temporary custody thereof, as insured, but only until the appointment and qualification of the legal representative.

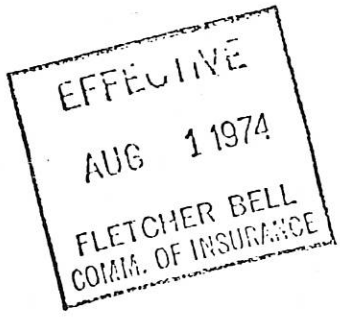
10. Three Year Policy. If this policy is issued for a period of three years any limit of the company's liability stated in this policy as "aggregate" shall apply separately to each consecutive annual period thereof.

11. Cancellation. This policy may be cancelled by the named insured [by surrender thereof to the company or any of its authorized agents or][3] by mailing to the company written notice stating when thereafter the cancellation shall be effective. This policy may be cancelled by the company by mailing to the named insured at the address shown in this policy, written notice stating when not less than ten days thereafter such cancellation shall be effective. The mailing of notice as aforesaid shall be sufficient proof of notice. The [time of surrender or the][4] effective date [and hour][5] of cancellation stated in the notice shall become the end of the policy period. Delivery of such written notice either by the named insured or by the company shall be equivalent to mailing.

If the named insured cancels, earned premium shall be computed in accordance with the customary short rate table and procedure. If the company 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 payment or tender of unearned premium is not a condition of cancellation.

12. Declarations. By acceptance of this policy, the named insured agrees that the statements in the declarations 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 the company or any of its agents relating to this insurance.





(For policy issued by one company)

In witness whereof, the Blank Indemnity Company has caused this policy to be signed by its president and a secretary at _____, and countersigned on the declarations page by a duly authorized agent of the company.

(FACSIMILE OF SIGNATURE)
Secretary

(FACSIMILE OF SIGNATURE)
President

(For policy issued by two companies)

In witness whereof, the Blank Indemnity Company has caused this policy, with respect to [Part][1] _____ and such other parts of the policy as are applicable thereto, to be signed by its president and a secretary at _____, and countersigned on the declarations page by a duly authorized agent of the company.

(FACSIMILE OF SIGNATURE)
Secretary

(FACSIMILE OF SIGNATURE)
President

In witness whereof, the Blank Insurance Company has caused this policy, with respect to [Part][1] _____ and such other parts of the policy as are applicable thereto, to be signed by its president and a secretary at _____, and countersigned on the declarations page by a duly authorized agent of the company.

(FACSIMILE OF SIGNATURE)
Secretary

(FACSIMILE OF SIGNATURE)
President

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9/1/66

[Part_____][1]

HOSPITAL PROFESSIONAL LIABILITY INSURANCE

I. COVERAGE O—HOSPITAL PROFESSIONAL LIABILITY

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury to any person arising out of the rendering of or failure to render, during the policy period, the following professional services:

(a) medical, surgical, dental or nursing treatment to such person or the person inflicting the injury including the furnishing of food or beverages in connection therewith,

(b) furnishing or dispensing of drugs or medical, dental or surgical supplies or appliances if the injury occurs after the named insured has relinquished possession thereof to others,

(c) handling of or performing post-mortem examinations on human bodies, or

(d) service by any person as a member of a formal accreditation or similar professional board or committee of the named insured, or as a person charged with the duty of executing directives of any such board or committee,

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

Exclusions

This [insurance][2] does not apply [under Part_____][1]:

(a) to bodily injury to any employee of the insured arising out of and in the course of his employment by the insured;

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

(c) to liability of an insured, if an individual, for his personal acts or omissions of a professional nature;

(d) to the ownership, maintenance, operation, use, loading or unloading of any motor vehicle, trailer, watercraft or aircraft.

II. PERSONS INSURED

Each of the following is an insured under this [insurance][2] to the extent set forth below:

(a) the named insured;

(b) if the named insured is designated in the declarations as a partnership, any partner or member thereof, but only with respect to his liability as such;

(c) if the named insured is designated in the declarations as other than an individual or partnership, any executive officer, stockholder or member of the board of trustees, directors or governors of the named insured while acting within the scope of his duties as such.

III. LIMITS OF LIABILITY

Regardless of the number of insureds under this [insurance][2] the company's liability [under Part_____][1] is limited as follows:

The limit of liability stated in the [declarations][3] as applicable to "each claim" is the limit of the company's liability for all damages because of each claim or suit covered hereby. The limit of liability stated in the [declarations][3] as "aggregate" is, subject to the above provision respecting "each claim", the total limit of the company's liability hereunder for all damages.

IV. AMENDED DEFINITION

When used in reference to this [insurance][2] "damages" means all damages, including damages for death, which are payable because of injury to which this [insurance][2] applies.

V. ADDITIONAL CONDITIONS

A. **Insured's Duties in the Event of Injury, Claim or Suit** When an injury occurs written notice shall be given by or on behalf of the insured, in accordance with the "Insured's Duties in the Event of Occurrence, Claim or Suit" Condition.

B. **First Aid Exclusion** The [insurance][2] shall not apply to expenses incurred by the insured for first aid at the time of an accident and the "Supplementary Payments" provision and the "Insured's Duties in the Event of Occurrence, Claim or Suit" Condition are amended accordingly.

[C. **Limitation of Coverage Under Any Other Liability Insurance** Except as stated in this [Part][4], the policy does not apply to injury arising out of the rendering of or failure to render the professional services described in paragraph I above.][6]

GA

(For policy issued by one company)

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(Ed. 1-73)

BLANK INDEMNITY COMPANY

(A _____ insurance company, herein called the company)

In consideration of the payment of the premium, in reliance upon the statements in the declarations made a part hereof and subject to all of the terms of this policy, agrees with the named insured as follows:

(For policy issued by two companies)

BLANK INDEMNITY COMPANY
and
BLANK INSURANCE COMPANY

(Each a _____ insurance company, herein called the company)

In consideration of the payment of the premium, in reliance upon the statements in the declarations made a part hereof and subject to all of the terms of this policy, severally agree with the named insured as follows, provided the Blank Indemnity Company shall be the insurer with respect to [Part]' _____ and no other and the Blank Insurance Company shall be the insurer with respect to [Part]' _____ and no other:

HOSPITAL PROFESSIONAL LIABILITY INSURANCE
(See Preceding Page)

(Insert or print here a Standard Coverage Part or Parts)

SUPPLEMENTARY PAYMENTS

The company will pay, in addition to the applicable limit of liability:

(a) all expenses incurred by the company, all costs taxed against the insured in any suit defended by the company and all interest on the entire amount of any judgment therein which accrues after entry of the judgment and before the company has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the company's liability thereon;

(b) premiums on appeal bonds required in any such suit, 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, and the cost of

bail bonds required of the insured because of accident or traffic law violation arising out of the use of any vehicle to which this policy applies, not to exceed $250 per bail bond, but the company shall have no obligation to apply for or furnish any such bonds;

(c) expenses incurred by the insured for first aid to others at the time of an accident, for bodily injury to which this policy applies;

(d) reasonable expenses incurred by the insured at the company's request in assisting the company in the investigation or defense of any claim or suit, including actual loss of earnings not to exceed $25 per day.

DEFINITIONS

When used in this policy (including endorsements forming a part hereof):

"automobile" means a land motor vehicle, trailer or semitrailer designed for travel on public roads (including any machinery or apparatus attached thereto), but does not include mobile equipment;

"bodily injury" means bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom;

["collapse hazard" includes "structural property damage" as defined herein and property damage to any other property at any time resulting therefrom. "Structural property damage" means the collapse of or structural injury to any building or structure due to (1) grading of land, excavating, borrowing, filling, back-filling, tunnelling, pile driving, cofferdam work or caisson work or (2) moving, shoring, underpinning, raising or demolition of any building or structure or removal or rebuilding of any structural support thereof. The collapse hazard does not include property damage (1) arising out of operations performed for the named insured by independent contractors, or (2) included within the completed operations hazard or the underground property damage hazard, or (3) for which liability is assumed by the insured under an incidental contract;]*

"completed operations hazard" includes bodily injury and property damage arising out of operations or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs after such operations have been completed or abandoned and occurs away from premises owned by or rented to the named insured. "Operations" include materials, parts or equipment furnished in connection therewith. Operations shall be deemed completed at the earliest of the following times:

(1) when all operations to be performed by or on behalf of the named insured under the contract have been completed,

(2) when all operations to be performed by or on behalf of the named insured at the site of the operations have been completed, or

(3) when the portion of the work out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

Operations which may require further service or maintenance work, or correction, repair or replacement because of any defect or deficiency, but which are otherwise complete, shall be deemed completed.

The completed operations hazard does not include bodily injury or property damage arising out of

(a) operations in connection with the transportation of property, unless the bodily injury or property damage arises out of a condition in or on a vehicle created by the loading or unloading thereof,

(b) the existence of tools, uninstalled equipment or abandoned or unused materials, or

(c) operations for which the classification stated in the policy or in the company's manual specifies "including completed operations";

"elevator" means any hoisting or lowering device to connect floors or landings, whether or not in service, and all appliances thereof including car, platform, shaft, hatchway, stairway, runway, power equipment and machinery; but does not include an automobile servicing hoist, or a hoist without a platform outside a building if without mechanical power or if not

attached to building walls, or a hod or material hoist used in alteration, construction or demolition operations, or an inclined conveyor used exclusively for carrying property or a dumbwaiter used exclusively for carrying property and having a compartment height not exceeding four feet;

["explosion hazard" includes property damage arising out of blasting or explosion. The explosion hazard does not include property damage (1) arising out of the explosion of air or steam vessels, piping under pressure, prime movers, machinery or power transmitting equipment, or (2) arising out of operations performed for the named insured by independent contractors, or (3) included within the completed operations hazard or the underground property damage hazard, or (4) for which liability is assumed by the insured under an incidental contract;][3]

"incidental contract" means any written (1) lease of premises, (2) easement agreement, except in connection with construction or demolition operations on or adjacent to a railroad, (3) undertaking to indemnify a municipality required by municipal ordinance, except in connection with work for the municipality, (4) sidetrack agreement, or (5) elevator maintenance agreement;

"insured" means any person or organization qualifying as an insured in the "Persons Insured" provision of the applicable insurance coverage. The insurance afforded applies separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the company's liability;

"mobile equipment" means a land vehicle (including any machinery or apparatus attached thereto), whether or not self-propelled, (1) not subject to motor vehicle registration, or (2) maintained for use exclusively on premises owned by or rented to the named insured, including the ways immediately adjoining, or (3) designed for use principally off public roads, or (4) designed or maintained for the sole purpose of affording mobility to equipment of the following types forming an integral part of or permanently attached to such vehicle: power cranes, shovels, loaders, diggers and drills; concrete mixers (other than the mix-in-transit type); graders, scrapers, rollers and other road construction or repair equipment; air-compressors, pumps and generators, including spraying, welding and building cleaning equipment, and geophysical exploration and well servicing equipment;

"named insured" means the person or organization named in Item 1. of the declarations of this policy;

"named insured's products" means goods or products manufactured, sold, handled or distributed by the named insured or by others trading under his name, including any container thereof (other than a vehicle), but "named insured's products" shall not include a vending machine or any property other than such container, rented to or located for use of others but not sold;

"occurrence" means an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured;

"policy territory" means:

(1) the United States of America, its territories or possessions, or Canada, or

(2) international waters or air space, provided the bodily injury or property damage does not occur in the course of travel or transportation to or from any other country, state or nation, or

(3) anywhere in the world with respect to damages because of bodily injury or property damage arising out of a product which was sold for use or consumption within the territory described in paragraph (1) above, provided the original suit for such damages is brought within such territory;

"products hazard" includes bodily injury and property damage arising out of the named insured's products or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs away from premises owned by or rented to the named insured and after physical possession of such products has been relinquished to others;

"property damage" means (1) physical injury to or destruction of tangible property which occurs during the policy period, including the loss of use thereof at any time resulting therefrom, or (2) loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period;

["underground property damage hazard" includes underground property damage as defined herein and property damage to any other property at any time resulting therefrom. "Underground property damage" means property damage to wires, conduits, pipes, mains, sewers, tanks, tunnels, any similar property, and any apparatus in connection therewith, beneath the surface of the ground or water, caused by and occurring during the use of mechanical equipment for the purpose of grading land, paving, excavating, drilling, borrowing, filling, back-filling or pile driving. The underground property damage hazard does not include property damage (1) arising out of operations performed for the named insured by independent contractors, or (2) included within the completed operations hazard, or (3) for which liability is assumed by the insured under an incidental contract.][3]

CONDITIONS

1. Premium. All premiums for this policy shall be computed in accordance with the company's rules, rates, rating plans, premiums and minimum premiums applicable to the insurance afforded herein.

Premium designated in this policy as "advance premium" is a deposit premium only which shall be credited to the amount of the earned premium due at the end of the policy period. At the close of each period (or part thereof terminating with the end of the policy period) designated in the declarations as the audit period the earned premium shall be computed for such period and, upon notice thereof to the named insured, shall become due and payable. If the total earned premium for the policy period is less than the premium previously paid, the company shall return to the named insured the unearned portion paid by the named insured.

The named insured shall maintain records of such information as is necessary for premium computation, and shall send copies of such records to the company at the end of the policy period and at such times during the policy period as the company may direct.

2. Inspection and Audit. The company shall be permitted but not obligated to inspect the named insured's property and operations at any time. Neither the company'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 property or operations are safe or healthful, or are in compliance with any law, rule or regulation.

The company 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.

3. Financial Responsibility Laws. When this policy is certified as proof of financial responsibility for the future under the provisions of any motor vehicle financial responsibility law, such insurance as is afforded by this policy for bodily injury liability or for property damage liability shall comply with the provisions of such law to the extent of the coverage and limits of liability required by such law. The insured agrees to reimburse the company for any payment made by the company which it would not have been obligated to make under the terms of this policy except for the agreement contained in this paragraph.

4. Insured's Duties in the Event of Occurrence, Claim or Suit.

(a) In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents as soon as practicable.

(b) If claim is made or suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons or other process received by him or his representative.

(c) The insured shall cooperate with the company and, upon the company's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the insured because of injury or damage with respect to which insurance is afforded under this policy; and the insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The 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.

5. Action Against Company. No action shall lie against the company 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 insured's obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written agreement of the insured, the claimant and the company.

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 the company as a party to any action against the insured to determine the insured's liability, nor shall the company be impleaded by the insured or his legal representative. Bankruptcy or insolvency of the insured or of the insured's estate shall not relieve the company of any of its obligations hereunder.

6. Other Insurance. 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 insured has other insurance which is stated to be applicable to the loss on an excess or contingent basis, the amount of the company's liability under this policy shall not be reduced by the existence of such other insurance.

When both this insurance and other insurance apply to the loss on the same basis, whether primary, excess or contingent, the company shall not be liable under this policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(a) Contribution by Equal Shares. If all of such other valid and collectible insurance provides for contribution by equal shares, the company 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, with respect to any amount of loss not so paid the remaining insurers then 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.

(b) Contribution by Limits. If any of such other insurance does not provide for contribution by equal shares, the company 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.

7. Subrogation. In the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefor against any person or organization and the insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The insured shall do nothing after loss to prejudice such rights.

8. Changes. Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this policy or estop the company 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 [, signed by _____ (here insert titles of authorized company officials or representatives); provided, however, changes may be made in the written portion of the declarations by _____ (here insert titles of authorized company representatives) when initialed by such _____ (here insert titles of authorized company representatives) or by endorsement issued to form a part of this policy signed by such _____ (here insert titles of authorized company representatives)][1].

9. Assignment. Assignment of interest under this policy shall not bind the company 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 (2) with respect to the property of the named insured, to the person having proper temporary custody thereof, as insured, but only until the appointment and qualification of the legal representative.

10. Three Year Policy. If this policy is issued for a period of three years any limit of the company's liability stated in this policy as "aggregate" shall apply separately to each consecutive annual period thereof.

11. Cancellation. This policy may be cancelled by the named insured [by surrender thereof to the company or any of its authorized agents or][2] by mailing to the company written notice stating when thereafter the cancellation shall be effective. This policy may be cancelled by the company by mailing to the named insured at the address shown in this policy, written notice stating when not less than ten days thereafter such cancellation shall be effective. The mailing of notice as aforesaid shall be sufficient proof of notice. The [time of surrender or the][3] effective date [and hour][3] of cancellation stated in the notice shall become the end of the policy period. Delivery of such written notice either by the named insured or by the company shall be equivalent to mailing.

If the named insured cancels, earned premium shall be computed in accordance with the customary short rate table and procedure. If the company 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 payment or tender of unearned premium is not a condition of cancellation.

12. Declarations. By acceptance of this policy, the named insured agrees that the statements in the declarations 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 the company or any of its agents relating to this insurance.

APPROVED AND FILED JUN 21 1974 FLETCHER COMM. OF INS.

EFFECTIVE AUG 1 1974 FLETCHER BELL COMM. OF INSURANCE

(For issued by one company)

In witness whereof, the Blank Indemnity Company has caused this policy to be signed by its president and a secretary at _____ and countersigned on the declarations page by a duly authorized agent of the company.

(FACSIMILE OF SIGNATURE)
Secretary

(FACSIMILE OF SIGNATURE)
President

(For policy issued by two companies)

In witness whereof, the Blank Indemnity Company has caused this policy, with respect to [Part][1] _____ and such other parts of the policy as are applicable thereto, to be signed by its president and a secretary at _____, and countersigned on the declarations page by a duly authorized agent of the company.

(FACSIMILE OF SIGNATURE)
Secretary

(FACSIMILE OF SIGNATURE)
President

In witness whereof, the Blank Insurance Company has caused this policy, with respect to [Part][1] _____ and such other parts of the policy as are applicable thereto, to be signed by its president and a secretary at _____, and countersigned on the declarations page by a duly authorized agent of the company.

(FACSIMILE OF SIGNATURE)
Secretary

(FACSIMILE OF SIGNATURE)
President

PHYSICIANS, SURGEONS AND DENTISTS PROFESSIONAL LIABILITY MANUAL

INDEX

PHYSICIANS, SURGEONS AND DENTISTS LIABILITY MANUAL

Issued by
Insurance Services Office
160 Water Street, New York, N. Y. 10038

Exhibit I, Part 3 of 4 parts

a period of one year and cancelled by the insured. is rule is not applicable where short term coverage written in order to secure a common policy date with other coverages or lines of insurance.

H. Whole dollar premium rule. The premium for each exposure* shall be rounded to the nearest whole dollar; separately for each coverage provided by the policy.

A premium involving $.50 or over shall be rounded to the next higher whole dollar.

This procedure shall apply to all interim premium adjustments, including endorsements, or cancellations at the request of the insured. In the case of cancellation by the company, the return premium may be carried to the next higher whole dollar.

*Note: The phrase "each exposure" as used herein shall mean exposure for which a separate premium is shown in the policy, endorsement, daily, or policy survey sheet or questionnaire.

VIII. CANCELLATIONS

A. By the Insuring Company. The earned premium shall be determined on a pro rata basis by multiplying the number of units of exposure for the period the policy was in force by the applicable rates, but shall be not less than the pro rata amount of the minimum premium.

B. By the Insured.

1. One-Year Policies

Apply the short rate percentage in the short rate cancellation table to the annual premium.

2. Policies With a Term Less Than or Greater Than Twelve Months

(i) If policy has been in force for twelve months or less, use the cancellation procedure described in division 1. of this rule.

SHORT RATE CANCELLATION TABLE

For One-Year Policies

Days Policy In Force	Per Cent of One-Year Premium	Days Policy In Force	Per Cent of One-Year Premium	Days Policy In Force	Per Cent of One-Year Premium
1	5%	95- 98	37%	219-223	69%
2	6	99-102	38	224-228	70
3- 4	7	103-105	39	229-232	71
5- 6	8	106-109	40	233-237	72
7- 8	9	110-113	41	238-241	73
9-10	10	114-116	42	242-246	74
11-12	11	117-120	43	247-250	75
13-14	12	121-124	44	251-255	76
15-16	13	125-127	45	256-260	77
17-18	14	128-131	46	261-264	78
19-20	15	132-135	47	265-269	79
21-22	16	136-138	48	270-273	80
23-25	17	139-142	49	274-278	81
26-29	18	143-146	50	279-282	82
30-32	19	147-149	51	283-287	83
33-36	20	150-153	52	288-291	84
37-40	21	154-156	53	292-296	85
41-43	22	157-160	54	297-301	86
44-47	23	161-164	55	302-305	87
48-51	24	165-167	56	306-310	88
52-54	25	168-171	57	311-314	89
55-58	26	172-175	58	315-319	90
59-62	27	176-178	59	320-323	91
63-65	28	179-182	60	324-328	92
66-69	29	183-187	61	329-332	93
70-73	30	188-191	62	333-337	94
74-76	31	192-196	63	338-342	95
77-80	32	197-200	64	343-346	96
81-83	33	201-205	65	347-351	97
84-87	34	206-209	66	352-355	98
88-91	35	210-214	67	356-360	99
92-94	36	215-218	68	361-365	100

(ii) If policy has been in force for more than twelve months, premium shall be determined for each complete annual period in accordance with the "Calculation of premium—three year policies" rule, and for the remaining period of time on a pro rata basis.

C. Combination policies. If insurance under two or more liability manuals is written in a single policy, the amount to be retained by the company shall be not less than the sum of the amounts provided in each such manual.

IX. ADDITIONAL INTERESTS

A. Policies may be written to cover additional interests, as follows:

Financial Control. A corporation holding title to real property used by an individual or a partnership and which, in addition, may hold title to facilities used by the individual or partnership and may perform administrative functions for the individual or partnership, if financially controlled by the individual, or the partnership or the members thereof, may be included without additional charge on the policy covering the individual or the partnership.

B. All other additional interests shall be submitted for rating.

X. UNDERWRITING PROCEDURE

A. Coverage Options. Policies may be written to include individual coverage, partnership coverage, or both.

B. Partnership Liability.

1. When both partnership coverage and individual coverage are provided, the premium to be charged shall be the sum of:

(i) The appropriate per person rate for each partner insured for individual coverage;

(ii) The appropriate rate for each employee of any partner insured for individual coverage; or of the partnership, of the type for which additional charge is specified under the classifications;

(iii) The partnership liability rate for each partner.

Example: A partnership consists of two physicians, one of whom does X-ray therapy work, one surgeon and one dentist, all of whom are to be insured for individual and partnership coverages. The partnership employs one radium technician and one physician who does X-ray therapy work. The surgeon employs one physician. Premium is developed as follows:

Individual Members of Partnership

One physician		$60.00
One physician	$60.00	
X-ray therapy	90.00	150.00
One surgeon		105.00
One dentist		20.00
		$335.00

Partnership Liability Coverage
(20% of above rates for individual partners)

One physician		12.00
One physician	12.00	
X-ray therapy	18.00	30.00
One surgeon		21.00
One dentist		4.00
		67.00

I. GENERAL INSTRUCTIONS

This manual contains the rules, classifications and rates governing the underwriting of Physicians, Surgeons and Dentists Professional Liability insurance. This manual does not apply to osteopaths.

This manual contains reference to Standard Provisions forms applicable to rules and classifications.

The rules, classifications and rates in this manual become effective as of the date indicated upon each page. When a change is made, a reprinted page containing the change and the effective date thereof will be distributed. The change will be specifically designated by a star (*) on the outer margin of the page.

Additional units of exposure, coverage for which is provided on or after the effective dates of any changes in this manual, either by endorsement of outstanding policies or by the issuance of separate policies, shall be written on the basis of the rates and rules in effect at the time the coverage is provided.

Exception—Such coverage, if provided on an outstanding Comprehensive Liability policy, shall be written on the basis of the rates and rules in effect at the time that policy was issued.

The following requirements must be observed in the preparation of policies for insurance covered by this manual:

A. Appropriate wording identifying the classification or classifications applicable for each risk shall be stated in the policy, followed by the proper code number provided the policy contains a declarations page.

B. Any language in classification phraseology or footnotes which affects the scope of a classification applicable or assigned to operations to be insured, shall be incorporated in the policy provided the policy contains a declarations page.

C. For each classification there shall be inserted the proper premium either actual or adequately estimated as the case may be.

II. SCOPE OF COVERAGE

For details of coverage and exclusions refer to standard coverage part.

III. PERSONS INSURED

For persons insured, refer to standard coverage part.

IV. DEFINITIONS

A. General Definitions

For general definitions refer to the standard provisions jacket.

B. Additional Definitions

The following is an additional definition of a term used herein which is not included in the standard provisions jacket.

1. **Damages** means all damages, including damages for death, which are payable because of injury to which the policy applies.

2. **N.O.C.** This expression is an abbreviation of the words "not otherwise classified". No classification so qualified shall be applied in any case where any other manual classification more accurately describes the enterprise or where the language of any manual classification so qualified prescribes other treatment.

V. LIMITS OF LIABILITY

A. Manual rates and minimum premiums provide for a basic limit of $25,000 for all damages on account of each claim or suit and, subject to the foregoing limit, a basic aggregate limit of $75,000 for all damages. For three year policies, aggregate limits apply separately to each annual period in the same manner as for one year policies. The foregoing limits apply separately to individual professional liability and partnership liability.

For individual professional liability the above limits apply separately to each individual insured. For partnership liability the inclusion of more than one insured shall not operate to increase the limits of liability.

B. Increased limits of liability may be provided by applying the appropriate factors for the limits stated in the following table. For limits not stated, submit for rating.

