

**CONNECTICUT GENERAL ASSEMBLY  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW  
& INVESTIGATIONS COMMITTEE

**Medical Malpractice  
Insurance Rates**

DECEMBER 2003

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# Introduction

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## Medical Malpractice Insurance Rate Study

Over the past two years, medical malpractice insurance rate levels and their increases have become a prominent state and national issue. In February 2003, the Connecticut State Medical Society's (CSMS) executive director testified before state legislators that there was a medical malpractice insurance crisis in the State of Connecticut. Citing increasing liability premiums, he stated "The real question is: Can your doctor stay in practice?"

Medical malpractice insurance affordability is just one of many factors in an incredibly complex set of systems reflecting public policy choices. Professional liability insurance, with its own regulatory structure, lies at the intersection of our current health care system, including its reimbursement structure and risk reduction mechanisms, and our tort system that resolves medical malpractice claims focusing on negligence. When assessing the insurance question, this intersection triggers long-ongoing debates about the appropriate role of tort litigation in our society to compensate for and deter negligent acts on the one hand, and how best to enhance patient safety in a systems-oriented manner on the other.

This study, approved by the Legislative Program Review and Investigations Committee in February 2003, assesses the circumstances underlying the costs of medical malpractice insurance and analyzes factors contributing to rising premiums, with the goal of providing remedies as needed. Specifically, the areas of claims resolution, insurance regulation, and physician oversight were reviewed.

**Scope of review.** The program review committee found Connecticut already has some of the tools commonly regarded as addressing the tort cost issue in place, but some were not operating as the legislature intended or were otherwise problematic. Proposed changes to the claims resolution process include tightening up the certificate of good faith, attorney contingency fee, and offer of judgment provisions, requiring pre-suit mediation, and exploring alternative mechanisms to handle patient injuries for the long term.

In the areas of insurance regulation and physician oversight, Connecticut also has systems in place, but aspects of each, from both a policy and operational perspective, are not optimum. The committee proposes changes to the way insurers selling medical malpractice insurance, as well as other providers, are regulated by the State of Connecticut. Further, the committee proposes changes to the state's physician oversight system, to assist the state in evaluating the quality of medical care received by patients and the competency of physicians. The collective intent of the program review committee recommendations is to address the rising premium cost issues by increasing accountability in the complex and multi-faceted system that affects these costs.

Last but not least, to address the immediate concern about the insurance impact on doctors and their ability to stay in Connecticut, the committee proposes a premium subsidy program targeted to the hardest hit specialties.

**Methodology.** A variety of resources and methods were used to gather and analyze information for this report. Numerous academic, governmental, and professional studies, reports, articles, and commercial publications on topics related to medical malpractice insurance rates were reviewed, as well as annual survey data on medical malpractice premium rates. Interviews were conducted with staff from the Connecticut Insurance Department and the Department of Public Health, plaintiff and defense attorneys, representatives of a victims' rights group, and the Connecticut Hospital Association.

Numerous sources of data were utilized, including the National Association of Insurance Commissioners (NAIC); the Connecticut Department of Public Health; the Connecticut Insurance Department<sup>1</sup>; the National Practitioner Data Bank (NPDB); the Connecticut Judicial Branch, the Connecticut Hospital Association<sup>2</sup>, and active and inactive Connecticut medical malpractice insurers. In particular, data from the Connecticut Medical Insurance Company (CMIC) was examined in depth, including financial and rate file information over a period of years, and committee staff interviewed several CMIC employees. Committee staff also interviewed employees and received data from ProSelect, an out-of-state insurer doing business in Connecticut. Committee members and staff attended meetings of practicing physicians. Further, information on other states was gathered collaboratively with the Office of Legislative Research, a nonpartisan staff research office of the Connecticut General Assembly.

Finally, the committee held a public hearing on September 18, 2003, and adopted the findings and recommendations in this report on December 18, 2003.

As a note, in addition to aggregated nationwide and Connecticut data, CMIC data and activities are cited throughout the report. Because of CMIC's unique characteristics—one of the two largest malpractice insurers in the state, a mutual company run by doctors, covering only Connecticut doctors since 1984—it is reasonable to focus on the company to assess what the state's experience has been.

Obviously, though, there are other providers of malpractice insurance, both commercial insurers and others, for Connecticut health care practitioners. To obtain as clear a picture of Connecticut's own medical malpractice insurance experience (and related factors) as possible, the committee made its best efforts to obtain pertinent information from all these insurance provider sources also, with some limited success. In general, it can be said that lack of data is a major impediment for policymakers to be able to independently determine the nature and extent of the medical malpractice insurance problem.

**Report organization.** The report is divided into six chapters. Chapter One provides an overview of the medical malpractice insurance market. The medical malpractice claims process is described in Chapter Two and includes committee findings and recommendations. Chapter Three explains the principal elements of insurance pricing. A summary of the oversight role of the Connecticut Department of Insurance is presented in Chapter Four, which also includes committee findings and recommendations in that area. Chapter Five examines the Department of

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<sup>1</sup> The committee appreciates the effort the Insurance Department expended by surveying medical malpractice carriers to assist the committee in its information gathering during its study.

<sup>2</sup> The committee also appreciates the assistance and efforts of the Connecticut Hospital Association in information gathering.

Public Health and Medical Examining Board roles in physician oversight, and also presents committee findings and recommendations. Finally, Chapter Six presents the pertinent data analysis.

### **Agency Responses**

It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comments on the recommendations prior to publication of the final report. Appendix G contains responses from the Insurance Department and the Department of Public Health.



## Medical Malpractice Insurance Market

### Medical Malpractice Defined

When a person seeks the services of a doctor or other health care practitioner, he or she depends on the practitioners to know what they are doing. Tort law provides that a person may expect a doctor to exercise the same degree of skill and care that doctors in the same line of practice ordinarily exercise in like cases. If not, and the person is injured as a result of the doctor's action or inaction, the doctor is negligent. The person may sue in civil court for monetary damages to compensate for the resulting injury. Medical negligence is commonly called medical malpractice.