When liability limits are increased on an outstanding policy, the additional premium therefor shall be the actual difference in premium charges or $2.00, whichever is greater. When liability limits are reduced on such a policy at the request of the insured, no refund of premium shall be made unless the difference in premium amounts to $2.00 or more.

Increased Limits Table

Limits (in thousands) per claim/ aggregate limit	Factors		
	Physicians *	Surgeons *	Dentists†
25/75	1.00	1.00	1.00
50/150	1.26	1.27	1.11
100/300	1.49	1.52	1.20

†The physicians increased limits table applies to the classifications applicable to dentists engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anethesia or analgesia.

C. Deductible Liability Insurance. Deductible liability insurance is a method of coverage under which the insured agrees to contribute up to a specified sum per claim towards the amount paid to claimants as damages. Risks to be written on this basis shall be submitted for rating.

Code No. 89990 applies for statistical purposes to all coverage written in accordance with this rule.

VI. POLICY PERIODS

Policies may be written for any period up to and including three years. If a policy is written for more than one year but less than three years, the premium shall be calculated pro rata.

VII. RATES AND PREMIUM CALCULATION

A. Rates will be found on the rate pages opposite the identifying code numbers of the classifications. The rates apply per annum.

B. Additional charges. The additional charges provided under the classifications in this manual measure the liability of the insured for the exposures covered by these additional charges. The additional charges must be obtained where the exposures exist except that for X-ray therapy and partnership liability, the additional charges shall be obtained only where coverage for such exposures is provided.

C. (a) Rated risks. Every risk described by a classification for which the symbol (a) appears in lieu of a specific rate or minimum premium, shall be submitted for rating.

D. Rate calculations for increased limits, additional interests, experience rating modifications and similar features shall be determined on an annual basis and shall be carried to two decimal places. If, in calculating the final rate, the third decimal is 5 or more, the second decimal is to be increased by 1; if the third decimal is less than 5, it is to be disregarded.

E. Calculation of premium—one year policies. The premium shall be determined on the basis of the units of exposure existing at policy inception.

F. Calculation of premium—three year policies. The premium shall be determined on the basis of the units of exposure existing and the rates in effect at the inception of each year of the three year policy.

G. Calculation of premium—short term policies. The premium on policies written for a period of less than one year shall be computed on a short rate basis in the same manner as the premium on a policy written

Employees (of individuals or partnerships)

One physician		15.00
One physician	15.00	
X-ray therapy	22.50	37.50
One radium technician		5.00
		57.50
		$459.50

2. When only partnership coverage is provided, the premium to be charged shall be the sum of:

   (i) The appropriate per person rate for each employee of the partnership of the type for which additional charge is specified under the classifications;

   (ii) The partnership liability rate for each partner.

C. **Corporate Liability.** Corporations or professional associations practicing medicine or dentistry shall be classified and rated as partnerships, that is, stockholders or members are to be classified and rated in the same manner as individual members of a partnership and corporations or professional associations as partnerships.

Use Standard Endorsement IRB-G1

CLASSIFICATIONS		Code No. *
Dentists	.....per person	80210
This classification applies to any dentist engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia.		
Dentists	.....per person	80211
This is an N.O.C. classification.		
Additional Charges:		
Corporate Liability (See General Rule X)		80999
***Employed Dentists**	.....per person	80212
This classification applies to any dentist engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia.		
***Employed Dentists**	.....per person	80213
This is an N.O.C. classification.		
Partnership Liability (See General Rule X)	.....	80999
***X-ray Therapy—by employed dentists**	.....	
	.....per person	80214
This additional charge applies to each employed dentist doing X-ray therapy work.		
X-ray Therapy—by insured dentists	.....per person	80215
This additional charge applies to each insured dentist doing X-ray therapy work.		
This classification applies to each insured dentist.		
For dentists while in the active military service of the United States, the following classifications apply:		
Dentists	.....per person	80216
Additional Charges:		
X-ray Therapy	.....per person	80217

*See note on page 5.

CLASSIFICATIONS		Code No. *
For dentists employed full time by the Federal Government, but not in Active Military Service of the United States, the following classifications apply:		
Dentists	.....per person	80225
This classification applies to any dentist engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia.		
Dentists	.....per person	80223
This is an N.O.C. classification.		
Additional Charges:		
X-ray Therapy	.....per person	80221

The footnotes under each classification should be observed in determining the application of the classification.

Class 1

PHYSICIANS—no surgery .....per person 80111

Additional Charges:

Additional charges apply for this classification. See schedule of additional charges following the classifications.

This classification applies to general practitioners and specialists hereafter indicated, who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and who do not ordinarily assist in surgical procedures.

Specialists

Allergists	*Pathologists
Cardiologists (not including catheterization)	Pediatricians
	Preventive Medicine Physicians
Dermatologists	Psychiatrists
Gastroenterologists	Public Health Physicians
Industrial Medicine Physicians	Rehabilitationists—Physiatrists
Internists	*Roentgenologists—Radiologists
Neurologists	

*If the insured is a pathologist or roentgenologist, substitute the following for the exclusion in the standard coverage part:

liability of the insured as proprietor, superintendent or executive officer of any hospital, sanitarium, clinic with bed and board facilities, or business enterprise other than an X-ray or pathological laboratory;

Use Standard Endorsement NB-G7.

This classification does not apply to the operation of regular bed and board facilities. Such risks shall be classified and rated in accordance with the Hospital Professional Liability manual. It does not apply also to physicians in the active military service of the United States or to those employed full time by the Federal Government.

Class 2

PHYSICIANS—minor surgery or assisting in major surgery on own patients ....per person 80112

Additional Charges:

Additional charges apply for this classification. See schedule of additional charges following the classifications.

Classification	Code No. *

This classification applies to general practitioners and specialists hereafter indicated, who perform minor surgery (including obstetrical procedures not constituting major surgery) or assist in major surgery on their own patients. Tonsillectomies, adenoidectomies, and Cesarean sections shall be considered major surgery.

Specialists

Allergists	*Pathologists
Cardiologists (not including catheterization)	Pediatricians
	Preventive Medicine Physicians
Dermatologists	Psychiatrists
Gastroenterologists	Public Health Physicians
Industrial Medicine Physicians	Rehabilitationists—Physiatrists
Internists	*Roentgenologists—Radiologists
Neurologists	

*If the insured is a pathologist or roentgenologist, substitute the following for the exclusion in the standard coverage part:

liability of the insured as proprietor, superintendent or executive officer of any hospital, sanitarium, clinic with bed and board facilities, or business enterprise other than an X-ray or pathological laboratory;

Use Standard Endorsement NB-G7.

This classification does not apply to the operation of regular bed and board facilities. Such risks shall be classified and rated in accordance with the Hospital Professional Liability manual. It does not apply also to physicians in the active military service of the United States or to those employed full time by the Federal Government.

Class 3

SURGEONS .....per person

*Statistical code 80113 applies to all insureds under this class except ophthalmologists and proctologists. See statistical code for these specialties below.

Additional Charges:

Additional charges apply for this classification. See schedule of additional charges following the classifications.

This classification applies to general practitioners who perform major surgery or assist in major surgery on other than their own patients and specialists hereafter indicated.

Specialists

Cardiologists (including catheterization, but not including cardiac surgery)

Ophthalmologists	80114
Proctologists	80115

This classification does not apply to the operation of regular bed and board facilities. Such risks shall be classified and rated in accordance with the Hospital Professional Liability manual. It does not apply also to surgeons in the active military service of the United States or to those employed full time by the Federal Government.

Class 4

SURGEONS—specialists .....per person

Additional Charges:

Additional charges apply for this classification. See schedule of additional charges following the classifications.

Classification	Code No. *

This classification applies to the specialists hereafter indicated. Other specialists shall be classified elsewhere.

Specialists

Cardiac Surgeons	80141
Otolaryngologists—No plastic Surgery	80142
Surgeons—General (Specialists in general surgery)	80143
Thoracic Surgeons	80144
Urologists	80145
Vascular Surgeons	80146

This classification does not apply to the operation of regular bed and board facilities. Such risks shall be classified and rated in accordance with the Hospital Professional Liability manual. It does not apply also to surgeons in the active military service of the United States or to those employed full time by the Federal Government.

Class 5

SURGEONS—specialists .....per person

Additional Charges:

Additional charges apply for this classification. See schedule of additional charges following the classifications.

This classification applies to the specialists hereafter indicated. Other specialists shall be classified in accordance with the foregoing classifications.

Specialists

Anesthesiologists	80151
Neurosurgeons	80152
Obstetricians—Gynecologists	80153
Orthopedists	80154
Otolaryngologists—Plastic Surgery	80155
Plastic Surgeons	80156

This classification does not apply to the operation of regular bed and board facilities. Such risks shall be classified and rated in accordance with the Hospital Professional Liability manual. It does not apply also to surgeons in the active military service of the United States or to those employed full time by the Federal Government.

Class 6

Physicians and Surgeons in Active United States Military Service:

Physicians—as defined under Class 1 .....per person	80131
Physicians—as defined under Class 2 .....per person	80132
Surgeons—as defined under Class 3 .....per person	80133
Surgeons—as defined under Class 4 .....per person	80134
Surgeons—as defined under Class 5 .....per person	80135

ADDITIONAL CHARGES:

X-ray Therapy .....per person	80136
Shock Therapy .....per person	80137

Class 7

For Physicians and Surgeons employed full time by the Federal Government but not in Active United States Military Service, the following classifications apply:

Physicians—as defined under Class 1 .....per person	80121
Physicians—as defined under Class 2 .....per person	80122

Classification	Code No. ★
Surgeons—as defined under Class 3 .....per person	80123
Surgeons—as defined under Class 4 .....per person	80124
Surgeons—as defined under Class 5 .....per person	80125
ADDITIONAL CHARGES:	
X-ray Therapy—Physicians, Classes 1 and 2 .....per person	80126
X-ray Therapy—Surgeons, Classes 3, 4 and 5 .....per person	80127
Shock Therapy .....per person	80128
Class 8	
Physicians or Surgeons Assistants	80116

This classification applies to physicians or surgeons assistants who have completed an approved course of study leading to university certification and who perform their duties under the direct supervision of a licensed physician or surgeon, assisting in the clinical and/or research endeavors of the physician or surgeon.

ADDITIONAL CHARGES

The following additional charges apply for all the foregoing classifications, except classifications applicable to Physicians and Surgeons in Active United States Military Service or to those employed full time by the Federal Government:

Classification	Code No.
Corporate Liability (See General Rule X)	80999
Employed Assistants .....per person	80129
Employed Physicians as defined under Class 1 .....per person	80130
*Employed Physicians as defined under Class 2 .....per person	80138
*Employed Surgeons as defined under Class 3 .....per person	80139
*Employed Surgeons as defined under Class 4 .....per person	80140
*Employed Surgeons as defined under Class 5 .....per person	80147
*Employed Technicians—radium, laboratory or pathological .....per person	80148
*Employed Technicians—X-ray Therapy .....per person	80149
Partnership Liability (See General Rule X)	80999
*Shock Therapy—by employed physicians or surgeons .....per person	80161

This additional charge applies to each employed physician or surgeon doing shock therapy work.

Shock Therapy—by insured physicians or surgeons .....per person	80162

This additional charge applies to each insured physician or surgeon doing shock therapy work.

*X-ray Therapy—by employed physicians or surgeons .....per person	80163

This additional charge applies to each employed physician or surgeon doing X-ray therapy work.

X-ray Therapy—by insured physicians as defined under Class 1 or Class 2 .....per person	80164

This additional charge applies to each insured physician doing X-ray therapy work.

X-ray Therapy—by insured physicians or surgeons as defined under Class 3, 4 or 5 .....per person	80165

This additional charge applies to each insured physician or surgeon doing X-ray therapy work.

*This rate applies not only to employees of individual insureds but also to employees of partnerships. It applies per employee regardless of the number of partners. It applies also to such personnel in pathological or X-ray laboratories operated or supervised by the insured in hospitals, whether or not employees of the insured.

Code No.	Rate *	Code No.	Rate *
80111	$ 238.00	80145	$ 952.00
80112	429.00	80146	1,905.00
80113	714.00	80147	298.00
80114	714.00	80148	12.00
80115	714.00	80149	24.00
80116	119.00	80151	1,191.00
80121	179.00	80152	1,905.00
80122	321.00	80153	1,429.00
80123	536.00	80154	1,905.00
80124	714.00	80155	1,191.00
80125	893.00	80156	1,429.00
80126	134.00	80161	59.50
80127	134.00	80162	179.00
80128	134.00	80163	59.50
80129	30.00	80164	179.00
80130	59.50	80165	179.00
80131	35.00	80210	126.00
80132	61.00	80211	92.50
80133	129.00	80212	32.50
80134	172.00	80213	23.50
80135	215.00	80214	(a)
80136	35.00	80215	(a)
80137	35.00	80216	17.00
80138	107.00	80217	(a)
80139	179.00	80221	(a)
80140	238.00	80223	69.50
80141	1,191.00	80225	95.50
80142	1,191.00	80999	*
80143	1,191.00		
80144	1,905.00		

* 20% of the per person rate for each individual comprising the partnership.

HOSPITAL PROFESSIONAL LIABILITY MANUAL

INDEX

HOSPITAL PROFESSIONAL LIABILITY MANUAL

Issued by
INSURANCE SERVICES OFFICE
160 Water Street, New York, New York 10038

GENERAL RULES

GENERAL INSTRUCTIONS

This manual contains the rules, classifications and rates governing the underwriting of Hospital Professional Liability insurance. This manual does not apply to osteopathic hospitals, institutions or clinics. Use Standard Coverage Part—Hospital Professional Liability Insurance.

The rules, classifications and rates in this manual become effective as of the date indicated upon each page. When a change is made, a reprinted page containing the change and the effective date thereof will be distributed. The change will be specifically designated by a star (★) on the outer margin of the page.

Additional operations or units of exposure, coverage for which is provided on or after the effective date of any change in this manual shall be written on the basis of the rates and rules in effect at the inception of the policy providing the coverage, if a one year policy. If the policy is written for more than one year, the rates and rules in effect at the inception of each year of the policy shall apply.

The following requirements must be observed in the preparation of policies for insurance covered by this manual:

A. If the risk to be insured is described by one or more of the classifications in this manual appropriate wording identifying such classification or classifications shall be stated in the policy, followed by the proper code number provided the policy contains a declarations page.

B. If the risk to be insured is not described by one or more of the classifications in this manual, such risk shall be definitely described in the policy followed by the code number of the manual classification to which the risk has been assigned provided the policy contains a declarations page.

C. Any language in classification phraseology or footnotes which affects the scope of a classification applicable or assigned to operations to be insured, shall be incorporated in the policy provided the policy contains a declarations page.

D. For each classification there shall be inserted the proper basis of premium calculation (either actual or adequately estimated as the case may be), and rate or premium; and in the space provided therefor, shall be inserted the minimum premium prescribed by this manual.

II. SCOPE OF COVERAGE. For details of coverage and exclusions refer to standard coverage part.

III. PERSONS INSURED. For persons insured refer to standard coverage part.

IV. DEFINITIONS

A. General Definitions

For general definitions refer to standard provisions jacket.

B. Additional Definitions

The following are additional definitions of terms used herein which are not included in the standard provisions jacket:

1. Damages means all damages, including damages for death, which are payable because of injury to which the policy applies.

2. For-Profit Hospital, Institution or Clinic is one to which the definitions of "Not-for-Profit Hospital, Institution or Clinic" and "Governmental Hospital, Institution or Clinic" as stated below, do not apply.

3. Governmental Hospital, Institution or Clinic is one operated by the Federal Government, or a state, county, city or other governmental unit.

4. Location as used in this manual shall mean premises involving the same or connecting lots, or premises whose connection is interrupted only by a street, roadway, waterway or right-of-way of a railroad.

5. N.O.C. This expression is an abbrevi[illegible] of the words "not otherwise classified". No classification so qualified shall be applied in any case where any other manual classification more accurately describes the enterprise.

6. Not-for-Profit Hospital, Institution or Clinic. A not-for-profit hospital, institution or clinic, other than governmental, is one, no part of the net earnings of which may lawfully inure to the benefit of any private individual.

V. LIMITS OF LIABILITY

A. Manual rates and minimum premiums provide for a basic limit of $25,000 for all damages on account of each claim or suit and, subject to the foregoing limit, a basic aggregate limit of $75,000 for all damages. For three year policies, aggregate limits apply separately to each annual period in the same manner as for one year policies. The foregoing limits apply separately to each location.

B. Increased limits of liability may be provided by applying the appropriate factors for the limits stated in the following table. For limits not stated, submit for rating.

When liability limits are increased on an outstanding policy, the additional premium therefor shall be the actual difference in premium charges or $2.00, whichever is greater. When liability limits are reduced on such a policy at the request of the insured, no refund of premium shall be made unless the difference in premium amounts to $2.00 or more.

Increased Limits Table

Limits (in thousands) per claim/ aggregate limit	Factors†
25/75	1.00
50/150	1.21 ★
100/300	1.39 ★

†The dentists professional liability increased limits table in the Physicians, Surgeons and Dentists Liability Manual is to apply to the "Convalescent or Nursing Homes—not mental psychopathic institutions" classification. ☆

C. Deductible Liability Insurance. Deductible liability insurance is a method of coverage under which the insured agrees to contribute up to a specified sum per claim towards the amount paid to claimants as damages. Risks to be written on this basis shall be submitted for rating.

Code No. 89990 applies for statistical purposes to all coverage written in accordance with this rule.

VI. POLICY PERIODS

Policies may be written for any period up to and including three years. If a policy is written for more than one year but less than three years, the premium shall be calculated pro rata.

VII. BASIS OF PREMIUM

The basis of premium is the base used for determining the premium charge and is indicated under each manual classification. The bases of premium used and the units of exposure for such bases are defined respectively as follows:

A. Outpatient Visits. Outpatient visits shall mean the total number of visits made during the policy period by patients who do not receive bed and board service.

The unit of exposure to which the rates are applied is each 100 outpatient visits.

B. Per Bed. The number of beds to which the "per bed" rate is to apply shall be the daily average number of beds, cribs and bassinets used for patients during the period the policy is in force.

The daily average number of beds, cribs and bassinets shall be the sum of the daily number of beds, cribs and bassinets used for patients for each day of the period the policy is in force, divided by the number of days in such period

VIII. RATES

A. Rates will be found on the rate pages opposite the identifying code numbers of the classifications. In connection with classifications for which more than one basis of premium applies, it shall not be permissible to provide insurance for the coverage contemplated by one basis of premium charge and not for the others.

B. (a) Rated and unclassified risks. Every risk described by a classification for which the symbol (a) appears in lieu of a specific rate or minimum premium, and every risk for which the manual contains no applicable classification, except osteopathic hospitals, institutions or clinics to which this manual does not apply, shall be submitted for rating.

C. Rate calculations for increased limits, additional interests, experience rating modifications and similar features shall be determined on an annual basis and shall be carried one decimal place beyond the number used in the basic rate. The figure in the last decimal place in the final rate shall be increased by one if the digit immediately following is 5 or more; if such digit is less than 5, it shall be disregarded.

D. Calculation of premium—one year policies. The premium for a period of one year shall be determined by applying the final rate computed in the foregoing manner to the number of units of exposure developed during such period.

E. Calculation of premium—three year policies. The premium shall be determined on the basis of the units of exposure existing and the rates in effect at the inception of each year of the three year policy.

F. Calculation of premium—short term policies. The premium on policies written for a period of less than one year shall be computed on a short rate basis in the same manner as the premium on policies written for a period of one year and cancelled by the insured; except for operations of a seasonal or temporary character or where short term coverage is written in order to secure a common policy date with other coverages or lines of insurance.

G. Whole dollar premium rule. The premium for each exposure* shall be rounded to the nearest whole dollar; separately for each coverage provided by the policy.

A premium involving $.50 or over shall be rounded to the next higher whole dollar.

This procedure shall apply to all interim premium adjustments, including endorsements, or cancellations at the request of the insured. In the case of cancellation by the company, the return premium may be carried to the next higher whole dollar.

*Note: The phrase "each exposure" as used herein shall mean each exposure for which a separate premium is shown in the policy, endorsement, daily, or policy survey sheet or questionnaire.

IX. MINIMUM PREMIUMS

The following rules govern the application of minimum premiums:

A. Minimum premiums are shown on the rate pages, and are the lowest amounts for which insurance coverage may be written for a period of one year. They apply per annum, per location.

B. Amounts to be charged on policies. The actual premium computed at the rates specified in the policy or the minimum premium, whichever is greater, shall be charged.

C. All minimum premiums are subject to increase for

1. increased limits.
2. additional interests.

D. Extended Coverage. Premium charges for coverage not within the scope of the basic policy coverage shall apply in addition to the minimum premiums.

E. Combination policies. If Hospital Professional Liability insurance is written in a policy affording other insurance, the minimum premiums provided in this manual shall apply in the same manner as if Hospital Professional Liability insurance were written in a separate policy.

X. CANCELLATIONS

A. By the Insuring Company. The earned premium shall be determined on a pro rata basis by multiplying the number of units of exposure for the period the policy was in force by the applicable rates, but shall be not less than the pro rata amount of the minimum premium.

B. By the Insured.

1. One-Year Policies

For premium developed as a "per bed" basis, apply the short rate percentage in the short rate cancellation table to the premium determined by applying the rate to the daily average number of beds for the period the policy was in force.

For premium developed on an "outpatient visits" basis the earned premium shall be determined on a short rate basis as follows:

(i) Multiply the number of units of exposure for the period the policy was in force by the applicable rates.

(ii) Determine the short rate factor as follows:

(a) Obtain the applicable short rate percentage from the short rate cancellation table and express it as a decimal.

(b) Divide the number of days the policy was in force by 365.

(c) Divide (a) by (b).

(iii) Multiply (i) by (ii).

(iv) If the earned premium so determined is less than the short rate amount of the minimum premium (full minimum premium if not subject to short rate adjustment), such short rate amount (full minimum premium if applicable) shall be the earned premium.

Example:

Period of coverage	146 days
Short rate percentage (50%) expressed as decimal	.50
146 ÷ 365	.40
Short rate factor (.50 ÷ .40)	1.25

2. Policies With a Term Less Than or Greater Than Twelve Months

(i) If policy has been in force for 12 months or less, use the cancellation procedure described in division A of this rule.

(ii) If policy has been in force for more than 12 months premium shall be determined for each complete annual period in accordance with the "Calculation of premium—three year policies" rule and for the remaining period of time on a pro-rata basis, except that, in the latter case, the full premium shall be charged if it is not subject to short rate adjustment.

C. Combination policies. If insurance under two or more liability manuals is written in a single policy, the amount to be retained by the company shall be not less than the sum of the amounts provided in each such manual.

SHORT RATE CANCELLATION TABLE

For One-Year Policies

Days Policy In Force	Per Cent of One-Year Premium	Days Policy In Force	Per Cent of One-Year Premium	Days Policy In Force	Per Cent of One-Year Premium
1	5%	95- 98	37%	219-223	69%
2	6	99-102	38	224-228	70
3- 4	7	103-105	39	229-232	71
5- 6	8	106-109	40	233-237	72
7- 8	9	110-113	41	238-241	73
9-10	10	114-116	42	242-246	74
11-12	11	117-120	43	247-250	75
13-14	12	121-124	44	251-255	76
15-16	13	125-127	45	256-260	77
17-18	14	128-131	46	261-264	78
19-20	15	132-135	47	265-269	79
21-22	16	136-138	48	270-273	80
23-25	17	139-142	49	274-278	81
26-29	18	143-146	50	279-282	82
30-32	19	147-149	51	283-287	83
33-36	20	150-153	52	288-291	84
37-40	21	154-156	53	292-296	85
41-43	22	157-160	54	297-301	86
44-47	23	161-164	55	302-305	87
48-51	24	165-167	56	306-310	88
52-54	25	168-171	57	311-314	89
55-58	26	172-175	58	315-319	90
59-62	27	176-178	59	320-323	91
63-65	28	179-182	60	324-328	92
66-69	29	183-187	61	329-332	93
70-73	30	188-191	62	333-337	94
74-76	31	192-196	63	338-342	95
77-80	32	197-200	64	343-346	96
81-83	33	201-205	65	347-351	97
84-87	34	206-209	66	352-355	98
88-91	35	210-214	67	356-360	99
92-94	36	215-218	68	361-365	100

XI. ADDITIONAL INTERESTS

A. Policies may be written to include the following additional interests, in addition to those included in the definition of insured, without additional premium charge:

1. Executors, administrators, trustees, or beneficiaries, on policies covering estates of deceased persons or living trusts.
2. Financial Control. An individual, group of persons, partnership or corporation which owns or financially controls one or more partnerships or corporations, on policies covering such risks, or corporations or partnerships which are owned or financially controlled by a single individual, group of persons, partnership or other corporation, on policies covering such controlling interests or interests which they control.
3. Husband and wife.
4. Mortgagees, assignees or receivers, but only for liability as such, on policies covering owners or general lessees.

B. All other additional interests shall be submitted for rating.

XII. DEPOSIT PREMIUMS

A. Annual Premium Adjustment. On policies which provide for adjustment of premium at the termination of policies of one year or less, the deposit premium shall be the full premium calculated at authorized rates on the estimated exposure for the policy period.

B. Interim Premium Adjustment. On policies which provide for adjustment of premium on an interim basis, the deposit premium shall be as follows:

Monthly basis—Not less than 25% of the annual premium.

Quarterly basis—Not less than 50% of the annual premium.

Semi-annual basis—Not less than 75% of annual premium.

The deposit premiums shall be retained by the company until expiration of the policy and credited to the final premium adjustment.

C. Minimum Deposit Premium. The minimum deposit premium is the premium for the risk payable in advance. In no case, whether upon monthly, quarterly, semi-annual or annual basis shall the deposit premium be less than the minimum premium.

D. Three Year Policies. The foregoing procedure is applicable for each year of policies written for periods of three years.

CLASSIFICATIONS

Code No. ★

The following classifications do not apply to:

A. Osteopathic hospitals, institutions or clinics. Such risks are not covered by this manual.

B. Drugless healing institutions such as chiropractic, naturopathic, sanipractic and Christian Science institutions. Such risks shall be submitted for rating.

Clinics, Dispensaries or Infirmaries—treatment of outpatients only—no regular bed and board facilities

For-Profit

Per 100 outpatient visits 80613

Not-for-Profit

Per 100 outpatient visits 80614

Governmental

Per 100 outpatient visits 93211

Clinics, dispensaries or infirmaries incidental to industrial or commercial risks shall be classified and rated under the "For-Profit" classification.

This classification does not apply to not-for-profit dental clinics. Such risks shall be submitted for rating.

Clinics, dispensaries or infirmaries operated by dentists or physicians shall be classified and rated as Physicians, Surgeons and Dentists Professional Liability insurance.

If regular bed and board facilities are provided, classify and rate in accordance with the appropriate classification in this manual.

Convalescent or Nursing Homes—not mental-psychopathic institutions

For-Profit

Per bed 80923
Per 100 outpatient visits 80951

Not-for-Profit

Per bed 80924
Per 100 outpatient visits 80952

Governmental

Per bed 92212
Per 100 outpatient visits 92216

This classification does not apply to risks with surgical operating room facilities, laboratory or medical departments or X-ray apparatus.

Homes for the Aged. Classify and rate homes for the aged operated for the purpose of providing care for the aged sick, infirm or injured as "Convalescent or Nursing Homes . . .". Other homes for the aged shall be submitted for rating.

Classification	Code No.	★
Hospitals		
For-Profit		
Per bed	80611	
Per 100 outpatient visits	80610	
Not-for-Profit		
Per bed	80612	
Per 100 outpatient visits	80617	
Governmental		
Per bed	93215	
Per 100 outpatient visits	93216	

This is an N.O.C. classification.

This classification applies to hospitals treating all general or special medical and surgical cases, including sanitariums with surgical operating room facilities.

Veterinary hospitals shall be classified and rated in accordance with the Miscellaneous Medical Professional Liability manual.

Mental-Psychopathic Institutions

For-Profit		
Per bed	80997	
Per 100 outpatient visits	80999	
Not-for-Profit		
Per bed	80916	
Per 100 outpatient visits	80917	
Governmental		
Per bed	91213	
Per 100 outpatient visits	91217	

This classification applies to institutions primarily for the restraint and treatment of mental, drug, narcotic or alcoholic cases.

Sanitariums or Health Institutions—not hospitals or mental-psychopathic institutions

For-Profit		
Per bed	80925	
Per 100 outpatient visits	80953	
Not-for-Profit		
Per bed	80926	
Per 100 outpatient visits	80954	
Governmental		
Per bed	93214	
Per 100 outpatient visits	93212	

This classification applies to risks with regular bed and board facilities, and with laboratory or medical departments. It does not apply to risks with surgical operating room facilities even though designated as sanitariums or health institutions.

Rates and Minimum Premiums

Code No.	Rate ★	Minimum Premiums Per Location ★
80611 80610	$ 75.00 7.50	$ 755.00
80612 80617	75.50 7.50	755.00
80613	(a)	(a)
80614	7.50	385.00
80916 80917	113.00 11.50	1,130.00
80923 80951	15.00 1.50	385.00
80924 80952	15.00 1.50	385.00
80925 80953	56.50 5.60	565.00
80926 80954	56.50 5.60	565.00
80997 80999	113.00 11.50	1,130.00
91213 91217	† †	†
92212 92216	† †	†
93211	†	†
93214 93212	† †	†
93215 93216	† †	†

†See Table below for Governmental Hospitals.

Governmental Hospitals, Institutions or Clinics
(Federal Hospitals, Institutions, or Clinics should be submitted for rating.)

Code No.	A. Operated by a city, town or county		B. Not operated by a city, town or county	
	Rate ★	Minimum Premiums Per Location ★	Rate ★	Minimum Premiums Per Location ★
91213 91217	$113.00 11.50	$1,130.00	$22.00 2.20	$385.00
92212 92216	15.00 1.50	385.00	2.20 .22	385.00
93211	7.50	385.00	1.10	385.00
93214 93212	56.50 5.60	565.00	8.30 .83	385.00
93215 93216	75.50 7.50	755.00	11.00 1.10	385.00

Exce

The following exception to this manual applies in the state of Kansas:

III. PERSONS INSURED

Add the following:

If the named insured is a governmental hospital, institution or clinic and is not operated by a city, town or county the following definition of insured applies:

Each of the following is an insured to the extent set forth below:

A. the named insured;

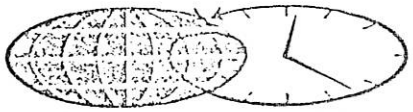
B. each member of the named insured's board of trustees, directors or governors while acting within the scope of his duties as a member of such board.

Use Standard Endorsement G418.

PHYSICIANS' AND SURGEONS' INDIVIDUAL COMBINATION PROFESSIONAL POLICY – CLAIMS MADE

SPECIMEN

THE ST. PAUL
COMPANIES



Serving you around the world... around the clock

TO OUR POLICYHOLDER

This is a claims made Policy. It covers claims arising from the performance of professional services subsequent to the retroactive date indicated and first brought against you while the Policy is in force. Please review the Policy carefully and discuss the coverage with your insurance agent.

Exhibit II

n consideration of the payment of the Premium, In reliance upon the statements made to the Company by application and subject to the terms set forth herein, ne Company designated on the Declarations page, herein called the Company, AGREES with the Insured.

INSURING AGREEMENTS

OVERAGE A – INDIVIDUAL PROFESSIONAL LIABILITY

o pay on behalf of the Insured all sums which the Insured shall become gally obligated to pay as damages because of any claim or claims made against e Insured during the policy period arising out of the performance of pro-ssional services rendered or which should have been rendered, subsequent to e retroactive date, by the Insured or by any person for whose acts or omis-ons the Insured is legally responsible, except as a member of a partnership, rporation, or professional association, and the Company shall have the right d duty to defend any suit against the Insured seeking such damages, even if y of the allegations of the suit are groundless, false or fraudulent, and may ake such investigation or such settlement of any claim or suit as it deems pedient, but the Company shall not be obligated to pay any claim or judg-ent or to defend any suit after the applicable limit of the Company's liability s been exhausted by payment of judgments or settlements.

xclusions

overage A does not apply:

- to liability of an Insured as a member of a partnership, corporation or professional association;
- to liability of the Insured for damages because of any injury resulting from an occurrence prior to the policy period if such liability is covered, in whole or in part, by any other insurance by reason of written notice of such occurrence to the insurance company providing such other insurance;
- to liability of the Insured for damages resulting from an injury to an individual if, prior to the policy period, any claim is first made against the Insured by anyone for damages resulting from such injury.

OVERAGE B – OFFICE PREMISES AND PERSONAL INJURY LIABILITY

pay on behalf of the Insured all sums which the Insured shall become legally ligated to pay as damages because of (1) bodily injury, (2) property damage (3) personal injury to which this insurance applies, caused by an occurrence d arising out of the ownership, maintenance or use, as a professional office, the insured premises and all operations necessary or incidental thereto, d the Company shall have the right and duty to defend any suit against the sured alleging damages, even if such suit is groundless, false or fraudulent, d may make such investigation and settlement of any claim or suit as it ems expedient, but the Company shall not be obligated to pay any claim or dgment or to defend any suit after the applicable limit of the Company's bility has been exhausted by payment of judgments or settlements.

Exclusions

Coverage B does not apply:

(1) to bodily injury or property damage arising out of the ownership, maintenance, operation, use, loading or unloading of
   (a) any automobile or aircraft owned or operated by or rented or loaned to the Named Insured, or
   (b) any other automobile or aircraft 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 Insured's professional office premises, if such automobile is not owned by or rented or loaned to the Named Insured;

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

(3) to bodily injury to any employee of the Insured arising out of and in the course of his employment by the Insured;

(4) to property damage to
   (a) property owned or occupied by or rented to the Insured,
   (b) property used by the Insured, or
   (c) property in the care, custody or control of the Insured or as to which the Insured is for any purpose exercising physical control

   but part (c) 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;

(5) to bodily injury or property damage due to nuclear reaction, nuclear radiation or radioactive contamination, or to any act or condition incident to any of the foregoing;

(6) as respects personal injury, to liability assumed by the Insured under any contract or agreement;

(7) to personal injury arising out of the wilful violation of a penal statute or ordinance committed by or with the knowledge or consent of any Insured;

(8) 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;

(9) to personal injury arising out of a publication or utterance described in Group (2) concerning any organization or business enterprise, or its products or services, made by or at the direction of any Insured with knowledge of the falsity thereof;

(10) to any obligation for which the Insured may be liable arising out of the performance of professional services.

The Company will pay, in addition to the applicable limit of liability:

(1) all expenses incurred by the Company, all costs taxed against the Insured in any suit defended by the Company and all interest on the entire amount of any judgment therein which accrues after entry of the judgment and before the Company has paid or tendered or deposited in court that part of the judgment which does not exceed the limit of the Company's liability thereon;

(2) premiums on appeal bonds required in any such suit, 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 the Company shall have no obligation to apply for or furnish any such bonds;

(3) expenses incurred by the Insured for first aid to others at the time of an accident, for bodily injury to which this Policy applies.

COVERAGE C – OFFICE PREMISES MEDICAL PAYMENTS

To pay to or for each person who sustains bodily injury caused by accident all reasonable medical expense incurred within one year from the date of the accident on account of such bodily injury, provided such bodily injury arises out of a condition in the Insured's professional office premises and all operations necessary or incidental thereto.

Exclusions

Coverage C does not apply to bodily injury:

(1) arising out of the ownership, maintenance, operation, use, loading or unloading of
   (a) any automobile or aircraft owned or operated by or rented or loaned to the Named Insured, or
   (b) any other automobile or aircraft 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 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 partner therein, any tenant or other person regularly residing on the 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 Insured's professional office premises rented from the Named Insured or to any 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 the Insured's professional office premises or alteration, demolition or new construction at such premises;

(6) to any person if any benefits for such bodily injury are payable or required to be provided under any workmen's compensation, unemployment compensation or disability benefits law, or under any similar law;

To pay to the Insured the necessary expenses and loss of time incurred by the Insured for each day or part of a day the Insured is required to attend the trial of a civil suit for damages against the Insured as a defendant resulting from causes of action as described under Coverages A and B.

Exclusions

Coverage D does not apply:

(1) to trials of law suits, if on or before the effective date of this insurance the Insured had any knowledge of or could reasonably foresee any circumstance which might involve a claim against the Insured.

(2) to trials of lawsuits before a court from whose judgment an appeal to a higher court cannot lawfully be taken solely upon the record of the trial before the courts.

DEFINITION OF INSURED

The word Insured shall mean:

(1) as respects Coverage A each individual named in the Schedule;

(2) as respects Coverages B and C, each individual named in the schedule and any organization or proprietor with respect to real estate management for the Insured;

(3) as respects Coverage D, the individual(s) named in the Schedule.

POLICY PERIOD – TERRITORY

This coverage applies:

(1) Under Coverage A this insurance applies only to professional services rendered or which should have been rendered after the retroactive date stated in the schedule and then only if claim is first made during the policy period. If, during the policy period, the Insured shall have knowledge or become aware of any occurrence, arising out of the rendering of or failure to render professional services after such retroactive date, which may subsequently give rise to a claim or suit and shall, during the policy period, give written notice thereof to the Company, then such notice shall be considered a claim hereunder. If any claim is first made during the policy period alleging injury to an individual that would be covered by this Policy, any additional claims made subsequent to the policy period for damages resulting from the same injury to the same individual shall be considered a claim hereunder. A claim shall be considered to be first made when the Company first receives written notice of the claim or occurrence. (See Condition 3 for Insured's rights to have extended reporting endorsements issued.)

(2) Under Coverages B, C and D to bodily injury, property damage, personal injury, accidents and expenses, including loss of time, (as applicable to each coverage) which occurs during the policy period in the United States of America, its territories or possessions, or Canada.

CONDITIONS

1. DEFINITIONS – WHEN USED IN THIS POLICY OR ENDORSEMENTS FORMING A PART HEREOF:

APPLICABLE TO COVERAGE A

"DAMAGES" means all damages, including damages for death, which are payable because of injury to which this insurance applies, including any counter claims in suit brought by the Insured to collect fees.

"PROFESSIONAL SERVICES" means any professional service and shall be deemed to include the dispensing of drugs or medicine and the service by the Insured as a member of a formal accreditation or similar board or committee of a hospital or professional society.

"REPORTING PERIOD" means the period of time stated in the reporting endorsement for reporting claims or suits arising out of professional services.

APPLICABLE TO COVERAGES B, C and D

"BODILY INJURY" means bodily injury, sickness or disease or death sustained by any person.

"DAMAGES" includes (1) damages for death and for care and loss of services resulting from bodily injury, (2) damages for loss of use of property resulting from property damage and (3) damages which are payable because of personal injury.

"MEDICAL EXPENSE" means expenses for necessary medical, surgical, x-ray and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services.

"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 Insured.

"PERSONAL INJURY" shall mean one or more of the following groups of offenses if 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.

LIMITS OF LIABILITY
APPLICABLE TO COVERAGE A

The limit of liability stated in the Declarations as applicable to "each claim" is the limit of the Company's liability for loss resulting from any one claim or suit or all claims or suits first made during the policy period because of injury to or death of any one person, subject, however, to the following special limit of liability:

If the Insured applies for reporting period(s) in accordance with Condition 3, the limit of liability stated in the Declarations as applicable to "each claim", at the time the policy is terminated, is the limit of the Company's liability for loss resulting from any one claim or suit or all claims or suits first made during each reporting period because of injury to or death of any one person.

The limit of liability stated in the Declarations as "annual aggregate" (which amount shall be three times the dollar amount of the "each claim" limit) is, subject to the above provisions respecting "each claim" the total limit of the Company's liability for all claims first made during the effective policy period or during each reporting period.

Such limits of liability shall apply separately to each Insured.

APPLICABLE TO COVERAGE B

The limit of liability stated in the Declarations as applicable to "each occurrence" is the limit of the Company's liability for all damages because of bodily injury, property damage or personal injury regardless of the number of (1) 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 the Company'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.

Subject to the above provision respecting "each occurrence" the total limit of the Company's liability under this coverage for all damages shall not exceed the limit of liability stated in the Declarations as "annual aggregate."

APPLICABLE TO COVERAGE C

The limit of liability stated in the Declarations as applicable to "each person" is the limit of the Company's liability for all medical expense for bodily injury to any one person as the result of any one accident; but subject to the above provision respecting "each person", the total liability of the Company under Office Premises Medical Payments Coverage for all medical expense for bodily injury to two or more persons as the result of any one accident shall not exceed the limit of liability stated in the Declarations as applicable to "each accident."

APPLICABLE TO COVERAGE D

The limit of liability stated in the Declarations as the "daily rate" shall be the limit of the Company's liability for each full day the Insured is required to appear in court. If the Insured is required to appear in court for only one half day the Company's liability shall be one half the "daily rate". The aggregate of the Company's liability for loss, resulting in any one or more trials arising out of the same alleged professional services, occurrences or acts described in Coverage A and B irrespective of the number of days of attendance at such trial(s) by the Insured, shall be the "per suit limit" as stated in the Declarations.

3. REPORTING ENDORSEMENT

APPLICABLE TO COVERAGE A

In the event of termination of insurance either by non-renewal or cancellation of this Policy, or termination of a reporting period the Insured shall have the right upon payment of an additional premium (to be computed in accordance with the Company'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 hereunder must, however, be exercised by the Insured by written notice not later than thirty (30) days after such termination date.

4. INSURED'S DUTIES IN THE EVENT OF OCCURRENCE, CLAIM OR SUIT

A. AS RESPECTS COVERAGES A, B AND C

(1) Upon the Insured becoming aware of any alleged injury, written notice containing the fullest information obtainable with respect to the circumstances, time and place thereof, and the names and addresses of the injured and of available witnesses shall be given by or for the Insured to the Company or any of its authorized agents as soon as practicable. The Named Insured shall promptly take at his expense all reasonable steps to prevent other bodily injury or property damage from arising out of the same or similar conditions, but such expense shall not be recoverable under this Policy.

(2) If claim is made or suit is brought against the Insured, the Insured shall immediately forward to the Company every demand, notice, summons or other process received by him or his representative.

(3) The Insured shall cooperate with the Company and, upon the Company's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the Insured because of bodily injury, property damage or personal injury with respect to which insurance is afforded under this Policy; and the Insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The Insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than the first aid to others at the time of accident.

B. AS RESPECTS COVERAGE D

Written notice shall be given by or on behalf of the Insured to the Company or any of its authorized agents as soon as practicable following the last date of loss. Such notice shall contain particulars sufficient to identify the Insured and all reasonably obtainable information as respects the time, place and circumstances of the loss including the identity of the court and all parties to the action before the court.

5. ACTION AGAINST COMPANY

No action shall lie against the Company 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 Insured's obligation to pay shall have been finally determined either by judgment against the Insured after actual trial or by written agreement of the Insured, the claimant and the Company.

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 the Company as a party to any action against the Insured to determine the Insured's liability, nor shall the Company be impleaded by the Insured or his legal representative. Bankruptcy or insolvency of the Insured or of the Insured's estate shall not relieve the Company of any of its obligations hereunder.

6. OTHER INSURANCE

With respect to Coverage A, if the Insured has other insurance against a loss covered by this Policy, the Company shall not be liable under this Policy for a greater proportion of such loss than the limit of liability stated in the Schedule bears to the total limit of liability of all valid and collectible insurance against such loss.

This Policy is not complete unless a Declarations page is attached.

With respect to Coverages B and C, 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 Insured has other insurance which is stated to be applicable to the loss on an excess or contingent basis, the amount of the Company'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, the Company shall not be liable under this Policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

A. CONTRIBUTION BY EQUAL SHARES
If all of such other valid and collectible insurance provides for contribution by equal shares, the Company 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 then 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.

B. CONTRIBUTION BY LIMITS
If any of such other insurance does not provide for contribution by equal shares, the Company 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.

SUBROGATION

Except with respect to Coverage D, in the event of any payment under this Policy the Company shall be subrogated to all the Insured's rights of recovery therefor against any person or organization (excluding, under Coverage A, employees of the Insured) and the Insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Insured shall do nothing after loss to prejudice such rights.

CHANGES

Notice to any agent or knowledge possessed by any agent or by any other person shall not affect a waiver or a change in any part of this Policy or estop the Company 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.

9. ASSIGNMENT

Assignment of interest under this Policy shall not bind the Company 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 (2) with respect to the property of the Named Insured, to the person having proper temporary custody thereof, as Insured, but only until the appointment and qualification of the legal representative.

10. CANCELLATION

This Policy may be cancelled by the Named Insured by surrender thereof to the Company or any of its authorized agents or by mailing to the Company written notice stating when thereafter the cancellation shall be effective. This Policy may be cancelled by the Company by mailing to the Named Insured at the address shown in this Policy, written notice stating when not less than ten days thereafter such cancellation shall be effective. The mailing of notice as aforesaid shall be sufficient proof of notice. The time of surrender or the effective date and hour of cancellation stated in the notice shall become the end of the policy period. Delivery of such written notice either by the Named Insured or by the Company shall be equivalent to mailing.

If the Named Insured cancels, earned premium shall be computed in accordance with the customary short rate table and procedure. If the Company 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 payment or tender of unearned premium is not a condition of cancellation.

11. DECLARATIONS

By acceptance of this Policy, the Named Insured agrees that the statements in the Declarations 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 the Company or any of its agents relating to this insurance.

12. SPECIAL STATUTES

Any and all provisions of this Policy which are in conflict with statutes of the State wherein this Policy is issued are understood, and acknowledged by this Company to be amended to conform to such statutes.

SPECIAL EXCEPTIONS

Wisconsin exceptions:

1. Paragraph A (1) of Condition 4 – entitled "Insured's Duties in the Event of Occurrence, Claim or Suit" is amended to read:

   Insured's Duties in the Event of Occurrence, Claim or Suit

   (1) In the event of an occurrence, written notice containing particulars sufficient to identify the Insured and also reasonably obtainable information with re spect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the Insure to the Company or any of its authorized agents within 20 days following the date of the occurrence; provided, that failure to give such notice within th time specified shall not invalidate any claim made by the Insured if it shall be shown not to have been reasonably possible to give such notice within th prescribed time and that such notice was given as soon as reasonably possible. The Named Insured shall promptly take at his expense all reasonable step to prevent other bodily injury or property damage from arising out of the same or similar conditions, but such expense shall not be recoverable under thi Policy.

2. Condition 8 entitled "Changes" is amended to read:

   Changes

   The terms of this Policy shall not be changed, except by endorsement issued to form a part of this Policy. Knowledge of an agent of the Company at the tim this Policy is issued or an application made shall be knowledge of the Company, and any fact which breaches a condition of the Policy and is known to the agen when the Policy is issued or the application made shall not void the Policy or defeat a recovery thereon in the event of loss.

3. The following paragraph is added to Condition 11 entitled "Declarations":

   No oral or written statement, representation or warranty made by the Insured or in his behalf in the negotiation of this Policy shall be deemed material or de feat or avoid the Policy, unless such statement, representation or warranty was false and made with intent to deceive, or unless the matter misrepresented o made a warranty increased the risk or contributed to the loss. No breach of a warranty in this Policy shall defeat or avoid this Policy unless the breach of suc warranty increased the risk at the time of the loss, or contributed to the loss, or existed at the time of the loss.

4. Condition 10 entitled "Cancellation" is amended to read:

   This Policy may be cancelled by the Named Insured by surrender thereof to the Company or any of its authorized agents or by mailing to the Company writte notice stating when thereafter the cancellation shall be effective. This Policy may be cancelled by the Company by mailing to the Named Insured at the addres shown in this Policy, written notice stating when not less than thirty days thereafter such cancellation shall be effective. The time of surrender or the effectiv date and hour of cancellation stated in the notice shall become the end of the policy period. If the Company elects not to renew this Policy, it shall mail to th Named Insured, at the address shown in the Policy, written notice of such nonrenewal not less than thirty days prior to the termination or expiration of thi Policy. The mailing of notice as aforesaid shall be sufficient proof of notice. Delivery of such written notice either by the Named Insured or by the Compan shall be equivalent to mailing.

   If the Named Insured cancels, earned premium shall be computed in accordance with the customary short rate table and procedure. If the Company 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 can cellation becomes effective, but payment or tender of unearned premium is not a condition of cancellation.

ST. PAUL FIRE AND MARINE INSURANCE COMPANY ONLY:
PROVISIONS REQUIRED BY LAW TO BE STATED IN THIS POLICY: -- "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.

IN WITNESS WHEREOF, the Company designated on the Declarations page has caused this Policy to be signed by its President and Secretary and countersigne on the Declarations page by a duly authorized representative of the Company.

Secretary. *President.*

SHORT RATE TABLE
(For One Year Policies)

Days Policy in Force	Per Cent of 1 Yr. Prem.
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Carefully note Condition requiring Immediate Notice of Every Occurrence, Claim and Suit.

ST. PAUL MERCURY INSURANCE COMPANY
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
STATE OF KANSAS

Filing Memorandum

This is an independent rate filing for Physicians and Surgeons Professional Liability insurance for the St. Paul Mercury Insurance Company. The request is based on St. Paul Fire & Marine Insurance Company statistics since we currently write all or nearly all of this business in that company. The request consists of base limits rate increases of 49.8%, 50.0%, 49.9%, 50.0%, and 50.0% for Classes 1 through 5 respectively, for a total limits composite increase of 49.93%.

Exhibit I shows accident year incurred loss and allocated loss expense development and relates it to calendar year earned premium.

Exhibit II shows the derivation of the proposed rate change. Earned premiums are adjusted to current rate level while loss and allocated loss expense costs are adjusted to current costs levels to produce a Five-Year Current Cost and Rate Level Loss Ratio. This Loss Ratio is credibility-weighted with the Permissible Loss Ratio based on number of incurred claims during the five-year period to produce a Formula Loss Ratio. This Loss Ratio is then trended to a point six months after the effective date of the proposed rate change so that the indication will reflect our best estimate of the situation which will prevail at the time the rates are in effect. The indication is produced by dividing the Trended Loss Ratio by the Permissible Loss Ratio. The composite effect of the proposed rate change on the five classes of business based on our current mix of exposures is shown.

Exhibits III through V are informational exhibits which support the indication produced in Exhibit II. Exhibit III-A shows the countrywide loss development pattern for Physicians and Surgeons Professional Liability. Exhibit III-B applies the development factors calculated in Exhibit III-A to the actual countrywide loss development to date to bring all accident years to a common valuation point. Exhibit III-C shows that the countrywide IBNR is distributed to the various states based on earned premium.

Exhibit IV-A shows the derivation of the countrywide cost adjustment factors used in Exhibit II. These factors are calculated by fitting the Countrywide Current Rate Level Loss and Allocated Loss Expense Ratios for each of the last five years to a straight line using the least-squares method. The Current Cost Adjustment Factor, which adjusts the experience to mid-1973 is then determined by dividing the 1973 Fitted L/R ("Current") by the Fitted L/R for the year in question. Exhibit IV-B, shows the derivation of the Cost Trend Factor, which is used to bring the experience from mid-1973 to a point twelve months beyond the earliest possible effective date of this requested rate change.