The incidence of medical malpractice was examined in a widely cited 1991 Harvard Medical Practice Study<sup>3</sup>. The Harvard report found 3.7 percent of all hospitalizations in its sample involved adverse events. Of those adverse events, 27 percent were due to negligence and only 2 percent of the negligent injuries resulted in a claim being filed. Further, it has been reported that deaths due to medical errors in hospitals exceed deaths due to motor vehicle accidents, breast cancer, and AIDS.<sup>4</sup>

### Purpose of Medical Malpractice Insurance

Medical professional liability insurance is composed of three major categories, as illustrated in Figure I-1. Hospitals and other health care facilities have corporate liability for the medical operation of the institution (such as properly maintaining records, developing appropriate patient care procedures, etc.) and vicarious liability for the acts of their employees.

Figure I-1. Medical Malpractice Insurance



The liability exposure of physicians and other health care professionals is a function of the nature of the services provided. In the course of a medical career, there is a risk a doctor will act negligently or be accused of acting negligently. The purpose of medical malpractice insurance is twofold: 1) to protect health care practitioners from the negative economic consequences of being found negligent in their medical practices; and 2) to provide compensation for individuals who suffer harm from negligent doctors. In theory, there are three ways a doctor can protect his or her assets from a lawsuit: self-insure, purchase insurance from a

<sup>3</sup> Cited in *Liability for Medical Malpractice*, Patricia Danzon, Handbook of Health Economics, Volume 1, Edited by A.J. Culyer and J.P. Newhouse, (Elsevier Science, B.V.), 2000 pg. 1351-1354.

<sup>4</sup> *To Err is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press, November 1999.

licensed insurance company, or be employed by a health care facility (e.g. a hospital) that provides coverage.

Self-insurance is not an option for certain health care practitioners in Connecticut. Since 1996, seven types of health care practitioners are required to maintain professional liability insurance or “other indemnity” in the minimum amount of \$500,000 per occurrence (medical incident), with a minimum aggregate of \$1.5 million per year. The following practitioners<sup>5</sup>, all licensed by the Department of Public Health (DPH), are required to maintain insurance coverage if they provide direct patient care services:

- physicians and surgeons (C.G.S. Sec. 20-11b);
- chiropractors (C.G.S. Sec. 20-28b);
- natureopathic physicians (C.G.S. Sec. 20-39a);
- podiatrists (C.G.S. Sec. 20-58a);
- advanced practice registered nurses (APRN) (unless an APRN is also a certified nurse anesthetist working under the direction of a licensed physician) (C.G.S. Sec. 20-94c);
- dental hygienists (C.G.S. Sec. 20-126x); and
- optometrists (C.G.S. Sec. 133b).

No state agency affirmatively confirms if doctors and other health care practitioners maintain insurance coverage. Rather, health care practitioners affirm on their annual license renewal forms that they have the required coverage. An example of a more practical check is that hospitals require doctors (to whom they give privileges) have medical malpractice coverage by insurance companies with strong financial ratings.

As noted, doctors and other health care practitioners who are employed by hospitals and other health facilities are typically covered through the facility’s insurance method. (Hospitals cover themselves in a variety of ways, sometime using traditional insurance companies, but more often than not using alternative methods, described later in this chapter.) In addition, some institutions will provide coverage at cost to doctors in the community who are not employees.

*Numbers of doctors covered.* According to DPH, in 2003 there are 10,346 licensed doctors (with another 138 who are licensed but have some kind of disciplinary restriction on their licenses). Not all licensed doctors provide direct patient care, though, and thus do not need to be insured. No definitive figure exists for how many doctors actually need to be insured. However, the Connecticut State Medical Society, using American Medical Association numbers, estimates currently there are around 7,000 active patient care physicians in Connecticut.

**Types of coverage.** A medical malpractice insurance policy typically covers a 12-month period because rates are determined annually. Some company policy years coincide with the calendar year; others are different, based on the rate cycle.

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<sup>5</sup> Dentists are not required to maintain professional liability insurance.

Most medical malpractice insurance policies are “claims-made” policies, meaning they cover any *claim that is made* during the policy year, regardless of when the underlying medical incident occurred (although companies can have a retroactive date for any underlying incidents). In reality, because of the statute of limitations, discussed later, there is a de facto limit to how long before the policy year an incident could have actually happened and be covered. Another, less used type of medical malpractice policy is an “occurrence” policy, which covers claims made based on medical *incidents that happened* during the year the policy was in effect. These incidents may not be reported until years later (but again, if the statute of limitations passes, any danger of legal liability is gone, along with the need for indemnification.)

State statutes require professional liability contracts issued on a claims-made policy to contain: 1) a provision for the purchase of prior acts coverage; and 2) a contractual right of the insured to purchase, at any time during the policy period and within 30 days after the termination of the policy period, equivalent coverage for all claims occurring during an insured policy period regardless of when made.

## **Medical Malpractice Insurance Policy Features**

This description focuses on insurance policies for doctors who seek individual coverage. A medical malpractice insurance policy is, like all insurance policies, a contract between two parties, with rights and obligations on both sides. A doctor pays money (premium) to an insurance company in exchange for the insurance company’s agreement to pay, on behalf of the doctor, sums up to the contract limit the doctor becomes legally obligated to pay as damages (indemnification) because of any claim made during the policy period. Individual physician policies also can cover damages for employees of the doctor and for a substitute doctor. Some provisions of a typical medical malpractice insurance policy are discussed below.

- **Amount of coverage:** Insurance policies set out a certain specified amount of coverage and the price of the insurance will vary accordingly. As noted above, Connecticut doctors are required to have coverage of at least \$500,000 per incident with a \$1.5 million aggregate per year. However, companies typically offer different levels of coverage, at different prices (premiums). A common level in Connecticut is \$1 million per incident, with a total of \$4 million in the aggregate referred to as “one/four” coverage. A physician can get more coverage, though, for example, \$2 million per incident with a total of \$5 million in the aggregate.
- **Legal defense of claim:** Under the insurance contracts, a company has the exclusive right and duty to defend each claim or suit covered, with the right to appoint counsel and investigate and defend claims. The company has the exclusive control to select defense counsel.
- **Settlement:** Once claims are brought, they are often settled before trial. An insurance policy will spell out how the decision to settle a case is reached. Under CMIC’s policy, it has the right to settle a claim if 1) the doctor has consented in writing or 2) the company determines by a majority vote of the executive committee that such a claim or suit should be settled or an offer of

judgment accepted (offers of judgment are described in Chapter Two.) ProSelect's policy established that a doctor must agree to any settlement offer before the company can accept. (In general, some liability companies provide the company will make settlement decisions as it "deems expedient.")