Exhibit V shows the calculation of the permissible loss and allocated loss expense ratio used in Exhibit II.

THE ST. PAUL
COMPANIES

Serving you around the world... around the clock
385 WASHINGTON ST., ST. PAUL, MINN. 55102

November 4, 1974

Honorable Fletcher Bell
Commissioner of Insurance
1st Floor - State Office Building
Topeka, Kansas 66612

11-7
2R
2 Co

Physicians' and Surgeons' Professional
Liability Insurance
Rate Increase
Manual Page

Dear Sir:

This letter and the enclosed materials are submitted as a deviation filing on behalf of the undersigned.

By this filing we propose a 49.93% increase in the base limits rate for Physicians and Surgeons Professional Liability Insurance. The attached Filing Memorandum and Statistical Exhibits more fully explain our proposal.

We propose an effective date for this filing of December 9, 1974. No policy effective prior to December 9, 1974 shall be endorsed or cancelled and rewritten to take advantage of or to avoid the application of this change, except at the request of the insured and at the customary short rate charges as of the date of such request.

Your acknowledgment and approval of this filing by stamping and returning the extra copy of this letter will be appreciated.

Yours very truly,

ST. PAUL MERCURY INSURANCE COMPANY

M. W. Harnisch

M. W. Harnisch
State Filings Director
Insurance Law Department

MWH/nc

Enc.

cc: I.S.O. of Kansas

Exhibit III

EXHIBIT II - DERIVATION OF PROPOSED RATE CHANGE

(1) Accident Year	(2) Earned Premium At Collected Rate	(3) Earned Premium Adjusted to Current Rate Level	(4) Incurred Loss & Alloc. Loss Expense (From Exhibit I)	(5) Current Cost Adjustment Factor (From Exhibit IV-A)	(6) Inc. Loss & Alloc. Loss Exp. Adj. to Current Cost Level (4) x (5)	(7) Current Cost and Rate Level Loss & Alloc. Loss Exp. Ratio (6) ÷ (3)
1969	168,623	563,461	158,462	2.9974	474,974	84.30
1970	189,085	540,459	104,812	1.9990	209,519	38.77
1971	348,144	560,107	425,945	1.4997	638,790	114.05
1972	585,911	606,577	459,956	1.1998	551,855	90.98
1973	668,179	668,179	1,019,184	1.0000	1,019,184	152.53
5 Year Total	1,959,942	2,938,785	2,168,359		2,894,322	98.49

(A) Five-Year Current Cost and Rate Level L/R (From Column 7 above) 98.49%

(B) Permissible L/R (From Exhibit V) 73.30%

(C) Number of Incurred Claims 1969-1973 103

(D) Credibility Factor: $\frac{1.00}{\sqrt{(C) \div 384}}$ if (C) $\geq$ 384; if (C) $<$ 384 .51

(E) Formula L/R (A) x (D) + (B) x [1.00 - (D)] 86.15%

(F) Cost Trend Factor (From Exhibit IV-B) 1.3888

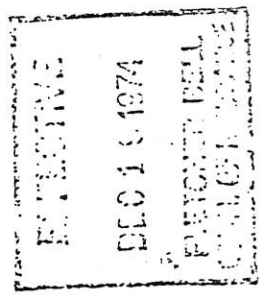
(G) Trended L/R (E) x (F) +119.65%

(H) Indicated Rate Change (G) ÷ (B) - 100% + 63.23%

(I) Composite Effect of Proposed Rate Change + 49.93%

EXHIBIT I

ST. PAUL FIRE & MARINE INSURANCE COMPANY
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
LOSS AND LOSS EXPENSE EXPERIENCE
STATE OF KANSAS



(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
			Accident Year Paid		O/S Case @ 12/31/73		O/S IBNR @ 12/31/73		Accident Year Incurred		
Period	Written Premium	Earned Premium	Loss	Loss Expense	Loss	Loss Expense	Loss	Loss Expense	Loss	Loss Expense	Total
1969	193857	168623	44750	25212	59000	29500	0	0	103750	54712	158462 93.97
1970	198716	189086	19661	48240	22414	11207	2193	1097	44268	60544	104812 55.43
1971	458820	348144	19140	22152	241500	120750	14935	7468	275575	150370	425945 122.35
1972	645778	585911	24300	9686	108500	54250	175480	87740	308280	151676	459956 78.50
1973	694051	668178	0	1441	297500	148750	380995	190498	678495	340689	1019184 152.53
ear Total	2191222	1959942	107851	106731	728914	364457	573603	286803	1410368	757991	2168359 110.63

EXHIBITS III-B AND III-C

ST. PAUL FIRE & MARINE INSURANCE COMPANY
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
STATE OF KANSAS

EXHIBIT III-B
APPLICATION OF DEVELOPMENT FACTORS
COUNTRYWIDE

(1) Accident Year	(2) Developed Loss Cost (12/31/73)	(3) Development Factor (See Exhibit III-A)	(4) Incurred Loss Cost (2) x (3)	(5) Developed Loss Cost 6/1/74	(6) IBNR Loss Cost (4) - (5)
1970	$14,490,168	1.061	$15,374,068	$15,192,515	$ 181,553
1971	14,539,709	1.290	18,756,225	17,713,375	1,042,850
1972	11,323,403	2.182	24,707,665	15,484,420	9,223,245
1973	6,102,635	5.430	33,137,308	13,102,387	20,034,921

EXHIBIT III-C
DISTRIBUTION OF COUNTRYWIDE IBNR
BY EARNED PREMIUM

(1) Acc. Year	(2) Countrywide Earned Premium	(3) Countrywide IBNR Loss Cost	(4) (3) ÷ (2)	(5) Kansas Earned Premium	(6) Kansas IBNR Loss Cost (4) x (5)
1970	$15,673,398	181,553	.0116	$189,086	$ 2,193
1971	24,320,715	1,042,850	.0429	348,144	14,935
1972	30,795,852	9,223,245	.2995	585,911	175,480
1973	35,137,798	20,034,921	.5702	668,178	380,995

EXHIBIT III-A

ST. PAUL FIRE & MARINE INSURANCE COMPANY
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
ACCIDENT YEAR LOSS DEVELOPMENT
COUNTRYWIDE

ACTUAL DEVELOPMENT
(,000 Omitted)

Accident Year	Annual Age 0	1	2	3	4
1965	-	-	-	3,795	4,309
1966	-	-	3,423	3,746	4,056
1967	-	2,489	4,246	5,212	5,293
1968	1,562	3,750	5,904	7,428	7,278
1969	1,478	4,159	7,278	8,579	9,360
1970	3,224	6,958	10,985	14,490	
1971	3,339	7,880	14,540		
1972	4,176	11,323			

ANNUAL DEVELOPMENT FACTORS

	Age 1/Age 0	Age 2/Age 1	Age 3/Age 2	Age 4/Age 3
1965				
1966				1.135
1967			1.094	1.083
1968		1.706	1.228	1.016
1969	2.401	1.574	1.258	.980
1970	2.814	1.750	1.179	1.091
1971	2.158	1.579	1.319	
1972	2.360	1.845		
	2.711			
Average Factor	2.489	1.691	1.216	1.061

COMPOUND FACTORS

Age 4/Age 0	2.489	x	1.691	x	1.216	x	1.061	=	5.430
Age 4/Age 1			1.691	x	1.216	x	1.061	=	2.182
Age 4/Age 2					1.216	x	1.061	=	1.290
Age 4/Age 3							1.061	=	1.061

EXHIBIT IV-B

DERIVATION OF COST TREND FACTOR
COUNTRYWIDE BASIS

(A)	Past Annual Increase in Fitted L/R 1969-1973: From Exhibit IV-A, Column (5)	19.39%
(B)	Trend Period: 7/01/73 to 11/1/75 *	28 Months
(C)	Projected Increase in L/R Over Trend Period: (28 ÷ 12) x 19.39%	45.24%
(D)	1973 Fitted Current Rate Level L/R: From Exhibit IV-A, Column (5)	116.36%
(E)	Projected Current Rate Level L/R At End of Trend Period: (C) + (D)	161.60%
(F)	Cost Trend Factor: (E) ÷ (D)	1.3888

* 12 Months beyond earliest possible effective date.

EXHIBIT IV-A

DERIVATION OF COST ADJUSTMENT FACTORS
COUNTRYWIDE BASIS

(1) Acc. Year	(2) Earned Premium At Current Rate Level	(3) Incurred Loss & Allocated Loss Expense	(4) Current Rate Level Loss & Allocated Loss Expense Ratio (3) ÷ (2)	(5) Fitted L/R (Straight Line, Least Squares)	(6) Current Cost Adjustment Factor 116.36 ÷ (5)
1969	$ 34,689,904	$ 13,595,102	39.19%	38.82%	2.9974
1970	34,694,512	22,064,582	63.60	58.21	1.9990
1971	38,114,160	27,450,460	72.02	77.59	1.4997
1972	40,284,656	36,440,240	90.46	96.98	1.1998
1973	40,383,360	49,547,559	122.69	116.36	1.0000

C E R T I F I C A T E

THIS IS TO CERTIFY that to the best of my knowledge, information, and belief the filing being submitted is in compliance in all respects with the provisions of the Insurance Laws and Rules and Regulations of the State of Kansas.

By _____

Secretary
Title

EXHIBIT V

ST. PAUL FIRE & MARINE INSURANCE COMPANY
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
PERMISSIBLE LOSS AND ALLOCATED LOSS EXPENSE CALCULATION
STATE OF KANSAS

Commission	11.0%
Taxes	2.5
Other Acquisition Expense	2.0
General Expense	3.2
Unallocated Loss Expense	3.0
Total Expense Ratio	21.7%
Breakeven Loss and Allocated Loss Expense Ratio	78.3%
Allowance for Profit	5.0
Permissible Loss and Allocated Loss Expense Ratio	73.3%

20. Omit ad damnum clause from malpractice pleadings

21. Adopt sealed letter offer of settlement technique with reasonable penalties for excessive demands and inadequate offers

22. Liability without fault

23. Introduction of workmen's compensation type system

24. Substitution of claims made coverage for occurrence type coverage

25. Flat rate premiums for all doctors

26. Experience rating with surcharges for "repeaters"

27. Reduction of agents' commissions

28. Impose dollar ceiling on
    (1) physician's liability
    (2) insurer's liability
    (3) patient's recovery

29. Impose exclusive liability on hospital and immunize physician from liability where malpractice occurs in hospital (as in veteran's hospitals)

30. Shorten statute of limitations

31. Tighten "informed consent" liability; expert testimony required

32. Enforce locality rule for expert testimony

33. Provide immunity for physicians who render care after another physician has treated patient

34. Provide immunity for physicians in "red alert" cases - cardiac arrest, emergency

35. Provide immunity for physicians in Good Samaritan cases

36. Tighten the application of the doctrine of res ipsa loquitur

37. Citizen's committee

38. Reinsurance "facility"

39. Joint Underwriting Associations

    (a) (monopolistic vs. (non-monopolistic

    (b) (profit---with or without assessments against physician for deficit or (non-profit--with or without cut-off date, e.g. two years

    (c) freezing rates at existing levels vs. leaving rate levels flexible to vary according to the experience

ILLUSTRATIVE LIST OF PROPOSED SOLUTIONS TO MEDICAL MALPRACTICE INSURANCE PROBLEMS*

1. Arbitration
   Voluntary binding, non-binding
   Compulsory binding, non-binding
2. Impartial mediation
3. Trial before a judge instead of a jury
4. Regulation of contingent fees for attorneys
5. Advance payments by insurers, no admission of liability
6. Advance payments deductible from final settlement
7. Legal sanction for peer review groups with protection against retaliatory measures
8. Formally structured grievance procedures for patients
9. Stiffer disciplinary measures for incompetent doctors
10. Require malpractice pleadings to be filed in court
11. Modest filing fee for pleadings required
12. Bond to be posted (except in cases of poverty)
13. Court, instead of lawyers, examines the jury
14. Permit evidence of remarriage of spouse in actions for wrongful death
15. Avoid double recovery for medical bills (collateral source rule)
16. Remove restrictions on the patient's access to medical records
17. Use of special verdicts - apportion liability and damages where multiple defendants, not all physicians, are involved
18. Impose restrictions on punitive damages
19. Give defendant option of paying the verdict in installments to avoid windfalls where patient dies prematurely

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(*) Source: Bills, Media, Industry Publications, etc.

61. All investment income on policyholder supplied funds unearned premium reserve - loss reserve would be credited to the stabilization reserve fund
Trustees would be
(1) Insurance commissioner
(2) Policyholder (public member)
(3) Representative of JUA

62. Patient compensation fund (for verdicts in excess of $100,000)

63. Retrospective rating -- to help make policies self-supporting

64. Patient to carry and pay for his own malpractice protection (like a personal accident policy)

65. Graduated premiums for doctors to reflect fact that not all doctors work full time, e.g. semi-retired doctors, doctors on reduced work load because of health, etc.

66. State to organize its own malpractice insurer (as distinguished from using existing state fund, i.e. workmen's compensation insurer)

67. Reciprocal insurers allowed to write medical malpractice insurance

68. Self-insurance authorized (in some states; prohibited in others)

69. Malpractice rates to be based on regional rather than national basis

70. Formation by State Medical Society of its own broker organization

71. Establishment of Federal Reinsurance Program

72. Formation, by Medical Society, of its own reinsurer

73. Use of courts (injunctions) to prefent insurers from withdrawing from malpractice market

74. Investigation of insurance company rates and reserves

75. Creation of pre-litigation insurance panel to review cases

76. Comparative negligence rule

77. Punitive damages permitted, where injury was intentional

40. Annual statement of JUA

41. Annual examination of JUA

42. Doctors report claims to state society

43. No recovery on contract to cure, unless in writing (Statute of Frauds)

44. Compulsory coverage, with minimum limits

45. Study by legislative committee or commission on malpractice

46. Creation of physicians' mutual with or without ceilings on recovery

47. Creation of use of state funds (New York-Michigan)

48. Creation of county mutuals to insure health care providers

49. Change state agency that disciplines medical profession

50. Relicense doctor every three years - 150 hours of training in between

51. Extend guaranty fund laws to cover medical malpractice insurance

52. Privileged communications

53. 90-day notice of cancellation of malpractice insurance policy - other provisions

54. Prior approval of malpractice insurance rates

55. Provisions to speed up disposition of medical malpractice cases

56. Premium refunds (if rate too high)

57. Co-insurance -- 25% - doctor $3,000, hospital $6,000

58. Insurers report malpractice claims to Superintendent every six months

59. Audit of physician's books (for rate making)

60. Stabilization of reserve fund
    Funded by special surcharge to policyholders
    To assure retrospective rating adjustments <u>if</u>
    basic premiums proved inadequate

78. Insurance commissioner to collect premium loss, expense, and profit data

79. Insurance commissioner to evaluate law and report periodically to governor and legislature

80. Insurance commissioner to take steps to enable JUA policyholders, etc. to participate, if and when federal reinsurance program is adopted and implemented

81. Create catastrophe reserve, if states act as insurer

82. National Medical Injury Compensation Act (amending Public Health Service Act) covering both tort and no-fault claims and with standards for the medical profession

83. Penalty provision against health care provider who fails to inform patient of compensable injury

84. Narrow definition of malpractice so as to rule out liability for bad results

85. Require insurers to offer periodic payment plans so as to reduce single large cash outlays for premiums

86. Require state medical boards, with disciplinary powers over physicians, to include laymen --- public members to be in a majority/minority

NAIC MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFORM CLAIMS REPORT

File one report for each defendant insured by filing insurer. Include claims closed without payment.
See reverse side for instructions.

Complete for all claims

1. Name of insurer _____ Claim file identification _____
2. Date of injury _____ Date reported _____ Date reopened _____
3. Insured's name _____ Age ____ City _____ State _____ Zip _____
4. Profession or business _____ Specialty _____ Type of practice _____
5. Board certification? _____ Foreign medical graduate? _____ Country _____
6. Place where injury occurred _____ City _____ State _____ Zip _____
7. Name of institution _____
8. Injured person's name _____ Age _____ Sex _____
9. Total defendants involved in claim _____ Derivative claim _____
10. Amount of reserve for indemnity if still outstanding $ _____
11. Amount of reserve for expense if still outstanding $ _____

Complete for Paid and Closed Claims Only

12. Plaintiff attorney's name _____ City _____ State _____ Zip _____
13. Describe action which caused claim to be made _____
14. Final diagnosis _____
15. Operation, diagnostic or treatment procedure causing the injury _____
16. Describe principal injury giving rise to the claim _____ Severity of injury _____
17. Misadventures in procedures _____ Misadventures in diagnosis _____
18. Others contributing to injury _____ Associated issues _____ Coverage _____
19. Companion claim file identification 1. _____ 2. _____ 3. _____

Complete for Paid and Closed Claims Only

20. Date of this payment or closure _____ Type settlement _____
21. Disposition of trial _____ Binding arbitration? _____
22. Indemnity paid by you on behalf of this defendant $ _____
23. Other indemnity paid by or on behalf of this defendant $ _____
24. Indemnity paid by all parties ((or all defendants) $ _____
25. Loss adjustment expense paid to all defense counsel $ _____
26. All other allocated loss adjustment expense paid by you $ _____
27. Injured person's incurred medical expense $ _____
28. Injured person's anticipated future medical expense $ _____
29. Injured person's incurred wage loss $ _____
30. Injured person's anticipated wage loss $ _____
31. Injured person's other expense $ _____

_____
person responsible for report

Exhibit V

UNIFORM CLAIMS REPORT INFORMATION DETAIL

Report each claim paid or closed during year within 15 days.

All fields are self explanatory except as follows. Leave code field blank where any of the following entries are not applicable or have been previously reported. Record all amounts in whole dollars only, all dates as MM YY and all ages (on date of occurrence) as YY.

2. Date of injury, report and reopening: Enter two digits each for month and year of occurrence and registration of incident as a claim (in the event of written notice of occurrence but no claim, leave report date blank). Enter date in field provided on reopened cases.

4. Profession or business code: 1) physicians and surgeons 2) hospitals 3) other medical professionals 4) other health care facilities. When 3 is entered, specify type of professional in addition. Enter specialty code (five digits) from ISO Common Statistical Base classifications. Enter type of practice code: 1) institutional 2) professional corporation or partnership 3) self-employed 4) employed physician 5) employed nurse 6) all other employees.

5. Indicate yes or no if an insured physician is board certified and/or a foreign medical graduate. Enter country in which primary medical education was received if other than the U.S.

6. Enter the appropriate code if the place where the injury occurred was in: 1) hospital 2) emergency room 3) out-patient facility 4) nursing home 5) office 6) patient's home.

9. Enter the total number of defendants (persons and institutions other than John Does) involved in claim. Enter the appropriate code if a derivative claim (on behalf of someone other than the medically injured) was made by: 1) spouse 2) children 3) parent 4) personal representative.

14. Use nomenclature and/or descriptions for the final diagnosis (actual abnormal condition), procedures and injury. Include methods of anesthesia; or name of drug used for treatment, with detail of administration and type of adverse effect where applicable.

16. Enter one digit code for severity of injury from scale provided below.

17. Enter the appropriate misadventure code if the procedure was: 1) not adequately indicated 2) contraindicated 3) there was a more appropriate alternative 4) delayed 5) improperly performed 6) not performed 7) occasioned by misdiagnosis. Enter the appropriate code if the following misadventures in diagnosis caused or aggravated the injury: 1) delay in diagnosis 2) misdiagnosis of the abnormal condition 3) misdiagnosis in the absence of an abnormal condition.

18. Enter the appropriate code(s) if any other person (s) caused or contributed to the injury: 1) attending physician 2) house staff 3) consultant 4) nurse R.N. 5) nurse L.P.N. or L.V.N. 6) aide 7) orderly 8) pharmacist 9) radiologist 10) radiology technician 11) anesthesiologist 12) anesthetist 13) pathologist 14) laboratory technician 15) physician's assistant 16) O.R.technician 17) physical therapist 18) inhalation therapist 19) other therapists 20) other technicians 21) dietitian 22) maintenance personnel 23) engineer 24) administrator 25) other personnel 26) patient.

18. Enter the appropriate code(s) if one or more of the following factors were associated issues in the claim: 1) abandonment 2) premature discharge from institution 3) false imprisonment 4) lack or delay of consultation 5) lack of supervision 6) breach of confidentiality 7) failure to prevent an abnormal condition 8) failure to accomplish intended result 9) failure to conform with regulation or statutory rule 10) lack of adequate facilities or equipment 11) laboratory error 12) pharmacy error 13) products liability 14) failure to timely disclose 15) failure to provide warning instructions 16) lack of consent from proper person 17) inadequate information for informed consent 18) procedure exceeded consensual understanding.

18. Coverage code: 1) claims made - basic 2) claims made - tail 3) occurrence.

20. Enter the appropriate type settlement code: 1) before trial 2) during trial 3) after trial but before verdict 4) after judgment 5) claim or suit abandoned by plaintiff 6) by review panel.

20. Enter the appropriate trial disposition code: 1) directed verdict for plaintiff 2) directed verdict for defendant 3) judgment notwithstanding the verdict for the plaintiff 4) judgment notwithstanding the verdict for the defendant 5) judgment for the plaintiff 6) judgment for the defendant 7) mistrial 8) non-suit 9) all other. Indicate yes or no if the claim disposition was by binding arbitration.

	Severity of Injury Scale	Examples
	1) Emotional only	Fright, no physical damage.
Temporary	2) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
	3) Minor	Infections, misset fracture, fall in hospital. Recovery delayed.
	4) Major	Burns, surgical material left, drug side-effect, brain damage. Recovery delayed.
	5) Minor	Loss of fingers, loss or damage to organs. Include non-disabling injuries.
Permanent	6) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
	7) Major	Paraplegia, blindness, loss of two limbs, brain damage.
	8) Grave	Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
	9) Death	

MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIMS REPORT SUPPLEMENT

File one report for each defendant insured by filing insurer. Include claims closed without payment.

Complete for Closed Claims Only

32. Misdiagnosis, if any _____

33. Cause of error in diagnosis _____ Delay in diagnosis _____

34. Anesthesia as cause of injury _____ Drug injury _____

35. Drug name _____

36. Aggravation of injury _____ Incomplete treatment _____ End result prognosis ____

37. Institutions: Location of injury _____ Conduct of responsible person _____ Mechanism _____

38. Date of admission _____ Date of discharge _____

39. Claim file identification _____

SUPPLEMENT INFORMATION DETAIL

Entries in this supplement will be used for a separate report. In many instances these entries will be duplications of information provided in the uniform claims report and are to be construed as such, rather than being additive.

32. Use nomenclature and/or descriptions to enter misdiagnosis, if any, of patient's true condition for which treatment was sought or rendered.

33. Enter the appropriate code if any error in diagnosis was due to: 1) an inadequate history 2) an inadequate physical examination 3) improper performance of diagnostic tests or x-rays 4) misinterpretation of diagnostic tests or x-rays 5) misinterpretation of information acquired by history or physical examination.

33. Enter the appropriate code if a delay in diagnosis, causing the injury, was due to: 1) an incorrect diagnosis, or 2) no diagnosis.

34. Where an anesthesia procedure caused the injury, enter the appropriate code(s) for the type (or combinations thereof) of anesthesia used: 1) inhalation 2) intravenous 3) muscle relaxant 4) spinal 5) epidural 6) regional nerve block 7) peripheral nerve block 8) sympathetic nerve block 9) topical, eye 10) other topical 11) acupuncture 12) local.

34. Enter the appropriate code if the injury caused by a drug was due to: 1) overdose 2) inadequate dose 3) improper route of administration 4) improper method of administration 5) adverse interaction with another drug 6) allergic reaction 7) wrong drug 8) wrong patient.

35. Enter the name of the drug causing the injury, if any.

36. Enter the appropriate code if there was an aggravation of the principal injury by 1) a delay in diagnosis or 2) improper treatment of it. Enter the appropriate code if the injury resulted from incomplete 1) cure or 2) removal of the original abnormal condition.

36. Use the appropriate code to enter the prognosis of the end result of injury at the time of closing the claim file: 1) no injury 2) temporary and corrected 3) brain damage only, temporary 4) temporary but not yet corrected 5) permanent but not disabling 6) brain damage only, permanent 7) permanent and disabling 8) alive but fatal prognosis 9) death.

37. Enter the appropriate code if the location of the injury within an institution or hospital was: 1) patient's room 2) patient's bathroom 3) hallway 4) stairway 5) elevator 6) labor and delivery room 7) operating suite 8) recovery room 9) critical care unit 10) intermediate care unit 11) special procedure room 12) nursery 13) radiology department 14) laboratory 15) emergency room 16) outpatient department 17) physical therapy department 18) dining room.

37. Enter the appropriate code to describe the conduct of the person responsible for the injury in an institution: 1) inadequate assessment 2) misidentification of patient 3) delay in notifying physician 4) failure to notice improper order 5) failure to obtain proper order 6) failure to instruct patient 7) improper protection of patient 8) failure to use side rails 9) failure to use restraints 10) failure to maintain floors.

37. Enter the appropriate code(s) if the mechanism by which an institutional injury occurred was: 1) drug or fluid administration technique 2) blood administration 3) obtaining specimen 4) insertion or management of tube or drain 5) position of patient 6) transportation
Fall: 7) from bed 8) from table 9) from chair or stool 10) while walking or standing 11) in tub or shower.
Infection control techniques: 12) sterilization of equipment 13) skin preparation 14) aseptic technique 15) isolation.
Monitoring of patient's signs: 16) vital signs 17) cardiac system 18) neurologic system 19) renal system 20) respiratory system 21) labor 22) fetus.
Maintenance and operation of equipment: 23) emergency equipment 24) cooling devices 25) heating devices 26) cautery 27) x-ray 28) radiation therapy 29) traction 30) anesthesia 31) operative equipment 32) surgical instrumentation and materials 33) food preparation 34) laboratory.
Laboratory: 35) mislabeling 36) computation error 37) inadequate specimen 38) lost specimen 39) interpretation 40) reporting error 41) delay in reporting.

38. Enter dates of admission and discharge from an institution as: DD MM YY.

39. Enter same claim file identification as in question number one (1) of U.C.R. (Uniform Claims Report).

LIST OF SUBCOMMITTEES TO BE APPOINTED TO STUDY
THE FOLLOWING SPECIFIC AREAS AND MATTERS RELATED TO MEDICAL MALPRACTICE INSURANCE
IN THE STATE OF KANSAS:

1. Subcommittee on Re-evaluation, Re-licensure and Re-certification of Health-care Providers
2. Subcommittee to Study Peer Review
3. Subcommittee to Study Prevention of Medical Injuries
4. Subcommittee to Study Grievance Procedures
5. Subcommittee to Study Patient/Health-Care Provider Relationships
6. Subcommittee to Study Arbitration
7. Subcommittee to Study Claims Review
8. Subcommittee to Study the Ad Damnum Clause
9. Subcommittee to Study Contingency Fees
10. Subcommittee to Study Informed Consent
11. Subcommittee to Study the Kansas Statutes of Limitations

Attachment R

MEDICAL MALPRACTICE AND PROFESSIONAL LIABILITY INSURANCE IN THE STATE OF KANSAS

FLETCHER BELL
COMMISSIONER OF INSURANCE
STATE OF KANSAS

MARCH 14, 1975

TABLE OF CONTENTS

I.

INTRODUCTION

The deterioration of the Kansas medical malpractice and professional liability market during the last six months will ultimately affect the health care facilities and costs in the state of Kansas if the physician, surgeon and hospital cannot obtain adequate insurance coverage at reasonable rates. That is, the citizens of Kansas could conceivably suffer from lack of adequate numbers of health care providers and/or higher health care costs. These potential results require immediate action to be taken by the various disciplines which can resolve the problems that have created the steadily increasing amount of exposure to malpractice claims by physicians, surgeons and hospitals. Resolution of these problems cannot be the sole responsibility of those directly involved in the functional aspects of the insurance mechanism. Other disciplines such as the Kansas Medical Society, Kansas Hospital Association, and Kansas legal profession must accept their responsibility and, with the assistance of the Kansas legislature, make a concerted effort to correct problems wherever they might exist.

Historically, Kansas has not been subject to some of the more severe malpractice and professional liability problems which have occurred in other states during the last 10 - 15 years; i.e., while the current market situation in Kansas is deteriorating, what we are facing now has repeatedly occurred in other states. This fact does not make the solution any easier. Non-availability of these important insurance

coverages is nationwide and there does not appear to be an easy solution in any state.

This report is intended to summarize the findings of this Department's investigation of medical malpractice and professional liability insurance. The information contained herein presents the most current data available to this Department.

In Section II, an overview of the Kansas medical malpractice insurance market is provided. In the third section, the various causes of the medical malpractice problem in general are reviewed. This is followed by a series of implications as to what the continued restrictions of availability and increased costs of medical malpractice insurance will have on the health care industry in the state of Kansas in the fourth section. A final summary section is also provided.

II.

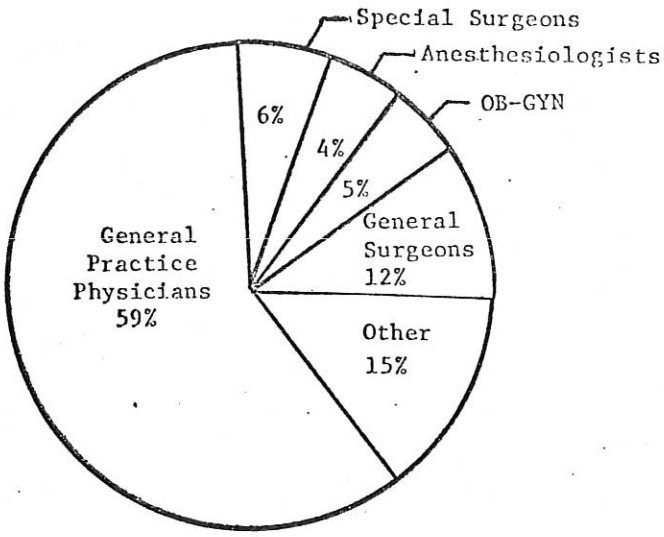
MEDICAL MALPRACTICE AND PROFESSIONAL LIABILITY INSURANCE IN KANSAS

Based on information furnished this Department it is estimated that there were approximately 2,500 physicians and surgeons purchasing approximately $2,000,000 of insurance coverage in 1974 from approximately 15 insurance companies licensed to do business in this state. According to statistics contained in the 1973 report of the Secretary's Commission on Medical Malpractice, the estimated Kansas premium volume represents only 0.7% of the national total of premium collected.* These facts are depicted in Charts 1 and 2 below.

CHART 1

Number of Medical Practitioners in Kansas

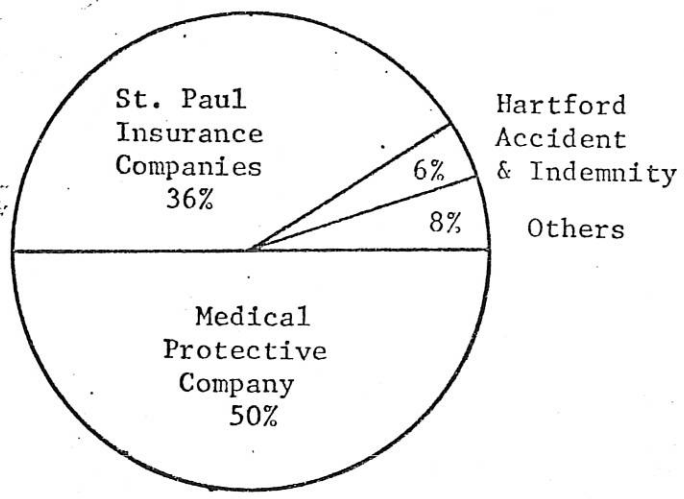
Total Number: 2,500



*Mark Kendell and John Haldi, "The Medical Malpractice Insurance Market," Appendix to the Report of the Secretary's Commission on Malpractice, Washington: DHEW, 1973, pp 530.

CHART 2

Number of Insurance Companies Providing Medical Malpractice Insurance in Kansas



Approximate Total Number of Insurance Companies: 15

Since rates (price) for these lines of insurance have been continually emphasized by the news media, it is important to note that Kansas has the 37th lowest rate out of states compared in the following Table:

TABLE I

RATE COMPARISONS - STATE BY STATE
FOR THE ST. PAUL INSURANCE COMPANIES

Ranking of States and D.C., 1975 vs. 1970

(Rates in effect January 1, 1975 for $100,000/$300,000 liability limits for the lowest rating classification and for the highest)(1)

1975 Ranking & State	1975 Class 1 Rate	1970 Class 1 Rate	1975 Class 5 Rate	1970 Class 5 Rate
1. New York(2)	$1,763	$619	(3)(4)$14,390/$21,584/$17,988	$5,477
2. California(2)	1,539	831	(3) 7,826/ 12,522/ 9,392	5,254
3. Michigan	1,411	396	8,830	2,892
4. Florida	1,217	493	(4) 7,702	3,119
5. Texas	1,082	155	(4) 6,772	1,304
6. Ohio	922	305	(3) 4,707/ 7,532/ 5,648	1,928
7. So. Dakota	788	126	(3) 4,017/ 6,428/ 4,821	794
8. New Jersey	705	389	4,463	2,457
9. Arizona(2)	679	475	(3) 3,469/ 5,550/ 4,162	2,998
10. New Mexico	675	311	4,241	1,966

1975 Ranking & State	1975 Class 1 Rate	1970 Class 1 Rate	1975 Class 5 Rate	1970 Class 5 Rate
11. Illinois	667	212	4,208	1,342
12. Nevada(2)	655	365	4,139	2,306
13. Wisconsin	629	194	(3) 3,207/ 5,133/ 3,850	1,229
14. D.C.	599	218	3,790	1,380
14. Indiana	599	185	(3) 3,555/ 5,689/ 4,267	1,172
15. Kentucky	577	216	(3) 2,940/ 4,704/ 3,528	1,361
16. Montana	559	425	(3) 2,853/ 4,566/ 3,425	2,684
17. Washington	558	293	3,518	1,852
18. Colorado	548	377	3,429	2,381
19. Missouri	540	191	(4) 3,421	1,210
20. Utah	504	275	3,189Median	1,731
21. Hawaii(2)	502	215	3,140	1,361
22. Maine	501	132	(3) 2,552/ 4,083/ 3,061	832
23. Oregon	484	189	3,023	1,010
24. Iowa	471	185Median	2,979	1,172Median
25. Louisiana	469	155	2,924	777
25. Massachusetts	469Med.	119	3,060	622
26. W. Virginia(2)	467	170	(3) 2,410/$ 3,856/$ 2,892	1,077
27. Idaho(2)	459	212	(3) 2,342/ 3,748/ 2,810	1,342
28. Connecticut	454	251	(3) 2,320/ 3,712/ 2,783	1,588
29. Virginia	433	135	(4) 2,728	824
30. Vermont	413	114	2,116	492
31. Nebraska	410	152	2,586	964
32. Alaska	398	248	2,514	1,569
33. Tennessee	383	148	(3) 1,955/$ 3,128/$ 2,347	738
34. Arkansas	373	266	2,557	1,682
35. Maryland(2)	360	163	(4) 2,273	816
36. Minnesota	347	144	2,196	726
37. Kansas	341	170	2,756	1,077
38. Oklahoma	296	256	1,871	1,282
39. Wyoming	286	120	(3) 1,459/ 2,335/ 1,751	756
40. Georgia	285	152	1,530	571
41. Alabama	275	147	1,738	926
42. North Dakota	224	120	(3) 1,137/ 1,819/ 1,365	756
43. Rhode Island	215	85	1,209	479
44. Pennsylvania	206	206	(4) 2,207	2,208
45. Delaware(2)	185	185Median	1,172	1,172
46. North Carolina	172	78	857	389
47. South Carolina	160	93	1,010	586
48. Mississippi	146	102	924	650
49. New Hampshire	98	65	486	324

(1) The rates that The St. Paul charges for medical malpractice insurance increased an average of 64 percent in 44 states and D.C. in 1974.

(2) The St. Paul either does not market malpractice insurance in this state or writes a negligible amount, not necessarily because the state has an unusually poor claims climate, but for a variety of reasons.

(3) First rate is for anesthesiologists and otolaryngologists (with plastic surgery); second rate is for neurosurgeons and orthopedic surgeons and third rate is for obstetrics-gynecologists and plastic surgeons.

(4) Florida, Maryland, Missouri, New York, Pennsylvania, Texas and Virginia have more than one rating territory. The rates shown for these states are the highest ones charged.

Source: Data submitted by The St. Paul Insurance Companies.

From the above table it is apparent that "excessively" high rates for the average Kansas medical practitioner do not currently exist. Conversely, the relatively low Kansas rates are not the reason for the insurance companies' reluctance to increase their participation in the Kansas market since many insurance companies have indicated that they would not provide coverage for additional doctors at any rate.

The reluctance of insurance companies to write additional doctors has been stated as being the direct result of steadily increasing malpractice claims settlement costs and claims frequency potential as indicated in Tables 2 and 3 below:

TABLE 2

Countrywide Record of Medical Malpractice Payments

Medical Protective Company

Dollar Amount of Claims	1963	1968	1973	1974*
$10,000 to 50,000	$529,000 (30)	$2,638,000 (99)	$10,268,992 (310)	$6,277,000 (134)
$50,000 to 100,000		$ 854,000 (12)	$ 5,656,000 (64)	$4,131,000 (41)
Over $100,000		$1,000,000 (1)	$ 2,468,000 (19)	$2,861,000 (21)
Total	$529,000 (30)	$4,492,000 (112)	$18,392,992 (393)	$13,269,000 (196)

*First six months only.

Number of claims shown in parenthesis.

Source: Figures from "Best's Insurance News Digest," edition date unknown.

TABLE 3

Countrywide Record of Medical Malpractice Claims

St. Paul Fire and Marine Insurance Company

	1969	1970	1971	1972	1973	1974*
Number of Claims Pending	2,115	2,434	2,961	3,687	4,348	5,015
Average Reserve Per Claim	$6,705	$7,746	$8,395	$9,021	$11,057	$12,534
Doctors With Pending Claims	1 in 23	1 in 21	1 in 18	1 in 15	1 in 13	1 in 10

*First nine months only.

Source: Figures reprinted from "Malpractice Digest," copyright 1974, St. Paul Fire and Marine Insurance Company.

In view of the fact that the above tables are based on countrywide data and may not properly represent the actual Kansas situation, the statewide information presented in Table 4 not available prior to this date must be considered.

TABLE 4

Kansas Medical Malpractice Claims

(Data compiled from results of Department Bulletin 1975-1*)

	1969	1970	1971	1972	1973
Number of Claims	55	77	101	86	104
Number of Doctors	1,782	1,873	1,912	1,939	1,900
Ratio of Claims Per Doctors	1 in 33	1 in 24	1 in 19	1 in 23	1 in 18

*Not all companies responding to this bulletin provided sufficient information and these composite figures represent data furnished from 9 of the 15 companies reporting malpractice experience in this state. These figures represent approximately 75% of the Kansas malpractice business.

Consideration must be given to the amount of Kansas premium dollars collected and the amount of dollars paid out because of malpractice losses in the state of Kansas in order to determine whether or not the countrywide data shown in Tables 2 and 3 apply to Kansas. Although this information may be subject to some degree of unknown deviation, it is the best known data available and is presented in the following Tables:

TABLE 5

Kansas Medical Malpractice Experience

Five Year Totals

A. Companies** Reporting Experience on Basic Limits Premiums and Losses:

(1) Premiums	(2) Paid Losses	(3) Incurred Losses*	(4) Paid Loss Ratio (2 ÷ 1)	(5) Incurred Loss Ratio (3 ÷ 1)
$3,751,378	$867,444	$1,408,456	.231	.375

B. Companies*** Reporting Experience on Total Limits Premiums and Losses:

(1) Premiums	(2) Paid Losses	(3) Incurred Losses*	(4) Paid Loss Ratio (2 ÷ 1)	(5) Incurred Loss Ratio (3 ÷ 1)
$4,326,980	$357,978	$2,610,978	.083	.603

* Incurred losses are defined as the paid losses and amounts reserved for unsettled claims.

** Figures shown were reported by two companies.

*** Figures shown were reported by eleven companies.

NOTE: Statistical information reported by two companies could not be included because detailed data was not available.

SOURCE: Results of Department Bulletin 1975-1.

Loss ratios shown in columns (4) and (5) of the above tables reflect only the known losses and claims; that is, future claims arising from occurrences of malpractice during the five years reported in these tables are not recognized. This type of claim is commonly referred to as "incurred but not reported" or the "long tail" of medical malpractice and professional liability insurance. Some recognition must be given to the unknown "long tail" of claims to be reported since the data contained in Tables 5A and 5B are inclusive of policy years as late as 1973 and 1974. Table 6 contains information provided by The Medical Protective Company and reflects the percentage of claims reported for each year after the expiration of the policy year; i.e., the pattern effect of the "long tail" of medical malpractice insurance.

TABLE 6

Kansas Claims Experience

(Based on claims experience during the period between 1-6-65 and 12-31-74)

Claims Reported During:	
The policy year	7.1%
The second year	31.6%
The third year	37.0%
The fourth year	15.0%
The fifth year	4.0%
The sixth year	1.4%
The seventh year	0.8%
After more than seven years	3.1%

Due to the number of companies reporting the information contained in Tables 5A and 5B, it is impossible to make the necessary adjustments for the "long tail" of medical malpractice insurance to such information. In order that an idea of how the application of the "long tail" of

malpractice claims may be applied, however, the following tables are provided. (These tables are based upon the latest rate filing of the St. Paul Insurance Companies submitted to this Department on November 4, 1974.)

TABLE 7

Kansas Medical Malpractice Experience

(from St. Paul Insurance Companies rate filing dated 11-4-74)

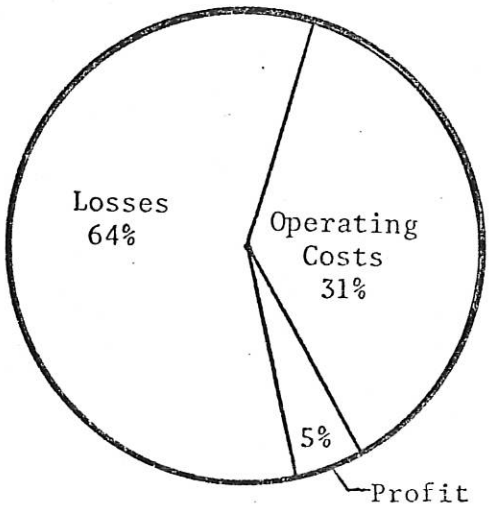
Policy Year	Premium	Incurred Losses*	Projected "Long Tail" Losses Not Yet Reported**	Total Loss Ratio
1969	$168,623	$158,940	-0-	.939
1970	189,086	101,522	$ 3,290	.554
1971	348,144	403,542	22,403	1.224
1972	585,911	196,736	263,220	.785
1973	668,178	447,694	571,493	1.525
	$1,959,942	$1,307,956	$860,406	1.1106

* These figures are representative of similar figures contained in column (3) of Tables 5A and 5B.

** Although these figures are based only on the St. Paul Insurance Companies' experience, similar projections are made by other companies.

CHART 3

Expected Distribution of The Kansas Premium Dollar For Medical Malpractice Insurance



Note: This represents the budgeted rate-making projection and the expected or budgeted profit margin may not be realized.

Source: Data furnished by insurance companies writing medical malpractice insurance in Kansas.

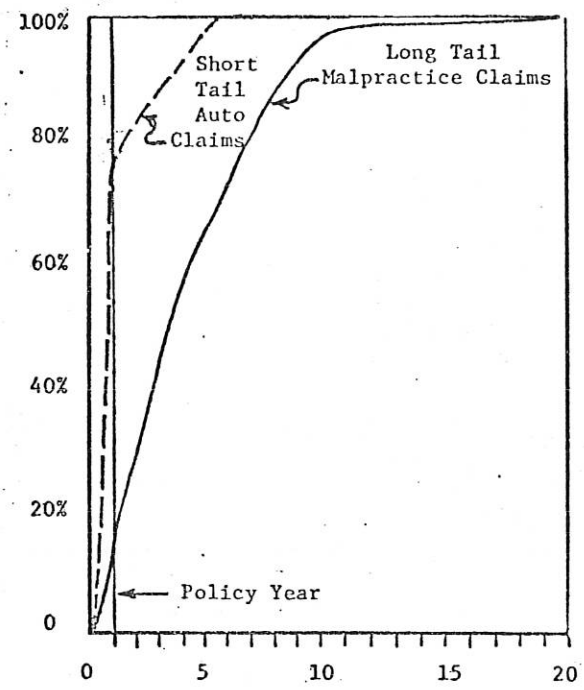
Comparison of Tables 5A and 5B with Table 7 presents a most perplexing problem. That is, since recent experience data reflects only the known claims information, projections or trending must be permitted in order to include the unknown claims which may develop in the future.

The information contained in Tables 5 through 7 is being provided only in general terms regarding the implication of the "long tail" or "incurred but not reported" claims which may arise from the application of the statutes of limitations. These statutes contain a discovery rule which permit an injured person to file an action within two years after discovery of the injury (not to exceed ten years after the act giving rise to the cause of the action). The two year limitation does not begin to run in the case of a minor until the age of majority is attained. The following chart, in conjunction with Table 6, depicts the "long tail" of malpractice claims and provides a comparison with similar experience for automobile losses (on a national basis):

CHART 4

Long Tail of Malpractice

Comparison of Age of Auto Claims with Age of Medical Malpractice Claims



Years from Incident to Closing of Files in 1970
All Incidents Occur in the Policy Year

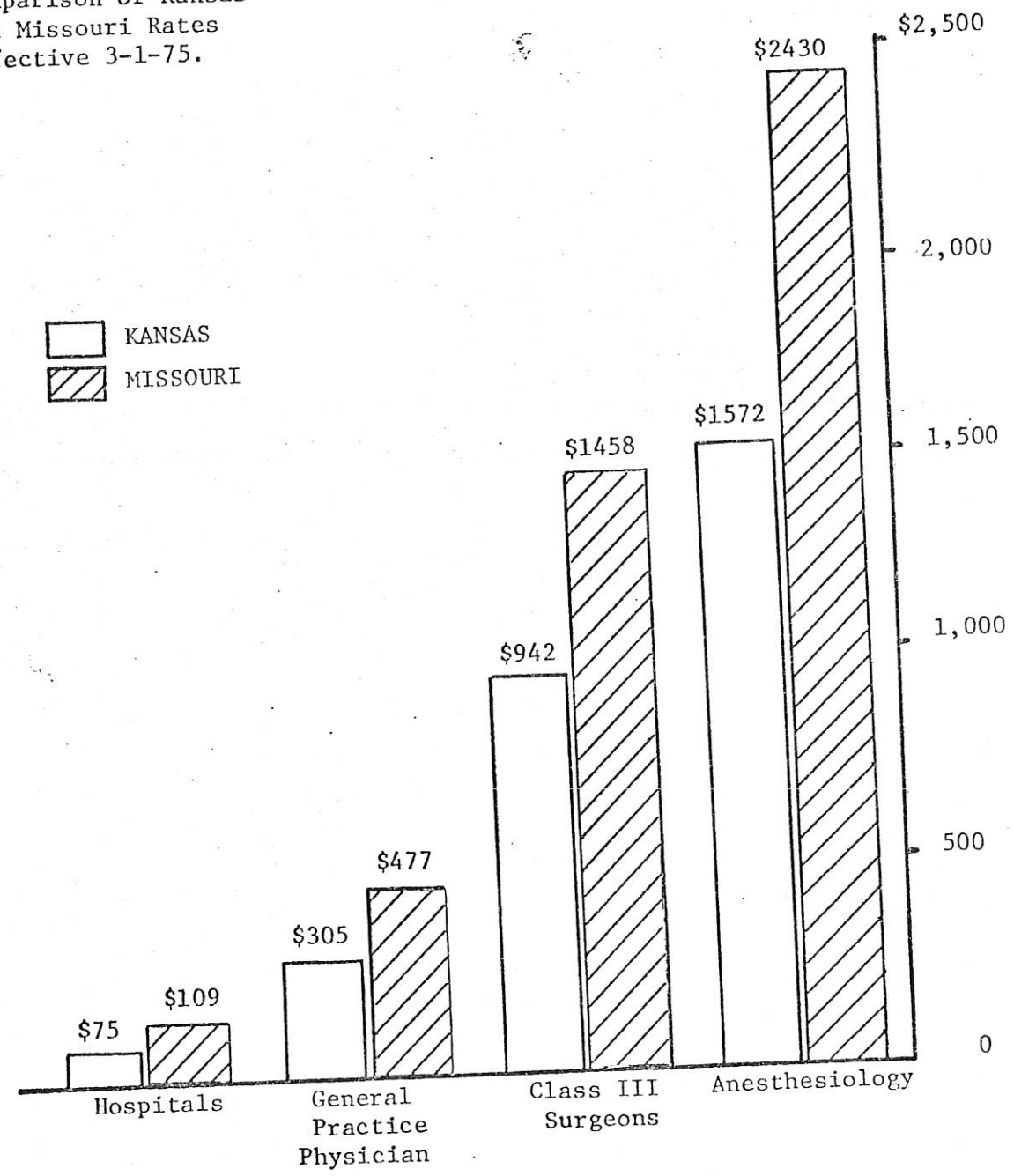
Source: Report of Secretary's Commission on Medical Malpractice, dated 1-16-73, page 42.

Conclusive Kansas data has not been provided by all companies to indicate that the "long tail" of malpractice insurance has similar effects in the state of Kansas; however, Kansas statutes of limitations are sufficiently broad to accomodate the "long tail" type of claim.

Charts 5 and 6, below, provide information concerning annual rates for medical malpractice and hospital professional liability insurance in the state of Kansas. The rates stated in these charts are for limits of liability of $100,000/$300,000, except for hospitals for which the stated rate is on a per bed basis at $25,000/$75,000 limits of liability.