Insurers can cover other items also, such as the cost of defending a doctor at a DPH administrative hearing or from a claim based on peer review activities. In addition to the above policy provisions, each policy is customized for the doctor or practitioner it covers. These conditions and limitations are set out in the policy's declaration page.

**Doctor responsibilities.** A doctor typically must report any claim or suit to the insurance company, in writing and as soon as possible after the claim or suit has been brought. Also, a doctor must report in writing about any potential claim or suit that might be made against the insured related to professional services that may reasonably result in a suit.

**Cancellation by company.** Per state statute, a company can cancel or not renew a policy by mailing the doctor a notice stating the date (at least 90 days before) the contract will terminate. An insurance company is supposed to report to the state insurance department by March of every year of all cancellations of and refusals to renew professional liability insurance policies during the preceding calendar year.

## Market Characteristics

The medical malpractice insurance market can be separated into two broad groups - the traditional market and the alternative market. The traditional market provides protection through regular insurers – both commercial and mutual, while the alternative market comprises a number of different arrangements that essentially allow related organizations to come together to insure themselves.

In 2001, the traditional medical malpractice insurance market generated over \$7 billion in premiums on a nationwide basis, while in Connecticut the total premium was about \$130 million.<sup>6</sup> The alternative market, while more difficult to calculate because of a paucity of data, is estimated to be about \$14 billion nationwide.<sup>7</sup> Though a number of large health care facilities utilize alternative risk vehicles, the size of this market has not been reliably estimated in Connecticut.

**Underwriting cycle.** In discussing the medical malpractice insurance market it is instructive to understand the underwriting cycle that appears to condition the market. Historically, the property/casualty insurance market – of which the medical malpractice insurance market is a segment - is cyclical in terms of premiums, profits, and insurance

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<sup>6</sup> National Association of Insurance Commissioners (NAIC), 2001 Property/Casualty Statistical Compilation, Exhibit of Premiums and Losses, 2002

<sup>7</sup> Estimates for the alternative market derived from Tillinghast-Towers Perrin, *U.S. Tort Costs: 2002 Update Trends and Findings on the Costs of the U.S. Tort System*, (New York, NY: Tillinghast-Towers Perrin 2003), Appendix 5. Based on total costs of about \$21 billion. Neither the NAIC nor state insurance departments maintain information from those who are self-insured or from many alternative market mechanisms.

availability (known as the “underwriting cycle”). This cycle is usually described in terms of a “hard” or a “soft” market.

Typically, a *hard market* is characterized by shrinking capacity. This exhibits itself through large premium price increases (unrelated to an individual’s loss experience), a loss of insurance carriers or a reduced number of lines offered by carriers, and fewer or restricted coverage offerings. A *soft market* consists of slow to no growth in premiums, robust competition among insurance providers, expanded coverage offerings, and less restrictive underwriting criteria.

The most recent soft market is thought to have ended in about 1998 and it is not certain the current hard market has peaked yet.<sup>8</sup> Previous hard markets have been experienced in the mid-1970s and mid-1980s and both have brought a number of changes to the structure of the insurance market.

- In the 1970s commercial medical malpractice insurance carriers began to exit the market and physician-owned mutual companies developed to take their place. By being immune from stockholder demands for profit of a traditional carrier, these nonprofit companies have some cost advantages. According to the Physicians Insurers Association of America, a trade association of physician-owned and operated medical malpractice insurance companies, mutual insurers now cover more than 60 percent of the physicians in private practice.
- Hospitals and large physician groups have left the traditional insurance market and created other risk-bearing entities, such as captives (described below) to underwrite their medical malpractice exposures.
- All states have enacted some elements of tort reform whose purpose is to limit the growth in malpractice premiums. Reforms have been aimed at reducing the number of claims, the severity of the losses, and tightening control over the rate increases that insurers may impose. Consequently, medical malpractice regulations, pricing, and legal climate may differ considerably on a state-by-state basis, making precise comparisons problematic. Reforms enacted in Connecticut are discussed in Chapter Two.

Another unique characteristic of the market is the fact medical malpractice insurance is a “long-tail” line of business – meaning a large portion of claims is paid a number of years after the coverage period. Thus, currently filed claims may not be sensitive to any regulatory or legal reforms enacted now, while changes limiting claims costs may have a more long-term effect throughout the reserve tail for anticipated but yet-to-be filed claims.

**Traditional market.** The number of insurers who provide medical malpractice insurance in Connecticut has fluctuated over the last decade from a low of 32 to a high of 52.

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<sup>8</sup> U.S. General Accounting Office, *Medical Malpractice Insurance*, (Washington, D.C. – GAO-03-702) June 2003.

The latest figures from the Connecticut Insurance Department indicate there were 41 insurers licensed and providing some form of medical malpractice coverage in 2002. However, the top five insurers covered 79 percent of the market.<sup>9</sup>

This apparently large number of insurers is misleading and some qualifications are necessary. As discussed further below, the majority of providers make up a very small percentage of total market share. In addition, some insurers have restrictive underwriting guidelines, including not offering coverage to new clients. As discussed earlier, several medical professions other than traditional (osteopathic) physicians are required to maintain malpractice insurance, such as chiropractors, naturopaths, podiatrists, and dental hygienists, and some insurers solely or primarily provide coverage to a particular specialty. Thus, the actual range of choices for any particular physician may be quite small. In September 2003, the Insurance Department stated that five companies were actively writing malpractice insurance (that is accepting new clients) for physicians in Connecticut (Connecticut Medical Insurance Company, ProSelect, The Doctor’s Company, Medical Protective, and Truck Insurance).<sup>10</sup>