CHART 5

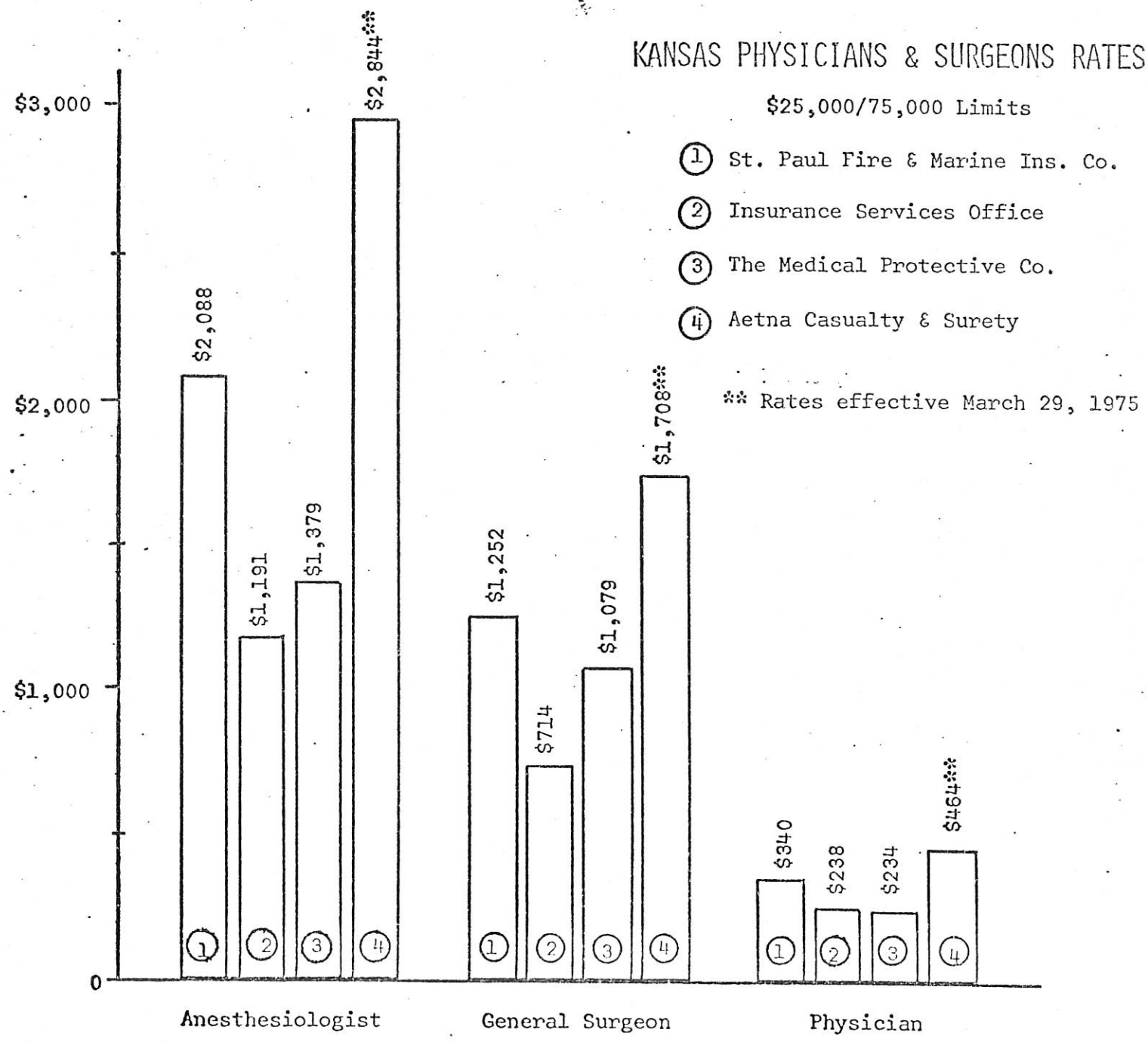
Comparison of Kansas and Missouri Rates Effective 3-1-75.



Source: Current rates for members and subscribers of the Insurance Services Office (a rating organization authorized by its members and subscriber companies to file rates on their behalf.)

CHART 6

Comparison of Company Rates for
Medical Malpractice Rates - Kansas.



III.

CAUSES OF THE MEDICAL MALPRACTICE AND PROFESSIONAL LIABILITY INSURANCE PROBLEMS

Specific data which isolates the exact causes of companies' inability to provide market stability in Kansas is not currently available; however, three general reasons can be given at this time:

First, the unfavorable loss experience of the insurance companies on a national basis. During the past decade, not only have claims settlement costs risen, but the number of claims has also steadily increased.

Second, changes in the general public's attitudes and legal opinions have contributed to an increase in the number of malpractice claims.

Third, the economy of recent years has presented unique circumstances wherein the insurance companies are faced with paying today's losses from premiums collected three to five years (or more) ago. Inflation has taken its toll and is certainly partially responsible for a portion of the higher claims costs.

These general reasons are exclusive, of course, of the inherent cause of all malpractice claims which is injuries suffered by patients.

IV.

IMPLICATIONS

IMPLICATIONS ON KANSAS HEALTH CARE FACILITIES AND COSTS:

Spiraling rate increases for physicians, surgeons and hospitals will ultimately result in higher health care costs for the residents of the state of Kansas. The medical providers can pass their insurance costs on to their patients in the form of higher charges for services rendered. In view of this, the health care providers are, at this time, primarily concerned with the continuity of availability of their insurance programs - cost of such coverage is only secondary.

Physicians and surgeons faced with the non-availability of adequate insurance coverage have, in a few instances, advised this Department that if coverage cannot be obtained, they will discontinue their practice in this state. Therefore, the magnitude of the problem cannot be measured in only dollars and cents. It is imperative that a viable insurance market be maintained in this state in order that the Kansas health care industry can expand, rather than contract.

IMPLICATIONS ON ATTRACTING NEW INSURANCE COMPANIES:

If the insurance companies which have traditionally provided current medical malpractice and professional liability market continue their restrictive underwriting positions, attraction of additional insurance companies into this market will be deterred. It is also conceivable

that these companies' attitudes have recently spread to the smaller companies (writing from 1 percent to 10 percent of the physicians and surgeons) and is adversely affecting their decisions to remain in the market.

The traditional providers of these essential lines of insurance must provide positive attitudes in order to attract additional insurance companies to participate in the Kansas medical malpractice and professional liability market.

IMPLICATIONS ON THE VOLUNTARY MEDICAL MALPRACTICE AND PROFESSIONAL LIABILITY INSURANCE MARKET:

Over the years a few companies have developed the degree of specialization required by their insured doctors and hospitals. It would be unfortunate if companies not familiar with medical malpractice and professional liability insurance were forced into providing these programs of insurance because continuity of availability had to be provided through some type of a pooling mechanism. It is the desire of the Kansas Insurance Department that the voluntary providers of these essential programs of insurance be given every possible opportunity to correct the availability problems; however, failing to do so will only result in the implementation of a Department initiated solution - such as an assigned risk program or some other pooling arrangement.

IMPLICATIONS ON MAINTENANCE OF ADEQUATE
PROFESSIONAL STANDARDS FOR HEALTH CARE PROVIDERS:

Responsible agencies and/or associations for the licensure of Kansas physicians, surgeons, hospitals and other health care providers must accept the responsibility of exercising reasonable actions which will assure that the highest degree of professional competency is maintained. It is imperative that insurance companies providing these essential programs of insurance are assured that the individual health care providers maintain professional standards. Just as the medical practitioner deserves the financial protection of professional liability insurance, the insurance company assuming the medical practitioner's risk deserves the assurance that the medical practitioner has and will maintain the necessary knowledge and skills required by the profession. It is also imperative that the individual served by the medical practitioner be assured that the Kansas health care profession, individually and collectively, maintain the highest degree of professional competency.

Presently there does not appear to be any formal procedures for the re-certification of physicians and surgeons in the state of Kansas. Insurance companies are often requested to issue insurance policies to individuals licensed and board certified prior to 1955.

These conditions require insurance companies to decide independently whether a medical practitioner with prior claims experience is to be renewed or cancelled. Appropriate actions should be initiated by the Kansas Medical Society and the Kansas Board of Healing Arts to alleviate or resolve the continuation of these conditions.

V.

SUMMARY AND CONCLUSIONS

The problems which have resulted in the non-availability of medical malpractice and professional liability insurance in this state are apparently related to difficulties encountered in states other than Kansas. Insurance companies currently providing these programs of insurance do not view the Kansas market as being immune to the country-wide trend toward increasing claims frequency and settlement costs.

Summarization of the current Kansas medical malpractice and professional liability market must start with recent informal commitments from the majority of the major insurance companies which have traditionally provided these essential coverages to not withdraw from the state of Kansas and continue to renew all existing individual policies whenever possible. Commitments were also received from these companies to provide coverage for the new physician and/or surgeon entering the Kansas market. The insurance companies are not, however, willing to provide coverage for any medical practitioner recently terminated or cancelled by another insurer. This latter provision will create severe problems for the individual medical practitioner with multiple claims if the insurance coverage is terminated by his existing insurance company. This is apparent since accomodation in the non-admitted market (e.g., Lloyds of London) is very restrictive at this time. It is important to note that insurance coverage for this type of individual medical practitioner with multiple claims experience would have been terminated even in a normal medical

malpractice and professional liability market. Restrictions in the availability in the non-admitted market are not correctable by any Insurance Department initiated action.

Throughout recent months, this Department has been confronted with numerous inquiries from individual physicians, surgeons and hospitals regarding non-availability problems encountered. For the most part, these individuals were assisted by this Department in locating the desired coverages on a one-to-one basis; however, certain individuals with prior claims history were not afforded coverage and could not be assisted by this Department. Although it might appear that higher rates for these programs of insurance would resolve the availability problems, this Department has been informed, and experience is indicating, that additional or higher rates will not induce availability. This is the paradox - as malpractice rates have increased, availability has nevertheless decreased.

In addition to individual contacts, this Department has been informed that some individual medical practitioners have ceased their practice in Kansas because adequate insurance coverage was not available.

The malpractice problem, in general, appears to result from three underlying causes: unfavorable loss experience on a national basis, changing public attitudes and general economic changes. Unfavorable loss experience on the national level is apparently due to increased claims frequency and settlement costs which result from patient injuries. These national

trends have not yet fully developed in this state; however, the Kansas market could develop similar claims and loss patterns in the future. The increased number of claims apparently stem from changing public attitudes which have resulted in the increased willingness of patients to utilize the legal system as a means of redressing cases of alleged malpractice.

In view of the demonstrated problems between the consumers and providers of medical malpractice and professional liability insurance, this Department has conducted meetings with representatives of the insurance companies, health care providers and legal profession in order that further deterioration of the Kansas market might be prevented. These meetings with the various parties have been productive in resolving the non-availability problem on a limited basis with respect to many individual and specific situations, but notwithstanding this fact, this Department's efforts to assure availability on a voluntary basis cannot be considered to be sufficiently successful to meet the requirements of all health care providers.

The possibility of the establishment of a pooling mechanism for the purpose of achieving enforced availability of malpractice and professional liability insurance for Kansas doctors and hospitals has been considered and this Department is in the initial stages of formulation of such a pooling mechanism to temporarily provide continuity of availability of these essential coverages. This appears to be one alternative available at this time.

The pooling mechanism is being developed under the authority of K.S.A. 40-2111; however, it is to be emphasized that such a mechanism will not provide a lasting solution to, or even address, the problems which have caused the current insurance companies' inability to maintain a stable market and rate structure. This is an important point. If a pool facility is established by this Department, such facility should only be considered temporary until more lasting solutions can be achieved.

Representatives of the Kansas Medical Society, Kansas Hospital Association and insurance companies believe that possible legislative revisions to statutes of limitations, arbitration, doctrine of Res Ipso Loquitur, law of informed consent, elimination of the Ad Damnum clauses in malpractice suits, etc., should be considered to provide a more equitable legal status for the medical practitioner and professional person (see Appendix I). In order to resolve these possible statutory matters, it is recommended that a legislative study committee be established to determine what, if any, statutory revisions should be made without endangering the rights of individual patients to be equitably compensated for their injuries.

Finally, if the need for legislative revisions is justified, then the Kansas Legislature should be receptive to the assumption of responsibility to assist in resolving any statutory inequities or deficiencies which might exist. The legislature should also consider the other issues involved, which include (1) providing a medico-legal environment which will attract physicians and surgeons; (2) the potential impact that the continued application of defensive medicine will have on the general

public's health care costs; and (3) the ultimate effect that continuing problems related to steadily increasing malpractice and professional liability rates and declining availability of adequate insurance coverage will have on the health care industry of this state. We are of the opinion that only a comprehensive large scale effort will permit us to develop lasting solutions to the problems facing Kansas citizens in the health care cost and delivery areas.

LEGISLATIVE REVISIONS CONTAINED IN THE REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE

The following legislative recommendations have been culled from the 1973 Report of the Secretary's Commission on Medical Malpractice (DHEW, January 16, 1973). These proposals are not being requested by this department per se.

Legislative revisions other than the following may be proposed and it is not this department's intent that these are the only matters which should be considered by the Kansas Legislature. The following comments do not represent the opinions of all effected parties and this was not the intent of this appendix.

Res Ipsa Loquitur

The Commission finds that the doctrine of res ipsa loquitur in its classical sense performs a useful purpose in common law, but that it should not be applied differently in medical malpractice cases than in other types of tort litigation. (Also, see Application of Legal Doctrines, page 2.)

Prior Notice - Statute of Limitations

The Commission recommends that state laws be amended to require that a written notice of intent to file a malpractice suit be given to the potential defendant within a specific time period prior to the running of the statute of limitations. Upon the filing of such notice, the statute of limitations would be automatically extended for a specified period, to enable the parties to negotiate an amicable settlement in good faith. (Also, see Application of Legal Doctrines, page 2.)

Ad Damnum

The Commission recommends that the states enact legislation eliminating inclusion of dollar amounts in ad damnum clauses in malpractice suits.

Contingency Fee

The Commission recommends that courts adopt appropriate rules and that all states enact legislation requiring a uniform graduated scale of contingent fee rates in all medical malpractice litigation. The contingent fee scale should be one in which the fee rate decreases as the recovery amount increases.

Application of Legal Doctrines

The Commission recommends that legal doctrines relating to the liability of health professionals should be applied in the same manner as they are applied to all classes of defendants, whether they be favorable or unfavorable to health professional defendants. Such doctrines would include (a) the application of the discovery rule under the statute of limitations; (b) the terms of the statute of limitations; (c) the application of the doctrine of res ipsa loquitur to injuries arising in the performance of professional services; (d) the rule allowing liability based on oral guarantee of good results, and (e) the doctrine of informed consent to treatment.

Qualified Immunity

The Commission recommends that the states enact legislation to provide qualified immunity to hospitals and members of hospital rescue teams while they are attempting to resuscitate any person who is in immediate danger of loss of life, provided good faith is exercised.

The Commission recommends that the states enact legislation designed to provide qualified immunity to physicians and other health care personnel who respond to emergencies arising from unexpected complications that arise in the course of medical treatment rendered by other physicians or other health care personnel.

The Commission recommends that all physicians who regularly practice in hospitals be encouraged, through continuing medical education, to become proficient in cardiac arrest and cardiopulmonary resuscitation techniques.

Informed Consent

The Commission finds that there is a generally recognized right of a patient to be told about the danger inherent in proposed medical treatment. That right is consistent with the nature of the doctor-patient relationship and with fundamental fairness. A much greater degree of communication between health care providers and patients is really good, basic medical practice and should be encouraged.

The Commission finds that the law relating to the nature of information which the health care provider must supply to obtain valid consent for treatment is presently in flux. Adoption of uniform standards requiring full disclosure of material risks would eliminate much confusion as to the basis and nature of informed consent. Under such standards, both patient and doctor would gain a clearer understanding of their respective rights and obligations.

The Commission recommends that a responsible member of the patient's family be given appropriate explanations where the physician is justifiably reluctant to explain such matters directly to the patient because of his concern that the explanation itself is likely to have an adverse effect on the patient.

The Commission finds that the doctrine of informed consent is subject to abuse when it imposes an unreasonable responsibility upon the physician.

Imposed Arbitration

The Commission recommends more widespread use of imposed arbitration as an alternative mode for resolving small medical malpractice disputes, providing the arbitration mechanisms have the following characteristics and do not preempt contractual arbitration agreements:

1. Arbitration statutes enacted by the States should be designed to give jurisdiction over all parties, plaintiffs and defendants, involved in a specific medical malpractice case.

2. State arbitration laws should set a maximum monetary limit for invoking the jurisdiction of the arbitration board, with cases demanding higher amounts being handled through the present jury system.

3. Arbitration panels should include some persons who are neither attorneys nor persons involved in the delivery of health care services.

4. There should be the right of trial de novo subsequent to arbitration in the highest level jury court in the State.

5. The State arbitration statute should provide economic and legal sanctions, in order to discourage subsequent trials de novo of questionable merit, (e.g., evidentiary rules, presumptions, taxation of court costs).

6. A fairly detailed synopsis of each arbitration decision should be made and published in order to establish precedents, provide information necessary to evaluate and improve the arbitration system, and provide adequate feedback information to the health care system.

7. Although the Commission has recommended that the results of formal arbitration proceedings be published, publicity focused on the names of parties involved in disputes should be avoided or minimized.

The Commission recommends that all States that have not adopted legislation to make binding arbitration awards possible enact such legislation.

COMPLAINTS RECEIVED FROM KANSAS DOCTORS REGARDING AVAILABILITY OF MEDICAL MALPRACTICE INSURANCE

This department has been requested to assist individuals of the following Kansas communities (since January 1, 1975):

Date	Location	Problem
1/03/75	Liberal, Ks.	New physician desiring to practice - referred agent to the regional agents for major insurance companies. Coverage then obtained.
1/09/75	Wichita, Ks.	Unable to locate coverage for new physician. Department assisted in obtaining the necessary coverage.
1/14/75	Topeka, Ks.	Emergency Room physician at Veterans Hospital unable to locate coverage - coverage obtained through local agents.
1/21/75	Arkansas City, Ks.	Possible termination of existing coverage. Department is currently attempting to resolve this matter.
1/27/75	Sterling, Ks.	New physicians at Sterling unable to locate coverage - Department will assist.
1/29/75	Wichita, Ks.	Ends residency in April - could not get companies to accept applications - referenced physician to the regional agents in K.C.
Other January calls: dates not recorded	Hutchinson, Ks.	New physician could not find coverage anywhere - department requested the insurance company writing the clinic to add the new physician onto the existing policy.
	Salina, Ks.	Coverage with existing insurance company. Department called K.C. agents of the major insurance companies - the hospital did not call back, so we assume coverage was offered and accepted.

Date	Location	Problem
	Topeka, Ks.	Physicians and surgeons facing possible termination of existing insurance policy. Matter not yet resolved.
2/6/75	Topeka, Ks.	Difficulties in maintaining excess insurance - department called company representatives and the matter is presently resolved.
2/7/75	Salina, Ks.	Called our attention to difficulties encountered in the Salina area - assistance not required at this time.
2/10/75	Topeka, Ks.	Problems with primary and excess insurance - matter still pending, but temporarily resolved.
2/12/75	Topeka/Wichita	Physician had difficulties in locating coverage - coverage offered at department request.
2/12/75	St. Marys, Ks.	Coverage for new physician could not be obtained - coverage offered at request of department.
2/12/75	Wichita, Ks.	Individual reports physicians are leaving Wichita area because coverage is not available - department advised individual to direct such physicians to this department for assistance.
2/14/75	Wichita, Ks.	Agent for several physicians and surgeons having difficulty in locating and maintaining insurance. Department requested specific problems regarding their physicians.
2/20/75	Quinter, Ks.	Physician could not locate coverage - department requested company assistance and coverage was afforded.
2/20/75	K.C., Ks.	Physicians existing company terminating coverage. Problem corrected by department action.
2/25/75	Wichita, Ks.	Coverage for new physician not available. Department obtained the assistance of insurance company and coverage was offered.

Date	Location	Problem
2/14/75	Leavenworth, Ks.	Two surgeon's existing coverage being terminated because of claims experience. No resolution at this date.
2/14/75	Wichita, Ks.	Surgeon experiencing difficulties in finding coverage because of claims history. Still pending.
2/17/75	Winfield, Ks.	Surgeon experiencing difficulties in finding coverage because of claims history. Still pending.

Approximately nine (9) other inquiries were made during January, a majority of which were resolved over the telephone and not recorded because they related to misunderstandings or misinformation between the individual and their insurance agent.

Approximately 10 to 15 other doctors (or their representatives) have contacted this department during February, but are not included above since the problems were resolved over the telephone without great difficulties.

In addition to the above physicians and surgeons, several individual hospitals have contacted this department for possible assistance. These hospitals' problems resulted primarily from the withdrawal of the Argonaut Insurance Company from the Hospital Professional Liability Insurance market - the Argonaut Insurance Company insured approximately five (5) hospitals in Kansas. During the recent months, this department has been requested to assist a 20 bed hospital in Westmoreland, Kansas and a major hospital complex in Wichita, Kansas. Other small hospitals have contacted this department for information regarding the availability of insurance coverage; however, our direct assistance was not required.

Attachment 5

KANSAS HOSPITAL ASSOCIATION

TESTIMONY BEFORE THE SPECIAL COMMITTEE ON MEDICAL MALPRACTICE

Wednesday, June 25, 1975

Mr. Chairman and Members of the Special Committee:

We appreciate the opportunity to appear before you on what we consider to be one of the most vital issues affecting the health field today. It is our intention to break our testimony into three parts. First, an expression of the severity of the problem; second, what we believe we in the health field can be doing to help solve some of the problems; and third, what we believe you folks in the Legislature can do towards alleviating the severity of the problem.

It may not be necessary for me to describe the severity of the problem, but I think a few statistics and figures will tend to put us on a common ground as we approach the problem that is not isolated to Kansas, but is nationwide. We have recognized the problems for a good many years. Actually, it began in 1956 when general-acute hospitals lost their immunity under the law through the Supreme Court decision here in Kansas. Insurance premiums took a marked increase immediately after that decision. It may surprise you to know that most hospitals were carrying malpractice insurance, even while they enjoyed the immunity. In 1959, we requested and the Legislature passed a bill limiting the liability of hospitals to the extent of its insurance. At that time, we committed our members to carrying a reasonable amount of medical malpractice insurance. This bill was declared unconstitutional a few years later, and once again, premiums increased. About ten years ago, in recognition of what we thought were serious problems then, a special committee of our Association on insurance explored and made

recommendations to our council and Board, which in turn acted to endorse the Argonaut Insurance Company, primarily for two reasons: (1) because of its reputed high caliber safety program in hospitals, and (2) to assure that coverage was available to the KHA member hospitals. For the next ten years after that, the problems faced by Kansas hospitals were isolated. We heard of hospitals receiving premium increases of say, 150%. We heard of problems of where there was difficulty in obtaining an umbrella-type coverage, but in the long run, these problems were resolved. It's only been in the last eighteen months that we have seen the situation worsen to the point where we feel that it is extremely severe. The withdrawal of the Argonaut Insurance Company from some fourteen states, including Kansas, even though it affected only five hospitals here in Kansas, seems to be the straw that broke the camel's back.

At that time, we began noticing, too, that other insurers were increasing premiums at a much faster pace. We invited the administrator of a hospital in Salina to appear before your Committee. His letter expressing regret at being unable to attend because of a regularly scheduled visit by the Joint Commission on Accreditation of Hospitals gave us some understanding of the current problem. That hospital had had its public and professional liability coverage with the same company for at least twenty-one years. Policies had always been written for a three-year period, with an anniversary date of March 30. The limits of liability afforded by the professional liability portion of the policy were, and are now, $100,000 per claim with a $300,000 ceiling on the aggregate. A few years ago, the Board of Directors of the hospital elected to purchase umbrella coverage

for professional liability in the amount of $1,000,000, and that policy was written by a different company. About six months before the expiration of that umbrella policy, the hospital elected to increase the limits of liability to $2,500,000, and the company accepted the responsibility. Then, this year, approximately one month before the anniversary date of the policies, they were informed by the company offering basic coverage of a sizable increase in the premium. All, or nearly all of it, was due to an increase in the professional liability coverage. They were asked to sign, and did, an application for rate in excess of standard, which was submitted to the Commissioner of Insurance of the State of Kansas. The amount of premium for the professional liability was increased 300%. The term was reduced from three years to one year. They were subsequently informed by the agent for the second company that the umbrella policy would not be renewed. He went on in his letter to say that their record of claims processed and awards for the period from July, 1969, through July, 1974, showed that three claims had been paid totaling something less than $13,000. In addition to the claims paid, the company's outside expenses totaled $785. Further, in addition to the cases upon which settlements had been rendered, the insurance company had reserved $2,000 for claim and expenses totaling $1,500, pending a possible suit arising from another alleged incident which occurred in January of 1974. In his letter he went ahead to describe the three claims which constituted the $13,000 settlement. He states that no claims were ever paid by the umbrella policy. In his two-page letter he stated that the recitation of claims was not intended to expose his ignorance as to the nature of insurance. He said that he realized that

the purpose of insurance was to spread the risk among many insureds. He felt, though, that if all insureds had similar experience, that the premium they were paying would certainly have been excessive and encouraged consideration of realistic limits of liability and discovery on time of incidents.

Another small county hospital in southeast Kansas reports that their premiums were increased by 300%, in spite of the fact that they had had no claim since 1916.

We, too, recognized that the risk must be spread. I am convinced, although I have no way of proving it, that the national factor is computed in a fashion which actually overloads the premiums in Kansas, with relation to the claim experience in Kansas. Another example of the problems we have observed down through the past ten years is the need for some hospitals to go to a higher deductible in their insurance protection. At least one, and I think two, Wichita hospitals went to a $5,000 deductible a number of years ago in the policy to cover the standard coverage up to a certain limitation, and then had to shop in the world market for their umbrella policy. One of those hospitals now advises it has encountered another problem. A group of 7 obstetricians serve on its faculty for medical interns and residents. Their insurance company is withdrawing from the market. This hospital happens to be one that was with Argonaut until this spring. After considerable shopping, it found another company--but with an over 400% increase. Now, it may have to add an additional premium in order to continue the educational program we all need so badly.