<b>Table I-1. Top Five Med Mal Insurance Companies and % Market Share in Connecticut<sup>1</sup></b>											
<b>1992</b>	<b>%</b>	<b>1994</b>	<b>%</b>	<b>1996</b>	<b>%</b>	<b>1998</b>	<b>%</b>	<b>2000</b>	<b>%</b>	<b>2002</b>	<b>%</b>
CMIC	37	CMIC	36	CMIC	34	CMIC	39	CMIC	34	CMIC	41
St. Paul	26	St. Paul	26	Cont. Cas.	28	St Paul	16	St. Paul	24	ProSelect	18
Cont. Cas.	25	Cont. Cas.	23	St. Paul	20	MIXX	10	Amer. Health	17	Docs Co	7
TIG	3	Cont. Ins.	4	Cont. Ins.	2	Cont. Cas.	6	Truck	5	Med. Protect	6
Nat. Union	3	Nat. Union	2	Amer. Cont.	2	Truck	9	ProSelect	3	Exec. Risk	6
<b>Top 5</b>	<b>93</b>		<b>91</b>		<b>87</b>		<b>71</b>		<b>75</b>		<b>79</b>

<sup>1</sup> Amount of market share is defined by percent of premium compared to total premium. St. Paul premiums have been adjusted by annualizing multi-year large account contracts.  
Source: CID, NAIC, and LPRIC calculations

As Table I-1 shows, the top five insurers over the last decade have written between 71 and 93 percent of the total medical malpractice premium in Connecticut. The top two have written over 50 percent of total premium and one company alone has consistently written over one-third of the coverage. This does not appear to be unusual. One national study suggests the

<sup>9</sup> Total premiums written include the amount written for individual physicians and medical facilities (such as hospitals and clinics).

<sup>10</sup> Testimony of Susan Cogswell, Commissioner, Connecticut Insurance Department, February 13, 2003, and subsequent interviews with the Connecticut Insurance Department, August 2003.

average market share for the largest single medical malpractice writer in each state is about 36 percent and the top two writers in each state average a total market share of about 56 percent.<sup>11</sup>

While CID maintains a listing of insurance companies currently licensed to provide medical malpractice, it does not maintain a listing of which providers were actively writing in the market on a historical basis. It has been estimated that at least 12 medical malpractice insurers have withdrawn from the Connecticut market over the last decade, while 10 have been added. However, only four of the 10 have been significant players in the market (i.e., writing over \$1 million dollars in premium). Of those four, only two (ProSelect and The Doctors Company) were still writing individual medical malpractice policies in Connecticut as of September 2003.<sup>12</sup>

Four significant writers of medical malpractice insurance have either left the Connecticut market or have limited their underwriting to large institutions over the last several years. Two of them became insolvent after trying to expand business in the mid- to late-1990s, while the other two have determined that medical malpractice is not sufficiently profitable to maintain that line of business. Specifically:

- St. Paul Corporation— A national company that offers several lines of insurance, St. Paul had about nine percent of total market share in the nation and about 23 percent of the market in Connecticut in 2001. The company, though, only insured about 272 physicians in Connecticut. The majority of its business in Connecticut (about 85 percent) was concentrated in insuring hospitals and other facilities. St. Paul stopped writing medical malpractice nationally in December 2001. At the time of its exit, St Paul had 20 percent or more of the market share of medical malpractice in at least 15 states.<sup>13</sup>
- MIXX Insurance Company - This New Jersey-based company started writing in Connecticut in 1999 and exited in 2002. It maintained a market share of about 3 percent in Connecticut. The company went public in 1999. It aggressively moved into other states, which contributed to weakening the company. It is now insolvent.
- PHICO – This Pennsylvania-based company started writing in Connecticut in 1995 and exited in 2001. It had about a 2 percent market share in Connecticut. It has also been accused of aggressive pricing that led to its insolvency.<sup>14</sup>
- CNA – This Illinois-based company has been licensed in Connecticut since 1902 and is one of the largest multi-line insurers in the nation. CNA stopped writing individual medical malpractice policies nationwide in 1998 (whose insureds were transferred to American Health Care, a subsidiary of SCPIE),

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<sup>11</sup> Blair Sanford, *Medical Malpractice – Now Curable*, Cochran, Caronia Securities, January 2002

<sup>12</sup> Based on NAIC Annual Statements and CID data

<sup>13</sup> IBID

<sup>14</sup> See for example, “Medical Malpractice Premium Data Summary” Department of Banking and Insurance, State of New Jersey for a discussion of both PHICO’s and MIXX’s insolvencies

but continues to write for large institutions both nationwide and in Connecticut. American Health Care still writes medical malpractice business in Connecticut.

**Alternative markets.** Historically, most businesses have handled risk by transferring risk to an insurance company by purchasing an insurance policy. More unconventional mechanisms for handling risk began to grow during the liability crisis in the 1970s and 1980s, when businesses had difficulty obtaining some types of coverages. Recently, growth in the use of alternative mechanisms has been reported in managing malpractice risk. Broadly speaking, these mechanisms include:

- *Self-insurance*, where a firm or group of firms assumes all or much of its own risk exposure. In many cases some form of insurance is purchased to cover catastrophic losses;
- *Captives*, which are companies set up (and wholly-owned) by one or more entities to finance and administer their insurance risk. The assets of a captive are owned by its insureds. Large numbers of captive companies are domiciled in Bermuda, the Cayman Islands, and Vermont. There are about 300 captive for U.S. health care providers according to the actuarial firm Tillinghast-Towers Perrin; and
- *Risk-retention groups*, which consist of a number of firms or individuals that come together to form a limited purpose insurer. It must be chartered and licensed as a liability insurance company under the laws of at least one state, but the group can write insurance in all other states. Risk-retention groups are organized under federal law – the Liability Risk Retention Act of 1986 – that preempts certain state laws that regulate the activities of these groups.

There are various tax and risk advantages and disadvantages to establishing any of the above alternatives. Generally, these alternatives to traditional insurance are created in part to save money because insureds recoup the investment income that would typically accrue to the insurer's bottom line, but at the same time providing a stable form of coverage.

Disadvantages to insurance alternatives include the amount of funding needed to initially establish and operate a captive or risk-retention group. Further, these alternative ventures still require the purchase of reinsurance to protect them from unusually high claims.

In Connecticut, many hospitals have been using alternatives to traditional insurance for some years. According to the Connecticut Hospital Association (CHA), of the 31 acute care hospitals in Connecticut, 13 self-insure or are part of a risk retention group, 12 are part of a captive, and six maintain commercial insurance. In addition, 13 members of CHA are exploring the feasibility of creating or joining a captive.

Moreover, the Women's Health Connecticut, a group practice of OB/GYNs with about 150 physicians, recently formed a captive after receiving notice of a 70 percent premium increase for its commercial insurer.

### **Market Impact on Physicians and Health Care Access**

The potential impact of rising medical malpractice rates on patient access to physicians raises the specter of many physicians curtailing or leaving their practices in Connecticut. The following illustrates medical malpractice rate increases in Connecticut over the last several years.<sup>15</sup>

- Over the last six years (between 1997 and 2003), premiums increased between 37 and 241 percent for internal medicine, 35 and 185 percent for general surgery, and 45 and 128 percent for obstetrics/gynecology depending on the company.
- Over the same time period, the cumulative consumer price index (CPI) and Medical CPI have increased 13 and 24 percent respectively.
- In comparison, rate increases in the 1990s were considerably smaller. For example, the Connecticut Medical Insurance Company's (CMIC) cumulative rate increase from 1993 through 1997 was about 12 percent for these three specialties, not including discounts or dividends. From 1997 through 1999, CMIC insureds *on average* experienced either no rate change or a reduction in their premium, not including dividend payments.
- These premiums do not include the most recent rate filing by the carriers as of December 2003. ProSelect requested a 30 percent overall increase in rates, which became effective November 1, 2003. Other Connecticut carriers that recently had newly filed rates go into effect include the Medical Protective Company (29.1 percent overall increase effective August 1, 2003), and Truck Insurance Exchange (57.3 percent overall increase effective December 1, 2003.) On November 1, CMIC submitted a request for a rate increase of 24.1 percent, to be effective January 1, 2004.

**Reimbursement.** Medical malpractice insurance rates, like other costs related to health care, rise within a reimbursement system tightly controlled by managed care entities. Although liability insurance is considered in setting rates, the rates do not keep pace with medical malpractice premium increases.

**Impact on patient access to physicians.** *The connection to physician access significantly elevates the medical malpractice insurance issue as a public policy priority. However, as of December 2003, the connection is difficult to quantify.* Connecticut traditionally

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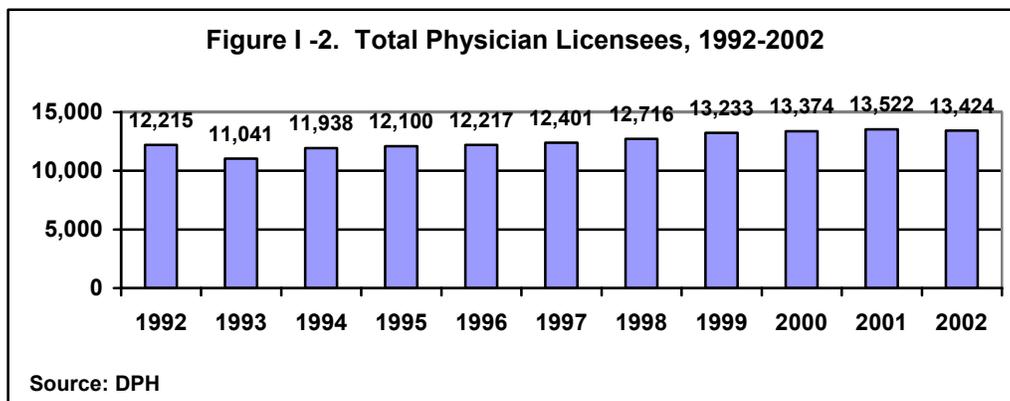
<sup>15</sup> Much of this information is presented and discussed in more detail in Chapter VI.

has had one of the highest physicians-in-patient-care per capita ratios in the U.S. It was ranked fourth in the nation in 2001 by the American Medical Association.<sup>16</sup> Yet the Connecticut State Medical Society asserts the number of physicians in active patient care in Connecticut has declined from 8,458 in 1998 to 7,000 in 2003. In addition, the medical society, along with the Connecticut Chapter of the American College of Obstetricians and Gynecologists, has stated the number of OB/GYNs has decreased from 500 in 2001 to 450 in 2003. Increasing medical malpractice rates, it is asserted, are the chief culprit that has forced physicians to cease or modify patient care services.

*The program review committee examined available data to try to determine what the trend in physician employment has been. No data source can give a complete picture – all have some type of deficiency. While the data are generally inadequate to make an unequivocal finding, when considered together, the data do not appear to indicate a crisis in access is currently occurring. This, of course, does not mean that some physicians have not made a decision to either leave practice early or leave the state based on medical malpractice premium concerns, or are not seriously considering it now.*

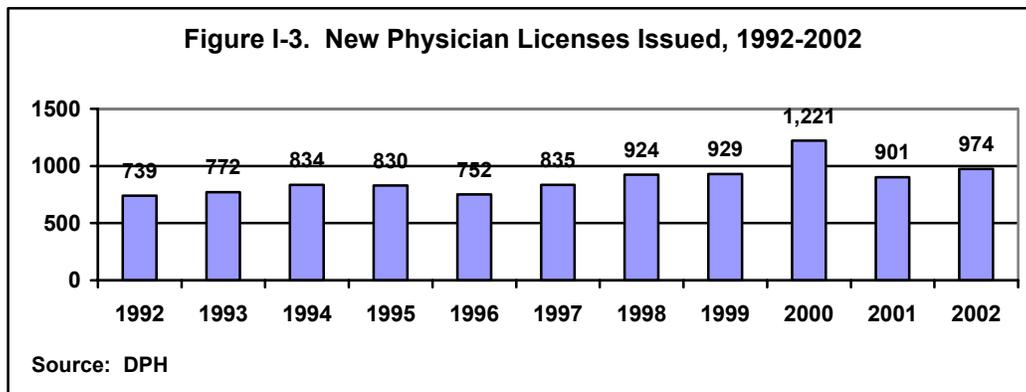
The committee reviewed three sources of information to try to understand the trend in the number of physicians in Connecticut: DPH; medical malpractice insurance companies; and a large health care insurer.