In cooperation with the State Insurance Department, we are now conducting a survey on increased premiums for professional liability insurance.

One of the things we are learning from the reports that have been returned at this point in time is that not all hospitals have yet realized the impact and won't until their existing term of coverage expires. From the 77 reports we have received to date, the average premium cost is something like 77¢ per patient day. This ranges from 12¢ to $2.77. Of 55 of the 77 reporting, there were no malpractice claims in the past five years, and very few large claims or potential ones. Less than five in the past five-year period reported claims exceeding $100,000.

Blue Cross is interested in the results of this survey as much as we are. They have analyzed the reports we have received to date. A representative of their actuarial staff is estimating that the increased liability insurance premiums will increase their hospital payments from 1% to 2% in 1975, and as much again in 1976. He compares this with the increased cost in California of from 5% to 10%. I think you all realize that this is not simply a problem in Kansas. As a matter of fact, it is more severe in some states than in others. The statistics being gathered by the California Hospital Association in their malpractice insurance program reflect these kinds of figures: For every 100 claims filed against the 400 hospitals in its malpractice insurance company, 33.3 are not pursued by the plaintiffs. 64.3 are settled before trial. Of the 3.4 that reach decision, 2.7 are won by the defense. It's the .7 of 1% that are mainly responsible for the soaring malpractice premiums. In another state, Michigan, a study by a consulting firm of 40% of the hospitals reveals that 60% of the paid claims come to less than $5,000. Only .8 of 1% of the paid claims are in excess of $100,000, but those claims account for

41% of the total amount paid to claimants. Moreover, they say it is anticipated that paid claims in excess of $100,000 will increase by 200% in 1975.

In preparation for this hearing, I read, among other things, a summary of the testimony presented by the President of the American Hospital Association before the Subcommittee on Health of the Senate Labor and Public Welfare Committee in Washington. He emphasized that this is a nationwide problem, but one which will undoubtedly require state-by-state solutions. Let me make reference to some of his comments.

He opened by acknowledging that hospitals recognize the legitimate concerns of patients, with regard to the possibility of accident or injury resulting directly from medical negligence or improper medical treatment, and that hospitals would not wish to eliminate the right of any patient so injured to seek just compensation. He made reference to the rapidly rising cost of malpractice professional liability insurance and the effect that this rising cost has on the overall cost of health care delivery. He made reference further to the potential for the unavailability of this kind of insurance coverage. He stated that the situation does not reflect a lowering of the quality of health care services delivered by doctors and hospitals. Many, in fact, he said, have commented on the irony that the great improvements in the overall quality of care and the rapid advances in medical science and technology are contributing to this problem because of increased awareness of what can be accomplished by doctors and hospitals, increased expectations on the part of the patient, and the resulting dissatisfaction with any result from a treatment that does not meet those expectations. He pointed to the unprecedented rate increases and the

withdrawal of certain insurance companies from the market. He referred to some hospitals having had premium increases in the last six months of as much as 700%. He cited the following as reasons for the deterioration of the hospital and physician malpractice/general liability insurance market place:

1. Public awareness of advances in medical science and life-saving techniques which have created in many instances an unrealistic expectation on the part of patients and their families, and to some degree, has made less personal the delivery of health care services.

2. Court litigation in the malpractice field has increasingly resulted in larger settlements and jury awards, with no real limitation yet in sight. Moreover, he said, some observers have argued that the contingency fee system, common under most retainer agreements, serves to increase the volume of this kind of litigation and the overall amount of individual claims.

3. Various statutes of limitations as they may apply to discovery of injuries or negligence lead to what is referred to as the industry's "long tail". Many claims are not made for years following the incident, leaving the carrier exposed to a lengthy period of liability--up to ten or fifteen years beyond the coverage period. It is precisely this period of uncertainty that requires the accumulation of substantial reserves in anticipation of potential claims.

4. A lack of clarity concerning the doctrine of informed consent and the absence of affirmative programs of patient education, which may contribute to misunderstanding and frustration.

5. Management of some casualty carriers is apparently not committed to a long-term future for this kind of underwriting. A combination of larger settlements, increased volume of claims, and a deterioration of value and income of investments have not created attractive business incentives in this area.

Mr. McMahon, the A.H.A. President, went on to say that whether the real cause of the current dilemma be one or some combination of the foregoing, the impact on the health delivery system and hospitals in particular is immediate and severe. The lack of available insurance could cause either a reduction of certain services or a complete termination of all services by an institution. Even if insurance is available, premium costs are consuming an ever-growing share of the health dollar at a time when we can ill-afford to commit our scarce resources in such a disproportionate manner. These added costs, he said, must be passed on to the purchasers of hospitals services, including the Government, and are coming at a time when hospitals are sincerely attempting to hold down costs to the consumer. While the problem for hospitals is serious, the problems of individual physicians and surgeons have recently moved the issue to a crisis stage. Already many physicians are having difficulty obtaining adequate coverage at a reasonable cost, and these developments could well force some to leave a particular area or to take early retirement from active practice

at a time when their services are critically needed.

Mr. McMahon went on and described possible solutions, both long-term and short-term, and made comments as far as what he thought would be appropriate for the Federal Congress to consider, and what portions of the solution should be left to the various states. Rather than go into detail on the suggestions he made to that committee, I think it would be appropriate now to call upon Jerry Jorgensen to describe what the Kansas Hospital Association feels is appropriate for hospitals to be doing to help solve these problems. Jerry is administrator of the Stormont-Vail Hospital here in Topeka and is now Chairman Elect of the Kansas Hospital Association Board of Directors.

# # # #

Frank L. Gentry
President
Kansas Hospital Association

Attachment F

JUN 5 1975

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-645-9400

June 6, 1975

TO: State Hospital Association Executives

SUBJECT: Malpractice Insurance Activities
Bulletin #1

Several important malpractice issues are covered in this memo, including--

1. Information concerning a national meeting on malpractice called jointly by AHA and AMA.

2. Some details on model malpractice statutes and the services AHA will be providing to you.

3. A summary of a recent meeting with the American Insurance Association along with a detailed analysis of the Joint Underwriting Association concept.

4. A report on the recent survey on malpractice legislation.

5. An update on the California situation.

AHA/AMA National Meeting

Awhile back the state associations were surveyed through our regional offices in regard to the interest in a national conference on malpractice jointly sponsored by AHA and AMA. The idea was to bring the state-level hospital and medical leadership together to consider mutual interests, strategies, and tactics in achieving substantive changes in the tort system and other areas that will help to resolve the malpractice cost problems. The state hospital associations were fairly universal in supporting the concept of such a meeting. AMA has agreed and July 9 will be the date for the conference. There are many details to be worked out in this regard, and I will communicate these to you shortly. In the meantime, please block out that date for this important meeting.

AHA Legislative Activities

In regard to AHA's activities and plans for seeking long-term solutions to the malpractice insurance problem, as you know we have retained Jim Ludlam of Musick, Peeler, and Garrett in Los Angeles as our special outside legal counsel. Jim and Jay Hedgepeth have been working on various model statutes that address tort system and other changes that can be carried out at the state level.

There are several "packages" in this regard in circulation already. In deciding the most appropriate role for AHA, however, we determined that it would be best for the Association to develop a comprehensive package of materials rather than put together a brief set of model statutes on a crash basis. Consequently, we will be sending you materials in loose-leaf notebook fashion. These materials will include model statutory language and/or general legislative guidelines on each of the key subject matters that can be addressed by state legislatures and others at the state level--for example, statute of limitations, limitations on liability, collateral sources, and so forth. In addition to some suggested language and broad guidelines on each of these areas, we will include references to relevant statutes or proposals in the other states and will also indicate, where appropriate, some of the pros and cons of moving in the particular direction being discussed. The loose-leaf notebook approach is essential, since we plan to keep these materials up to date on a continuing basis and there is a multitude of activity going on in the various states.

The first set of materials should be ready for mailing within two weeks and will include information on those items that we consider to be the most substantive in dealing with the problem. Other materials will be developed and sent to you on a continuing basis.

Clearly, the approach to the problem will vary on a state-to-state basis, and what will work or is feasible in one state will be inapplicable or unattainable in another. As a consequence, your local attorneys will have to make adaptations, additions, and deletions. Our hope is that the materials we do provide to you will serve as a comprehensive resource document, so that the best adaptations can be made at the state level. If the need arises for some further discussion with either Jim Ludlam or Jay Hedgepeth, you should consider one of two approaches: (1) questions of interpretation or information that can be easily handled can go directly to Jay or Jim; (2) if more extensive reaction is required, you or your attorney should send your request in writing to Jay or to Jim. Any services provided by Jay in this regard, of course, would be part of AHA's general services to the allieds and the membership. If you require assistance beyond this, it will be necessary for you to make the appropriate arrangements through your local counsel.

Activities with American Insurance Association

The American Insurance Association (AIA) has contacted us with a request to work together on common interests regarding achieving changes at the state level. AIA asked us for a list of the allied hospital associations for the purpose of making local contacts, and we complied with that request. Jay Hedgepeth and I have met with AIA representatives, and as soon as we receive the list of AIA field resources we will pass it on to you. AIA membership is made up of most of the large casualty insurance companies. AIA has seven regional offices, plus individual lobbyists in all 50 states.

In this regard,you have already received from Bill Robinson a copy of the AIA's model bill to create a Joint Underwriting Association (JUA). AIA does not plan to rewrite the bill, since many changes will be negotiated at the local level anyway. Enclosed is a staff analysis, prepared primarily by Jim Ludlam and Jay Hedgepeth (attachment 1). These materials will be part of the malpractice notebook.

Survey of State Malpractice Activities

Also enclosed (attachment 2) is a set of draft tables compiled on the basis of the written and telephone surveys we have made of the state associations, along with bits of information picked up from newspaper reports and the like. In compiling these tables, we found that we did not always have complete information, that the information we had could not be slotted into the categories without assumptions, and that there sometimes were conflicting pieces of information for a particular state. In addition, we know that activities have been extensive in the last several weeks and our information could be out of date in several important respects. Consequently, I would appreciate it if you would review these draft tables and provide any corrections and additional information regarding your state. Please call me or Jason Doskow (312/645-9515) not later than Monday, June 9, with the changes. A final survey will be published shortly thereafter.

California Malpractice Situation

I am sure everyone is familiar with the problems in California, and many of you heard a direct report at the May 16 House of Delegates meeting when Jim Ludlam spoke to some of the issues. As an indication of the kind of problems that can be created in polarized situations, attached is a copy of a proclamation issued by Governor Brown of California (attachment 3). Note the direct tie between a malpractice solution and such factors as utilization and excess hospital beds. As we understand, there has been a temporary agreement reached in California and the physicians are returning to practice. The many issues raised in the proclamation, however, are still very real considerations that will be debated between now and the end of 1975, when the temporary agreement expires.

Paul W. Earle
Director, Management Services

attachments

SUMMARY AND ANALYSIS OF AMERICAN INSURANCE ASSOCIATION'S MODEL TEMPORARY UNDERWRITING ASSOCIATION BILL

SUMMARY

1. Background

A proposal for a temporary Underwriting Association, under date of March 8, 1975, was prepared by the American Insurance Association (AIA) for introduction in New York but has been revised in the form of a model statute for consideration in any state.

The legislation combines two distinct matters. First is the creation of a Commission with responsibility for developing a comprehensive plan for medical injury insurance reparations. Second is the provision of a temporary market to make the necessary medical malpractice insurance available for a two-year period. The two matters tie together on the theory that the temporary market is necessary to give the Commission an opportunity to prepare its long-range plan for solutions to the problem. When the long-range plan is implemented, the Underwriting Association would be phased out.

2. Medical Injury Insurance Reparations Commission

This Commission is to consist of the Insurance Commissioner (who shall also be chairman), the Commissioner of Health, and nine members appointed by the governor, as follows: two representatives of the Underwriting Association, two physicians, two attorneys, a licensed insurance agent or broker, and two members of the public.

The purpose of the Commission is to prepare and submit to the governor and legislature recommendations for a comprehensive insurance reparations plan, in order to provide at a reasonable cost prompt, equitable compensation to those sustaining medical injury. It is the intent that such a system could be underwritten by private insurers on a self-supporting basis using actuarially sound rates. However, if the Commission find that this is not possible, then it would specify the extent and source of any subsidy it considers necessary in addition to private insurance.

The plan is to include provisions for reducing incidents of medical injury; reducing the cost of claims handling; and changing existing law governing eligibility of insured persons for compensation and the amount of compensation, including the statute of limitations and the elements of loss for which compensation may recover. A final catch-all would include such other matters as the Commission may deem relevant.

3. Temporary Underwriting Association

The proposed law also creates a temporary, short-term Underwriting Association (hereinafter called the Association) to underwrite, on a direct basis, personal injury liability insurance. The Association would include all

insurers licensed by the state covering personal injury liability insurance in multiple-peril package policies. The Association, on a self-supporting basis without subsidy, is to provide a market for medical malpractice for a period not to exceed two years. It would not commence underwriting until the Commissioner, after due hearing, has determined that malpractice insurance cannot be made available for physicians in the voluntary market. Upon such determination, the Assosication would be the exclusive agency through which medical malpractice insurance may be written on a primary basis for physicians. Similarly, after a hearing, the Commissioner may determine that medical malpractice insurance is not readily available for hospitals on the volunary market and may authorize the Association to issue policies to hospitals. Such coverage would not necessarily be on an exclusive basis.

For other licensed health care providers, the Commissioner may authorize the issuance of malpractice insurance by the Association if such insurance is not available in the voluntary market. This coverage must be on an exclusive-agency basis.

If the Commissioner determines that malpractice insurance becomes available to any of the above classes, the Association would thereby cease its underwriting operations for the particular class. The policy limits are based upon $1 million for each claimant and $3 million for all claimants in any one year. The premium would be based upon a group retrospective rating plan plus a stabilization reserve fund. The policy form would be on a claims-made basis, provided that on the termination of the policy the insured would have the right, on payment of appropriate additional premium, to extend or remove the discovery period limitation.

The rating plan would give due consideration to past and prospective loss and expense experience for the insurance written, including trends and the frequency and severity of losses, and would also include the investment income. The rates are to be on an actuarially sound basis, including the retrospective rating plan and the stabilization reserve fund, and would be calculated to be self-supporting. The final premium for all policyholders as a group would be equal to the administrative expense loss and loss adjustment expenses and taxes plus a reasonable allowance for contingencies and servicing. If, after all of the above calculations, the premium falls short, procedures are to be established for the recoupment of the deficit against future premiums on policies issued by the participants in the Association or by deduction of a share of the deficit from past or future franchise and/or premium taxes due the state.

The stabilization reserve fund would equal one-third of each premium payment due for the insurance through the Association, and it would be put in a separate fund administered by three directors. The monies would be held in trust and would be used solely for the purpose of discharging when due any retrospective premium charges payable to the policyholders of the Association under the group retrospective rating plan. If the stabilization reserve fund is exhausted, it would be closed out. However, if monies remain in the fund after all retrospective premium charges have been paid, the amount would be returned to the policyholders. No time is established for the termination of such closeout.

The Association would be governed by a board of 11 directors elected annually. Eight directors would be elected by cumulative voting by members of the Association, with votes weighed in accordance with premiums written during the preceding calendar year. Three of the directors would be appointed by the Commissioner as representatives of the medical profession.

ANALYSIS

1. General Comments

a. The plan is solely for the purpose of assuring the availability of insurance during a two-year period, during which a long-range plan will be developed. Since the premiums to be established during the two-year period are designed to be fully self-supporting, they probably will be very substantial.

b. The matter of developing a legislative long-range solution might better be developed through a vehicle not so closely tied into the insurance industry itself. To obtain maximum credibility, a Medical Injury Insurance Reparations Commission might best be a freestanding organization with greater public representation and a broader base. Also, the purpose of the Commission is laudable, but timing is critical in some states and a commission approach should not be permitted to become an excuse for delaying or avoiding necessary action.

c. A fundamental concept of the Underwriting Association is to make its program an exclusive one insofar as physicians and other professional providers are concerned. (AIA sources have indicated that this provision is intended to avoid "cream skimming," which would undermine the actuarial base for the physicians' group.) It is not exclusive insofar as hospitals are concerned. As a result, the Underwriting Association policies and premium structure will, in effect, be a monopoly, and a physician will be required to accept that premium and his personal classification with no recourse through a competitive market.

d. Since the policies will be written on a claims-made basis, it can be anticipated that as a practical result any carriers coming into the picture after the expiration of the two-year period will, of necessity, write on the same basis in order to avoid the impact upon the insureds of paying the additional premium, whatever that may be, for covering the tail.

e. The program for each insured group other than hospitals is on an all-or-none basis. In other words, once an Underwriting Association came into being, a new private carrier coming into the market must be prepared to assume, either separately or with other private carriers, the entire physician group at one time. This may not be attractive to new carriers and could undermine future competitiveness.

f. From the viewpoint of hospitals, particularly in areas where employed or contract physicians are covered under the hospital policy, or where Health Maintenance Organizations have similar arrangements, the physicians could be mandated out of the hospital or HMO policy as a named insured. This is a point that needs clarification in the proposed law, particularly in view of the physician's need for personal coverage.

g. From the viewpoint of hospitals, the cumulative limitation of $1 million per claim, but not to exceed $3 million for any one policy year, would create problems for hospitals in obtaining excess insurance.

h. It is hoped that the size of the initial premium would be moderated by the fact that the program is on a reciprocal basis with respect to the substantial stabilization reserve fund. However, from the viewpoint of the insured, it means that these funds could be tied up for a long time.

i. From the viewpoint of the hospital, a determination would have to be made as to whether or not payments into the stabilization reserve fund would be immediately reimbursable by Medicare, Medicaid, and other payors.

j. From the viewpoint of both hospitals and physicians, it would appear that representation on the stabilization reserve fund board of the insureds by three trustees appointed by the insurance commissioner would be inadequate. If it is to be assumed that the program is to be operated on a no-loss basis for the insurance companies, then major policy decisions should be shared with the insureds on an indepth basis.

2. Specific Comments (refer to March 8, 1975 AIA draft)

a. Page 1, para. 1
The inclusion of specific findings can be critical in establishing the legislation. No language is included in the proposal.

b. Page 3, para. 3.1
Note the exclusion of any reference to hospital representation on the Commission.

c. Page 4-5, para. 4.5

Note the linkage of considerations relating to standards of care and peer review. These and other matters the Commission might study and make recommendations on would be better dealt with as issues separate from the malpractive insurance problem. In addition, there is an opportunity here to focus some of the Commission's considerations by adding specific references to areas that need attention in the hospital's viewpoint.

d. Page 6-7, para. 5.3

Several issues are raised by this provision, which would create a monopoly situation for physicians and other licensed providers while allowing for some flexibility or competitiveness in hospital coverage.

(1) The exclusivity for physicians in large states may be impractical, since coverage may be available in some parts of the state but not in others. Thus, there could be an availability crisis affecting a substantial number of physicians without really triggering the Underwriting Asscciation mechanism.

(2) The exclusive aspect for physicians and other licensed providers could place these individuals at the mercy of rates established in a noncompetitive environment.

(3) The status of physicians who are employed by or under contract with hospitals, and whether they come under the hospital or physician provisions, should be clarified here.

(4) A definition of "availability" is needed. It is conceivable that some coverage would be available at a cost so excessive as to be tantamount to no coverage.

(5) The phrase "other licensed providers" needs definition. Does this include chiropractors, for example? How should individuals who fall into this category but are employed by the hospital be treated?

(6) On the top of page 7, the determination that a market is available will be extremely difficult to make, especially in states where a private market is available in one area but not another. The "claims-made" requirement can further complicate this point.

e. Page 9, para. 7.1

Since policies are to be written on a group retrospective rating plan, individual hospitals and physicians would not necessarily benefit from previous good experience in the malpractice area. In addition, the "claims-made" form creates a problem in that there is no assurance as to how the premium will be assessed for purchasing "the tail." This point is especially relevant in states where there are reimbursement controls in effect.

f. Page 10, para. 7.3

Giving the Underwriting Association credit for investment income is an important feature. In spite of this, however, rates under this program can be expected to be at relatively high levels.

g. Page 12, para. 8

The stabilization reserve fund concept is an excellent one. Questions that should be addressed here include the applicability of state premium rates and reimbursement aspects of the fund.

h. Page 14, para. 9.1

The mandatory inclusion of a broker or agent adds a layer of cost to the program that could be avoided, or at least reduced, through other arrangements.

i. Page 15, para. 11

Note that all three directors must be representatives of the medical profession. In addition, the 8 to 3 ratio is too heavily loaded in favor of the insurance industry, in view of the fact that providers must fully fund the program.

3. Recommendations

a. Any support from interested parties at the state level should be welcomed. However, it would appear to be in the best interests of the health providers that the matter of long-range remedies to the malpractice situation be recommended by a group more independent of the insurance industry and provider interests than the proposed Medical Injury Insurance Reparations Commission.

b. Although it would appear that under the present circumstances the availability of insurance for hospitals is not as critical as it was in early 1975, market problems can crop up at any time. Therefore, where availability is not the primary problem, the authorization of the use of a voluntary Underwriting Association, which would cover only those providers that could obtain no insurance, would be valuable and in the public interest. With proper protections, the voluntary approach would preserve the availability of existing markets and assure the salutary effects of competition.

c. Where availability is a problem and a voluntary Underwriting Association is not feasible, a mandatory Underwriting Association is desirable. In fact, many states may prefer to adopt a dual arrangement to authorize both a voluntary and a mandated Underwriting Association, with the option selected depending on local conditions.

PWE/JHH/JEL
5/29/75

Attachment

Table 1A

Type of State Malpractice Insurance Activities, Current Status and Where the Activities Initiated

Activity	Type of Activity			Current Status			Initiation				
	Legis	Admin	Other	In Effect	Formal Consid	Discuss Stages	Hosp Assn	Med Soc	Gov-ernor	Other	Not Spec.
a. Creation of high risk insurance pool or joint underwriting association.	19	2	3	5	13	4	8	11	1	9	4
b. Dollar limits on malpractice claims.	24	0	3	4	12	12	13	18	1	4	2
c. Restrictions on statute of limitation.	29	0	3	6	19	7	16	22	0	7	3
d. No-fault malpractice system.	2	1	1	0	0	6	2	3	0	2	0
e. Compensation plan similar to Workmen's Compensation approach.	14	1	4	1	9	10	8	13	1	3	1
f. Arbitration for malpractice disputes.	20	5	3	4	16	9	15	17	0	12	1
g. Elimination or limitations on punitive damages.	13	0	0	2	3	9	4	7	0	4	2
h. Other*											
1. Study commission.	10	0	0	8	2	0	2	2	1	4	3
2. Contingency fee limits.	8	1	0	2	7	0	1	5	0	1	3
3. Collateral Source	5	0	0	0	5	0	2	3	0	0	0
4. Screening Panel	7	0	0	2	5	0	1	4	0	1	2

*Other activities in the various states include: burden of proof; regulation or freezing of premium rates; pool for hardship awards; physician licensure; creation of or existing captive insurance company; periodic payments (reversionary trusts); informed consent; physician immunity under certain circumstances; 60-day advance notice of claims; elimination of ad damnum clause; requirements re insurance company reports; privileged documents/medical records.

Results based on survey of state hospital associations on May 8, 1975.

Table 1B

State Hospital Association Assessment of Legislative Activity

Assessment	Number of States	States
Legislation passed in 1975 or expected to pass before adjournment of current legislative session.	25*	Arkansas, California, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Michigan, Missouri, New Hampshire, New Jersey, Nevada, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Washington, Wisconsin.
Possible passage of legislation in 1976.**	12*	Alaska, Kansas, Massachusetts, Minnesota, Mississippi, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Virginia, West Virginia.
No passage of legislation expected in near future.	13	Connecticut, Delaware, District of Columbia, Georgia, Kentucky, Maine, Montana, Nebraska, New Mexico, North Dakota, Utah, Vermont, Wyoming.
No assessment available.	4	Alabama, Arizona, Colorado, Puerto Rico.

*Note that some states fall into both of the first categories, in that some actions have been taken by the legislature while other aspects were deferred for the next session.

**Included in this category are states with legislation pending but with no indication of passage in 1975.

Results based on survey of state hospital associations on May 8, 1975.