- The total number of physicians licensed by the Department of Public Health has increased since the early to mid-1990s and has remained fairly steady since 2000, as shown in Figure I-2 below. The DPH data, however, contain an unknown number of licensees who are retired but still maintain a license. In addition, it cannot be determined how many are in active patient care – those required to have medical malpractice insurance.
- The department does not normally maintain historical data about the number of physicians in subspecialties. However, it did have some records from 2002 for OB/GYNs. The number of licensed OB/GYNs in 2002 was 823. As of December 1, 2003, there were 833 -- 669 of whom have indicated a home address in Connecticut. (Further, DPH does not know how many OB/GYNs may have dropped the obstetrical part of their practices.)



<sup>16</sup> 2001 AMA Annual Survey

- The number of new licensees has also generally increased since the early to mid-1990s and remained fairly constant from 1998 through 2002, with the exception being an increase in 2000, as shown in Figure I-3. It is unlikely that any new licensees retired, but the issue of whether they engage in direct patient care still exists. Of the 990 new licensees for 2003, 682 indicated a subspecialty including 39 who declared OB/GYN to be their subspecialty.



- Retiring physicians will apply for insurance coverage to handle any claims that come up in retirement for incidents that occurred while they were practicing (i.e., tail coverage). A review of insurance data does not indicate any dramatic increase in the number of physicians requesting such coverage. For example, ProSelect reports six physicians in 2002 and five in 2003 (through mid-November) have requested tail coverage (not including those who died or were disabled). CMIC data indicate that in 2000 and 2001, 55 and 69 doctors respectively retired, while in 2002 and 2003 (to November) 45 and 42 doctors retired respectively. In 2000, 36 doctors under the age of 69 retired, while in 2002, 22 did.

The committee also reviewed data from one of the state's largest health care insurer. The data indicated that about 3 percent of the physicians had left voluntarily. The insurer stated that this was pretty much consistent with past years. Reasons for leaving could be retirement or some other reason. The OB/GYNs who left totaled 26.

Finally, DPH has not received any increase in complaints about problems in access to doctors or from hospitals not being able to provide a full range of services.

As noted above, the numbers cited may be masking an impending problem. Certainly many physicians believe strongly that the medical malpractice insurance problem threatens access and certain specialties, such as OB/GYNs, are the most commonly referenced as being affected.



## Medical Malpractice Claims Process

### Introduction

Medical malpractice claims are addressed largely as lawsuits in the framework of the civil tort system. This process and its outcomes impact medical malpractice insurance rates because “losses”, the primary component of ratemaking, are principally the payments an insurance company or self-insured entity makes to comply with a settlement or verdict in favor of an injured person. The claim resolution process is described in this chapter along with committee findings and recommendations related to the process. First, though, general information about the operations of tort law is presented.

**Tort of negligence.** A tort is a civil wrong against a person or property for which a civil court may provide a remedy through a lawsuit for money damages, as opposed to a criminal law violation or a breach of a contract claim. The tort of negligence is based on common law principles, which are found mostly in court cases (as opposed to statute). Negligence is defined as the omission or commission of an act that a *reasonably prudent person* would or would not do under given circumstances.

There are four elements that must be established to find general negligence:

- a duty was owed by one party to another;
- a duty was breached;
- the breach caused an injury; and
- damage (injury) has occurred.

**Public policy goals.** Two public policy goals underpin tort law: 1) an innocent person who is harmed should be compensated by the person who did the harm, if that person acted in breach of a reasonable standard of care; and 2) such accountability will deter future negligent actions.

**Medical malpractice and standard of care.** Medical malpractice is a type of negligence. One main distinction between general negligence and medical negligence (i.e., malpractice) is the nature of the duty owed. For general negligence, the question is what would a reasonably prudent person have done in a similar set of circumstances (to compare to what the person charged with negligence actually did.) In medical malpractice cases, the question is what would the reasonably prudent physician have done, or the reasonably prudent obstetrician-gynecologist or neurosurgeon, if a specialist is involved. Thus, the legal duty owed by a physician to a patient is to render professional services with the degree of skill and learning commonly applied, under all the circumstances present in a case under review, in the United States by the average prudent reputable physician. This is called *the standard of care*.

To fail to provide services in accord with the standard of care is to breach the duty owed. As for the other tort elements, if those services performed in a substandard way cause injury, loss, or damage to a patient, then medical malpractice has occurred. In addition to actual physical injuries, failure to obtain consent or breach of confidentiality may also be the basis for a medical malpractice claim.

Of course, a physician can act within the standard of care and there can still be a bad outcome for a patient. In theory, tort law will not compensate for any damage in that situation because the doctor acted appropriately. Also, even if a doctor did breach the standard of care, tort law requires that any injury or damage be “proximately caused” by the breach (i.e., the doctor’s action was a substantial factor in the injury). Finally, the relevant standard of care in a specific lawsuit is the standard followed at the time the incident occurred, even if that standard has changed in subsequent years because of a new medicine or new technology. Thus, the disputes at the core of medical malpractice cases are:

- what the standard of care is;
- whether the standard of care was breached; and
- whether the damages or injuries were caused by that breach.

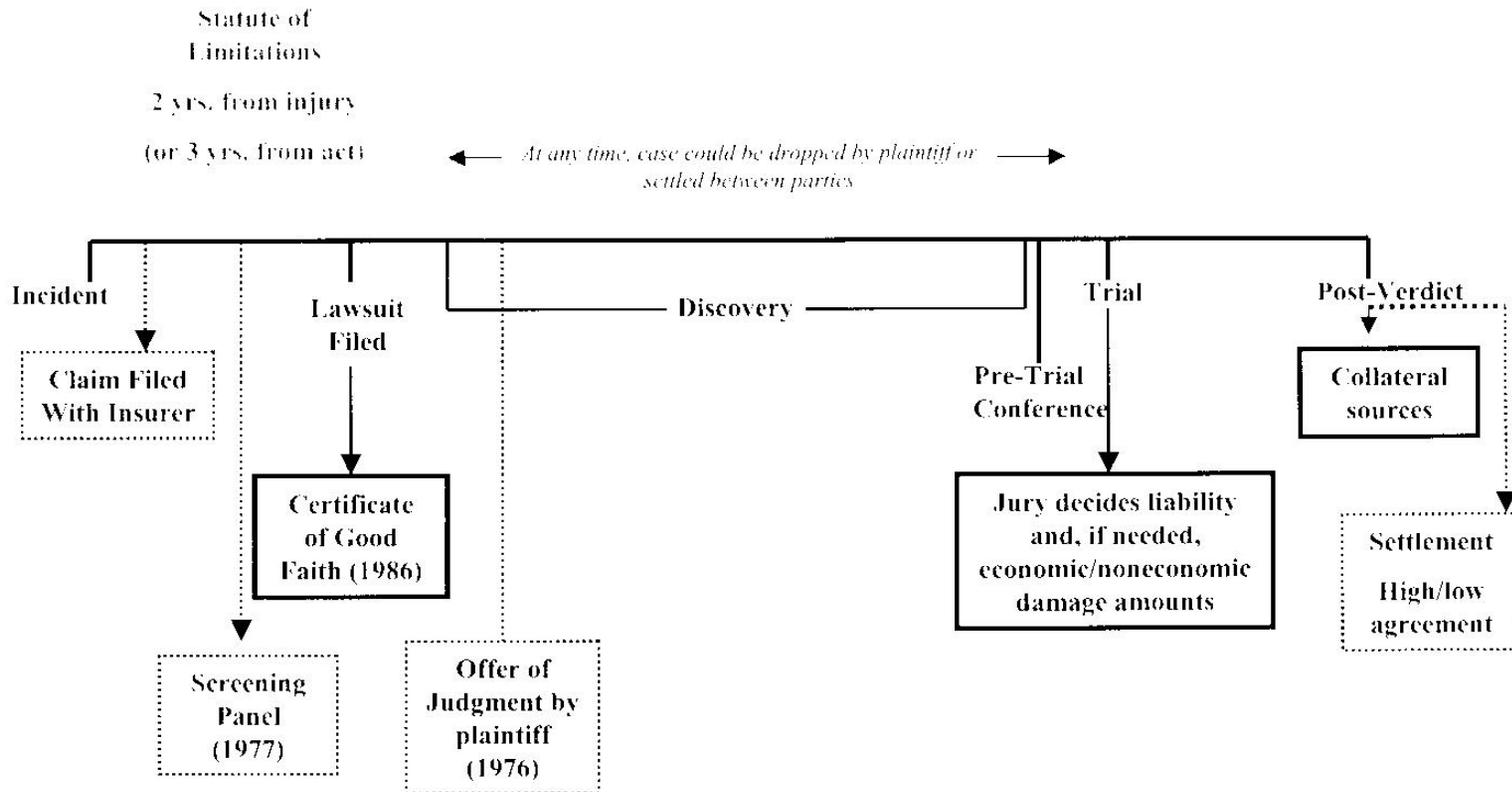
**Burden of proof.** In any negligence case, the person bringing the lawsuit (the plaintiff) has the burden of proving that the duty owed to him or her was breached. This is also true in medical malpractice cases. However, in medical malpractice cases, because the standard of care is medically-based, the plaintiff must present an expert witness qualified to express an opinion as to the standard of care customarily exercised by physicians in cases similar to the plaintiff’s. (Where the incident is so clearly based on negligence, such as the wrong limb being amputated, an expert is not required.)

**Impact of insurance factor.** Many interests can be at stake in a medical malpractice lawsuit and many different parties can be involved, depending on the nature of the injury and the age of the injured person among other factors. The presence of insurance companies and other mechanisms to indemnify individual doctors adds another party to the medical negligence resolution process. As discussed in Chapter One, medical malpractice insurance is intended to cover physicians and other health care professionals from the economic impact of any claims/lawsuits based on their negligence. This typically includes protection against a payment up to a certain coverage limit, and the provision of legal representation. In a malpractice case, then, a doctor’s interests—i.e., not being found negligent, avoiding damage to his/her reputation -- are joined with his or her insurer’s interest in paying no claim or as small a claim as possible. These interests, of course, can be in conflict.

## **Medical Malpractice Claim/Lawsuit Process**

Figure II-1 depicts the key points in a medical malpractice claim that becomes a lawsuit and is adjudicated through a trial. Most medical malpractice lawsuits never go to trial, but are either disposed of without payment or settled with payment.

# Claims/Lawsuit Process



**Tort reform.** In 1986 and again in 1987, the legislature enacted provisions affecting the tort process in Connecticut commonly known as Tort Reform I and Tort Reform II. In general, the primary intent of tort reform is to limit the financial impact of personal injury suits. Changes pertinent to medical malpractice lawsuits include: attorney contingency fees; categorization and calculation of damages; collateral source law; joint and severable liability; installment payments of judgment amounts; and good faith certificates. These provisions will be discussed as the claims process is described.

**Claim.** The term “claim” in relation to medical malpractice can refer to any formal written notice to an insurance company that a person believes an insured doctor has acted negligently. This notice can range from a demand letter from the patient or his/her attorney to the physician or the physician’s insurer to a summons and complaint served on the physician, signifying a lawsuit has been filed. While the number of medical malpractice lawsuits filed for the last several years in Connecticut has remained fairly level, averaging 365 from 1993 through 2002, these figures do not shed light on how many claims are submitted to insurance companies that never get filed as lawsuits. These claims are either settled to the parties’ satisfaction or the claimants do not pursue them.

Where insurance is involved, at least initially any negligence claim could be handled solely between the claimant and the insurance company as a claim against an insurance policy. Because of Connecticut’s statute of limitations on medical malpractice lawsuits, if a written claim is made to an insurance company and is unresolved within a certain amount of time, the injured person needs to file a lawsuit to preserve his/her right to have the matter resolved in court.