STATE MALPRACTICE INSURANCE ACTIVITIES

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF MAY 16, 1975	CURRENT LEGISLATIVE PROPOSALS			ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
REGION 1					
Connecticut	Study commission				
Maine	Study commission				
Massachusetts			Joint underwriting assn; statute of limitations; screening panel.		
New Hampshire		Mandatory risk sharing on all forms of liability & study commission (S-92 will pass as amended)			
Rhode Island		Study commission; change authority for "claims made" policies.		Freeze rates; no ad damnum in suits; statute of limitations; dollar limit on claims; arbitration	
Vermont					X
REGION 2					
New Jersey	Study commission; contingency fee limits (judiciary).	Dollar limits on claims			
New York			Dollar limits on claims; statute of limitations; compensation plan; arbitration; phys. licensure; burden of proof		
Pennsylvania				Approach similar to Indiana; JUA	

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF MAY 16, 1975	CURRENT LEGISLATIVE PROPOSALS			ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
REGION 3					
District of Columbia					X (some discuss)
Delaware					X
Kentucky	Study commission (governor appointed)				
Maryland	Insurance company for physicians, not hospitals; statute of limitations.				
North Carolina		High risk pool (passed House, now in Senate--passage expected in next two months)			
Virginia	Study commission				
W. Virginia			Arbitration; dollar limits on claims; elim. or limits on punitive damages		
REGION 4					
Alabama		Dollar limits on claims; statute of limitations; compensation plan; arbitration			
Florida	Joint underwriting assn.; statute of limitations				
Georgia					X

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF MAY 16, 1975	CURRENT LEGISLATIVE PROPOSALS			O ACTIVITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Puerto Rico					X
Mississippi			Dollar limits on claims; statute of limitations; elim. or limits on punitive damages		
South Carolina	Study commission		Joint underwriting association		
Tennessee		High risk pool or JUA; statute of limitations			
REGION 5 Illinois		JUA; dollar limits on claims; statute of limitations; arbitration; limits on punitive damages (not sure what, but think something will pass)			
Indiana	Limitation of recovery; limitation of liability for indiv. provider; statute of limitations; patient conpensation fund; screening panel admissible as evidence in court proceedings.				
Michigan	Risk insurance pool	Statute of limitations; arbitration; collateral source; affadavit of merit.			
Ohio		JUA; statute of limitations; binding arbitration (if M.D. & patient agree) (parts have chance)			

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF MAY 16, 1975	CURRENT LEGISLATIVE PROPOSALS			NO CIVI REPORT
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Wisconsin	Joint underwriting assn.	Statute of limitations (passed House, in Senate); "claims made" provision.			
REGION 6 Iowa		Informed consent; statute of limitations; JUA; review panel; collateral source, contingency fee limits, elim. of ad damnum			
Kansas	Annual insurer reports on suits; inclusion of phys. assts. under Good Samaritan Act.		Statute of limitations; arbitration; certain med staff records privileged.		
Minnesota			Screening panel; dollar limits on claims; statute of limitations; contingency fee limits		
Nebraska					X
North Dakota					X
South Dakota	Statute of limitations.				
REGION 7 Arkansas	High risk pool or JUA: dollar limits on claims; arbitration				
Louisiana	Elim. or limit on punitive damages.	High risk pool or JUA: dollar limits on claims; statute of limitations; arbitration.		Compensation plan; collateral source; burden of proof; 60-day advance notice of claims.	

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF MAY 16, 1975	CURRENT LEGISLATIVE PROPOSALS			Ac ITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
Oklahoma				Statute of limitations; elim. or limits on punitive damages; collateral source.	
Texas		JUA (already passed by Senate--should be enacted); also considering statute of limitations; compensation plan; dollar limits on claims; collateral source; screening panel; regulation of premium rates.			
REGION 8					
Colorado					X
Idaho	Dollar limits on claims; elim. or limits on punitive damages; informed consent				
Arizona		Arbitration (admin. program similar to Illinois' under consid)			
Montana					X
New Mexico	Study commission (House appointed)				
Utah	Statute of limitations.			Arbitration; contingency fee limits	
Wyoming	Study commission				

STATE	LEGISLATIVE OR ADMIN. ACTIONS ALREADY IN EFFECT AS OF MAY 16, 1975	CURRENT LEGISLATIVE PROPOSALS			Ac ITY REPORTED
		Poss. Passage in 1975	Poss. Passage in 1976	No Passage Expected	
REGION 9					
Alaska				Dollar limits on claims; elim. or limits on punitive damages.	
California		High risk pool or JUA; compensation plan; collateral source rule; periodic payments; contingency fee limits.	Statute of limitations; no-fault; arbitration.		
Hawaii		Contingency fee limits and insurance pool (passed House & Senate --awaiting governor signature)			
Nevada	Insurance pool, statute of limitations; compensation plans; screening panel; Good Samaritan law; collateral source; standards of evidence; informed consent; physician licensure; ability of legally disabled to bring suit.				
Oregon		Dollar limits on claims; statute of limitations; physician licensure; contingency fee limits; informed consent.			
Washington		Statute of limitations; arbitration (admin.); physician licensure.			

Table 2A

MARKET CONDITIONS BY STATE

MARKET CONDITION	NUMBER OF STATES	STATE
Poor*	3	New Hampshire, New York, Vermont
Mixed**	15	Alabama, Arizona, Arkansas, Delaware, D.C., Florida, Hawaii, Illinois, Iowa, Mississippi, New Jersey, Rhode Island South Carolina, Tennessee, Texas.
Coverage available through 1975	34	Alaska, Colorado, California, Connecticut, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Dakota, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming.

* Many institutions are without coverage, or carriers withdrawing coverage.

** Coverage generally available, carriers may be pulling out of the market, or certain types of coverage are not available.

Table 2B

NUMBER OF CARRIERS STILL OFFERING SOME HOSPITAL COVERAGE	NUMBER OF STATES	STATE
0	4	Colorado, Connecticut, Maine, New York
1	10	Alaska, Arkansas, California, District of Columbia, Florida, Hawaii, Kentucky, Nevada, South Carolina, Tennessee.
2	11	Iowa, Maryland, Massachusetts, Minnesota, New Mexico, North Carolina, Oregon, Utah, Vermont, Virginia, Washington.
3	6	Idaho, Nebraska, North Dakota, South Dakota, West Virginia, Wyoming.
4	4	Arizona, Montana, New Hampshire, Texas.
More than 4	9	Kansas, Illinois, Indiana, Michigan, Mississippi, Louisiana, Ohio, Oklahoma, Wisconsin.
Information not available	8	Alabama, Delaware, Georgia, Mississippi, New Jersey, Pennsylvania, Puerto Rico, Rhode Island.

Table 2C

SURVEY OF STATE MALPRACTICE INSURANCE MARKET CONDITIONS

Attachment 2/1

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
REGION #1						
Connecticut						Contracts expire 1977
Maine						Problem coverage for Phys., not hospital.
Massachusetts	Argonaut		X		100-500%	Will be some type of Legislation, and will have a market.
	St. Paul					
	Lumbermans			X		
	Traveler's			X		
New Hampshire	Hartford		X			Not good.
	St. Paul	X				
	U.S. Fidelity			X		
	Argonaut	X				
	N.H. Group					
Rhode Island	St. Paul) Prin.			X	420%	Upper limit umbrell problem, not basic.
	Aetna) Physician coverage					
Vermont	St. Paul			X	200 - 500%	No viable market.
	Hartford		X			
	Continental		X			
	Argonaut			X		
REGION #2						
New York	Argonaut			X		By July 1, 1975 ma not be available
New Jersey						Considering ive Prices up especiall umbrella coverage.

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELIATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITI
Pennsylvania						Coverage able thro 1975.
REGION #3						
Maryland	U.S.F.&G. INA				U.S.F.&G. Not yet announced rates. Seem to be O.K.	Coverage able thro 1975.
Delaware					Part of N.J. Program.	
Virginia	Continental * St. Paul *	X X			300%	Coverage able thro 1975.
W. Virginia	Aetna * Buckeye * Ambassador*				50%	"
D.of C.	St. Paul				179 - 652%	Influx fr Maryland to dropped physician coverage cause prob
Kentucky	Ambassador*				250%	Stable
North Carolina	St. Paul* Employer's Mutual *				Not significant.	Talk of switching "claims ma with incre averaging

STATE	CARRIER	NO NEW BUSINESS	NEW BUSINESS	CANCELIATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
EGION #4						
uerto Rico						
eorgia						
ennessee	Bellefonte	X			Up to 600%	Some hospitals do not have coverage. If bi pass, will have marke
lorida	Glacier Nat.		X		100%	
. Carolina	Employers of Wausau				60%	
labama					200%	Limited Market
lssissippi					250 - 400	
EGION #5						
llinois	Argonaut Continental Hartford Ambassador Bellefonte Aetna St. Paul Employers of Wausau		X		440%	Companies shrinking size of umbrella coverage. Increased premiums but coverage available.
ıdiana	Argonaut St. Paul U.S.F.&G. Continental Aetna		X X X X X		200 - 300%	Enacted malpractice la Law probably will be tested in court coul create confusio.

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKE CONDITIO
Michigan	Argonaut		X		600%	Coverage availabl
	Continental		X			throughout 1975
	All State					
	St. Paul					
	INA					
	Royal Globe					
	Aetna					
	Hartford					
	Chubb & Son					
Ohio	Buckeye		X		300 - 400%	Increased premiu
	St. Paul					but coverage ava
	Shelby Mutual					through 1975
	INA					
	Ambassador					
	Royal Globe					
	Aetna					
	U.S.F.&G					
	Home					
	Travelers					
	Continental					
	Hartford					
	Ohio Casualty					
	Western Cas.					
Wisconsin	Employers of Wausau *				100%	Coverage availabl
	Continental					through 1975.
	St. Paul					
	Aetna					
	Travelers					
	Hartford					
	INA					
REGION #6						
Iowa	St. Paul*	X			500 - 600%	Depends on actio
	Prof. Mutual*	X				of St. Paul

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELIATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
Kansas	St. Paul		X		300%	Coverage availabl through 1975.
	U.S.F.&G.		X			
	Aetna		X			
	Continental		X			
	Western Cas.		X			
	Surrity		X			
Minnesota	St. Paul*	X			300 - 600%	Coverage availabl through 1975.
	Argonaut*	X				
Missouri	St. Paul		X		300%	Coverage availabl through 1975.
	Argonaut		X			
	Kemper		X			
	Continental		X			
	Aetna		X			
	Hartford		X			
	Prof. Mutual		X			
Nebraska	St. Paul*	X			300 - 350%	Coverage availab through 1975.
	Continental*		X			
	Lloyds*		X			
N. Dakota	St. Paul*		X			
	Continental*		X			
	Ins. Co. NA		X			
S. Dakota	St. Paul		X		400%	Coverage availabl through 1975.
	Continental		X			
	Employers of Wausau		X			

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MA CONDI N
REGION #7						
Arkansas	St. Paul		X	X	Depends on Reinsurance Act.	Depends on re ance Act.
Louisiana	St. Paul			X	100 - 400%	Available thr
	Hartford			X		1975
	Ambassador*					
	Continental					
	Calif. Union					
	Bellefonte		X			
	Ind. Fund		X			
	Hazard		X			
	INA		X			
	Aetna		X			
	Appalachia		X			
	Reliance		X			
	Travelers		X	X		
	Argonaut			X		
Texas	Argonaut		X		300 - 400%	Problem may b
	U.S. Fire		X			basic to go u
	Hartford					umbrella limi
	St. Paul	X		X		
Oklahoma	St. Paul	X				Coverage avai
	Continental	X		X		through 1975.
	Travelers	X				
	U.S.F.&G.	X				
	Aetna	X				
	INA	X				
REGION #8						
Arizona	Farmers	X			120%	Potent rob
	St. Paul	X				if urba. osp
	Travelers	X				lose coverage.
	Imperial	X				

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELLATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITION
Colorado	St. Paul		X			Coverage available 1975.
Idaho	Argonaut				300%	Coverage available 1975.
	Farmers		X			
	Aetna		X			
Montana	Farmers		X		80 - 100%	Coverage available 1975.
	Aetna		X			
	Argonaut		X	X		
	U.S.F.&G.		X			
New Mexico	St. Paul		X		75 - 100%	Leg. Study Committ
	Aetna					
Utah	INA/Aetna	X/X			150 - 200%	
Wyoming	U.S.F.&G.	X				Study Committee
	Hartford		X			
	St. Paul	X				
REGION #9						
Oregon	Farmers		X		170%	Coverage available through 1975
	St. Paul		X			
Washington	Farmers		X		300%	Coverage available through 1975. Pre on monthly basis.
	Aetna (Phys)					
	Continental			X		
California	Farmers		X		150 - 185	Coverage available 1975.
	St. Paul			X		
Hawaii	Argonaut*				300%	Phys not r[illegible]d a end of year. Hospi coverage available 1975.
	Truck (Kaiser)			X		

STATE	CARRIERS	NO NEW BUSINESS	NEW BUSINESS	CANCELIATION WITHDRAW	GENERAL RATE SITUATION	MARKET CONDITIC
Alaska	Fireman's Fund		X		37%↓	Coverage availab through 1975.
Nevada	Argonaut - Phys.,		X			
	Truck - Hosp.		X			Coverage availab through 1975.

Note:
*Identified as a major carrier.

Information obtained from State Hospital Association Survey, conducted 5/8/75.

PROCLAMATION

The cost of medical malpractice insurance has risen to levels which many physicians and surgeons find intolerable. The inability of doctors to obtain such insurance at reasonable rates is endangering the health of the people of the State and threatens the closing of many hospitals. The longer term consequences of such closings could seriously limit the health care provided to hundreds of thousands of our citizens.

In my judgment, no lasting solution is possible without sacrifice and fundamental reform. It is critical that the Legislature enact laws which will change the relationship between the people and the medical profession, the legal profession, and the insurance industry and thereby reduce the costs which underlie these high insurance premiums.

Therefore, in convening this extraordinary session I ask the Legislature to consider:

(1) Reconstituting the Board of Medical Examiners to include a majority of public members.

(2) Giving the Board full authority to discipline and decertify practitioners for lack of competency.

(3) Provide the Board with authority to set recertification standards, including updated training and public service in order to minimize malpractice and increase the quality of medical care.

(4) Provide tne Board with authority to develop a system to minimize the present maldistribution of medical care in certain areas of the State.

(5) Establish a Medical Peace Corps to serve Californians who lack adequate medical care.

(6) Regulation of hospital rates, including authority over excessive hospital bed capacity and unnecessary duplication of expensive and under-utilized equipment.

(7) Voluntary binding arbitration in order to quickly and fairly resolve malpractice claims while maintaining fair access to the courts.

(8) Establishment of reasonable limits on the amount of contingency fees charged by attorneys.

(9) Elimination of double payments ("collateral sources"); institution of periodic payments and reversionary trusts; limitation of compensation for pain and suffering while insuring fully adequate compensation for all medical costs and loss of earnings; and setting a reasonable statute of limitations for the filing of malpractice claims.

In addition, I intend to:

(a) Convene a Special Panel to immediately conduct a complete investigation into all insurance company rates and reserve practices and;

(b) Support legislation in the regular session to insure adequate public representation on all professional Boards, including the Board of Governors of the California State Bar.

Therefore, by virtue of Article IV, Section 3 of the Constitution, I hereby assemble the Legislature of the State of California in extraordinary session at Sacramento at 1:00 P.M., Monday, May 19th, 1975, to consider and act on this legislation.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the great seal of the State of California to be affixed this 16th day of May, 1975.

EDMUND G. BROWN, JR.
GOVERNOR

Attachment 2

[Testimony presented June 25, 1975, before the Joint Interim Study Committee of the Kansas Senate and House of Representatives on Medical Malpractice]

THE MALPRACTICE DILEMMA FOR HOSPITALS

by Stephen M. Blaes, J.D.

Mr. Gentry and Mr. Jorgensen have described for you their first-hand knowledge of the malpractice dilemmas confronting Kansas hospitals and physicians. My testimony will address legal aspects of the malpractice crisis and bring you up to date on reform legislation which will soon be offered for your consideration.

Previous speakers described how the malpractice crisis impacts upon doctors and hospitals. Actually, the situation confronts all of us--it touches every person in this State--just from the standpoint of being ordinary citizens who seek medical care from time to time for ourselves or those in our families. And the frightening notion of the deterioration of availability of our highly skilled doctors to examine and treat us or our loved ones grows increasingly real.

Let no one suggest to you that there is no genuine malpractice crisis. Look at the evidence. Insurance companies which generated millions of dollars in premiums by offering

coverage to our hospitals and physicians are pulling out of the business. - Companies who cannot demonstrate actual losses in underwriting malpractice coverage nevertheless refuse to participate. And notice . . . this phenomenon of refusing to provide coverage is occurring in a climate in which hospitals and physicians are standing in line asking not "How much is it?" . . . but "Can I get it?"

Those companies which have not withdrawn from the market altogether have demanded unprecedented, indeed incredible premium increases. The impact is easily read. The cost of patient care is sure to increase so the hospital can pay its inflated insurance burden. In some cases the increase may be as much as $4.00 per patient per day. Even more substantial increases will occur, yet be unseen in the defensive practice of medicine. Doctors routinely attempt to protect themselves by ordering-up extra tests and X-rays. Some experts believe this is costing patients and our nation's hospitals anywhere from three to seven billion dollars a year.

Worse yet, the rising cost of insurance could make it difficult to obtain care at any price. The AMA is predicting that many older and part-time physicians will be forced into early retirement by high malpractice insurance premiums. Some young physicians may forego private practice entirely, seeking

the security of the Armed Forces or choosing the laboratory rather than the clinic.

The projection of these conditions over a year or two from now leads to very disturbing conclusions. Our hospitals and physicians in rural communities, the backbone of the health care delivery system in our State, will be most severely affected. These providers, even if the insurance coverage is available to them, simply cannot pay the price in terms of skyrocketing premiums and defensive medicine. It's going to be too easy, it will look too attractive, for the rural physician, where that great talent is so sorely needed, to just throw in the towel and go fishing. Our outlying hospitals which routinely refer some of the more exotic cases to the medical centers simply cannot keep pace with the great burdens imposed upon them by the malpractice crisis. Health care will soon become even more remote to people of rural Kansas unless this situation is brought under control with rational legislation.

Remember, we are examining perhaps the most dynamic, technically accelerated field in the world. Hospitals must keep pace with the medical profession and technology. It is an expensive and costly effort. We have already seen the disabling impact of the malpractice insurance crisis upon the ability of

hospitals to maintain a proper level of operations. Institutional lenders, bond underwriters, and others traditionally involved in financing our improvements are beginning to take a second look. And I don't blame them. Some hospital financings have been turned down; others handled at only an inflated price because insurance premiums are doubling and tripling year to year. These lenders understandably question whether we will be able to handle our fiscal obligations in a few years, when the malpractice insurance lug is even more out of proportion.

Malpractice complaints, once a rarity, have become commonplace. As recently as 1960, most physicians could expect to go through a lifetime of practice without seeing a summons. Now, according to a 44-state study, one out of every seven general surgeons is facing a malpractice complaint. The sums involved are horrendous. In California, there had never been a million-dollar judgment until 1967. There have been 13 of them in the last two years.

The causes of the crises are very complex. For one thing, the public is bombarded with reports of miracle drugs and surgical spectaculars like heart transplants. People enjoy television programs that show Marcus Welby and his colleagues regularly triumphing over death and disease. Since they now

expect more from doctors, they are less willing to accept what is simply a bad result and far more willing to blame them on a physician's failure.

Hospitals receive a double dose of the malpractice crisis. In addition to being held to the traditional concept of "respondeat superior," by which we as the employer are responsible for acts of our employees, we are not involved in a second area of liability. Courts in several states have concluded that hospitals are ultimately accountable for the quality of care provided within the institution.

Because of this second type of liability, it has become routine to include the hospital as co-defendant in allegations of malpractice, even though our liability is unfounded. Although the hospital may be dismissed later as a co-defendant, reserves have still been set up by insurance carriers to cover this potential liability. This procedure is one reason malpractice insurance premiums are so unfairly inflated.

Realizing the tremendous dilemmas confronting hospitals and physicians throughout our State, what response is most appropriate . . . how can this Committee act most responsibly to alleviate these pressures, enabling hospitals

and doctors to continue the delivery of quality patient care at a fair-price, without denying rightfully aggrieved patients their lawful right to redress? The answer, gentlemen, lies in rational malpractice legislation.

A good deal has been done along these lines already, particularly through the leadership of your Chairman, Senator Sowers. Senate Bill 353, calling for routine reporting of malpractice claims or actions, will do much to accurately define the true dimensions of the malpractice problem. Senate Bills 356 and 433, now held over and dealing with modifications in the statute of limitations and establishment of a medical malpractice board of review are definitely steps in the right direction . . . The long-term solution of the problem lies in enacting a general omnibus bill which takes into account the unique dimensions of the practice of medicine, delivery of health care, and intricacies of malpractice litigation.

The Kansas Hospital Association and the Kansas Medical Society are developing such a bill. A deliberate effort is being made to build-in reasonable ways of dealing with unique facets of malpractice controversies, while objectively preserving to the citizens of this State their lawful right to seek redress for wrongs done them by another. We are cognizant of the continuing need for self-analysis and professional audits. The bill will contain mandatory reviews of professional

performance of medical practitioners. After all, the best malpractice insurance we can buy is good patient care.

I want to mention some of the more important sections of the bill being drawn and of which we ask your sincere consideration. We believe, taken collectively, these reform concepts will materially alleviate the malpractice crisis in our State.

The Act contemplates the establishment of screening panels composed of physicians and lawyers working under the supervision of the district court. The panel will evaluate the issues of a malpractice claim and offer specific recommendations to the court. The findings of the panel will be admissible in evidence, and the professionals who comprise the membership of the panel will be available to testify as expert witnesses.

Indiana and Tennessee have created panels of doctors and lawyers to screen malpractice claims and weed out nuisance suits. A doctor-lawyer panel in Tucson, Arizona, has reviewed more than 100 cases since its establishment. Though its decisions are not binding, most doctors and patients go along, and with good reason. Very few of the doctors or patients whom the panel urged to settle have ever won their cases in court.

Screening panels have worked effectively in Hawaii and New Mexico. They enjoy excellent working relations with the courts, lawyers and the insurance industry.

We believe the panel system would be a major step toward fair disposition of most claims. It would expedite the presentation of reliable evidence in the few cases that would ultimately go to trial. It would obviate the lawyer's problem of the conspiracy of silence, the unavailability of medical witnesses. It would certainly abbreviate the time necessary for payment of recovery to an injured patient by shortening the time sequence of his claim from inception to determination. And it would increase the patient's recovery by diminishing the expenses of prolonged litigation.

The new bill will propose to you a Kansas Patients' Compensation Fund. Under supervision of the Commissioner of Insurance, the Fund will be maintained at appropriate levels by annual assessments against health care providers so as to guarantee an unlimited source for payment of meritorious malpractice judgments and claims up to $500,000 each. It is rare for a malpractice award in our State to exceed $100,000. In situations of prolonged disability and catastrophic loss compensation, the Insurance Commissioner would have the right to extend payments over several years, pending periodic reviews

so as to assure availability of resources to finance quality health care for an injured patient.

The Act would permit physicians and hospitals to provide immediate remedial care to patients having meritorious claims, or even to those who have doubtful claims, so as to promptly minimize the injury suffered or damage done. Such care could be provided without jeopardy to either side. Under the state of the law as it exists today, the volunteering of such care might reasonably be interpreted as an acknowledgment of liability or as an admission against interest and used against us or the doctor wishing to help or bring comfort to our patients.

The Act would shorten the statute of limitations. The "long-tail" aspect of malpractice claims is the facet most strongly condemned by insurance carriers, as making malpractice underwriting totally unmanageable, completely unpredictable, and extremely risky. You can appreciate how the companies' actuaries might get ulcers if a claim can lie dormant for five, ten, even 19 years and suddenly surface as a malpractice suit.

I often speak to groups of physicians and nurses about avoidance of malpractice. I talk with them about the statute of limitations. Invariably, I remind them that accurate and thorough record keeping, the maintenance of good medical

charts, is an extremely important part of malpractice defense and avoidance, because it is through these records that we are able to reconstruct what actually occurred and get to the truth. To drive home my point, I always tell these professionals that in our State a minor has one year after reaching the age of majority within which to file his lawsuit against the hospital or physician. This means that a baby born today at Hadley Regional Medical Center in Hays would have until June 25, 1994, within which to file a malpractice claim.

I tell doctors and nurses this because it so dramatically demonstrates the need for good charting. It always provokes a groan from my audience. Frankly, gentlemen, I never believed it would actually occur. But, in June 1973 a hospital I represent was served with a petition filed by a young man born in the hospital in June 1951. The claimant was two days short of being 22 years of age. He sued the hospital and two physicians, claiming negligence in performing diagnostic tests at the time of his birth. In his suit, the patient asked the court to award him $750,000. Yet, back in 1951 the hospital carried only $25,000 worth of public liability insurance. The doctors carried even less. We were confronted with an uninsured claim of $725,000. Medical science and the name of the game in malpractice claims have changed drastically over the last two decades. Fortunately, because a good medical chart was available,

we were able to defend the case and secure a favorable disposition.

But the case is a prime example of what drives away malpractice underwriters. When are they really off the hook? When can they safely adjust their reserves because the action is barred at law?

Under the Act which is to be offered to you, the statute of limitations is shortened to two years from the date of occurrence of the incident in all cases except minors. For minors, two years after the age of six appears reasonable since, according to medical experts, injuries resulting from malpractice are always apparent by the time the child is in school and out of the close parental influence in the home. Medical evidence likewise demonstrates that virtually all meritorious claims are known to the patient and the extent of injury determinable within two years of the incident. I encourage you to listen to the medical experts on this and the various other points to be taken up in the bill.

The new bill will require the reporting of malpractice claims and will create a study commission functioning at the State level. Appointed by the Governor, the commission will review all aspects of the malpractice situation on a continuing

basis, evaluate data, and make recommendations for necessary changes.

Other provisions are inserted to improve the general climate for the delivery of health care. No liability should be imposed upon a health care provider on the basis of breach of contract unless the contract is in writing. Because life and death emergencies require prompt response without the benefit of diagnostic studies, principals of the Good Samaritan Act should be extended to life endangering situations in the physician's office or the hospital. The Act would eliminate the prayer in a plaintiff's petition for a specific dollar amount because of the prejudicial publicity from reporting inflated demands even though a much smaller amount is ultimately paid in settlement or judgment.

The Act also addresses itself to the very positive dimension of striving for enhanced quality of patient care. It will require intensified quality controls, peer review, and quality assurance. Coupled with the requirement of continuing education and a comprehensive medical injury prevention program, we believe the Act will assure that high quality health care continues to be available to the citizens of Kansas.