**Statute of limitations.** Under Connecticut law, a suit for medical malpractice must be filed within two years of when the injury was first sustained, discovered, or should have been discovered with reasonable care. These timing limitations have one caveat. In recognition that some injuries are slow to present, but also that there is a need for finality, a total time limit is set -- three years from the date of the act or omission that is the source of the complaint. This means that if a medical procedure took place on Sept. 1, 2003, and an injury occurred during the procedure and was recognized as such, a lawsuit would have to be filed by Aug. 31, 2005, two years after the procedure. Under another scenario, if an injury resulting from that same procedure lay dormant until June 1, 2006, a lawsuit could be filed until Aug. 31, 2006, because the injury was not reasonably discoverable until the June date.

Statutes of limitation are intended to promote the public policy interest of avoiding the litigation of “stale” claims, where witness availability and memory lapses might be a problem. Prior to 1969, the statute of limitations for negligence cases was one year.

## **Filing a Lawsuit**

To initiate a lawsuit, the plaintiff files a “complaint” in court along with a “writ of summons,” a document of notice served on whomever is being sued – i.e., a doctor and/or a hospital. The summons informs the defendant when the “answer” to the complaint is due back to court, about a month after the summons is served. The complaint is typically a several page document describing in a “plain and concise” manner the malpractice allegation and how the

four elements discussed above are met in the particular circumstances of the case. The plaintiff does not state a monetary damage amount claimed. Rather, in compliance with statute and court rule to establish court jurisdiction only, the complaint must state that damages in excess of \$15,000 are sought.

**Good faith certificate.** Since 1986, state statute has mandated that a medical malpractice lawsuit cannot be filed unless the plaintiff's attorney has "made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant."<sup>17</sup> As proof of a reasonable inquiry, the complaint must be accompanied by a certificate from the attorney "that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant." The goal of the certificate requirement is to eliminate frivolous lawsuits.

The statute provides that good faith may be shown to exist if the claimant has received a written opinion of a similar health care provider (qualified as an expert) that there appears to be evidence of medical negligence. The statute further provides that "[i]n addition to such written opinion, the court may also consider other factors with regard to the existence of good faith." It is not clear whether a written opinion from a health care provider is required or not; based on committee staff interviews, not all lawyers believe it is.

If a plaintiff requests, he or she can get an automatic 90-day extension of the statute of limitations to allow for the reasonable inquiry.

*Access and review status.* Any written opinion that may have been received by the plaintiff's attorney is not available to a defendant through discovery, "except for questioning the validity of the certificate." According to the statute, this question can only be raised after discovery is completed (which could be years after the complaint is filed). If an inquiry is raised, a judge may find the certificate was not made in good faith and no "justiciable" (i.e., appropriate for court review) issue existed against a doctor (or other health care provider), provided the doctor "fully cooperated in providing informal discovery." A judge can impose appropriate sanctions on a lawyer signing such a certificate of good faith, and lawyer disciplinary rules can come into play.

*Multiple defendants.* It is not uncommon in a medical malpractice lawsuit for a plaintiff to sue multiple defendants. These can include multiple doctors in the same or different specialties involved in a patient's care, as well as a health care facility like a hospital, if it is alleged a hospital employee (which can include doctors) acted in a negligent manner. Through the course of litigation, defendants can be dropped from a case or work out a settlement while other defendants do not. The certificate of good faith is supposed to cover each defendant named by the plaintiff in the complaint, meaning multiple opinions (written or not) must be obtained if different types of health professionals are involved.<sup>18</sup>

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<sup>17</sup> C.G.S. Sec. 52-190a

<sup>18</sup> In CT, joint tortfeasors may seek contribution in med mal actions if they are required to pay more than their originally allocated amount. If a settlement is reached between claimant and person, that person is discharged from all liability for contribution, but the total award of damages is reduced by the amount of the released person's

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**Defendant answer.** Once a complaint has been filed, the defendant can make motions to dismiss or otherwise dispute the adequacy of the complaint, but at some point a defendant has to formally answer the complaint, or be in default. Typically, the answer will agree with factual items in the complaint (such as the doctor's specialty) but otherwise deny all allegations or indicate the defendant cannot say one way or another due to lack of knowledge. The defendant's answer can counter the complaint with "special defenses," which include a charge the statute of limitations has run out, or the plaintiff failed to follow the doctor's orders.

**Closing pleadings.** The complaint and answer documents are called "pleadings" in Connecticut. The pleadings encompass all the documents that need to be filed and responded to to ensure all parties are clear on what exactly is being claimed by the plaintiff, and how the defendant responds to the claim. There is a step in any civil case where the parties notify the court that their pleadings are complete. This means the case can be put on a trial list at the pertinent court location, and an actual trial date can be set. While the amount of time after which pleadings are closed and a trial date set can vary by judicial district, the milestone exposes both parties to the possibility of actually going to trial, which can encourage settlement.

**Discovery.** Discovery is the process through which both sides seek to get as much information from the other party and other relevant sources as possible to assist them in the lawsuit. The process can extend over months and years, beginning not too long after a complaint is filed and continuing right up to (and even during) trial. An important outcome from the discovery process is that both sides can assess the strengths and weaknesses of each other's case, which is used in the calculus to seek a settlement or go to trial. Witness testimony during discovery is taken at recorded depositions, which can be used to attack witness credibility at trial.

Information sought during discovery includes information about:

- liability insurance coverage for the defendant;
- collateral sources of income for the plaintiff;
- medical records;
- statements of the plaintiff, defendant, and witnesses;
- statements of medical experts through depositions, including the basis for why they are considered qualified to be experts, on one or more of the following elements of a case:
  - the particular event claimed to have been negligent;
  - whether the doctor's act or omission proximately caused injury;
  - and
  - the nature and duration of the injury; and

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percentage. Further, since 1995, a defendant in a civil suit may file a complaint to add a person who is not a party to the action who is or may be liable for a proportionate share of the plaintiff's damages. This must be filed within 120 days after the return date (about a month after the original case if filed). This person is the apportionment defendant, and can be a person who has either settled with or been released by the P. This applies to any civil action file on or after July 1, 1995.

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- past and future economic damages.

**Settlements.** At any point after a lawsuit is filed and before a jury verdict (although sometimes even after a jury verdict), the parties can agree to settle the case. Typically, a settlement, reduced to writing, will call for the defendant to pay the plaintiff a sum of money in exchange for the withdrawal of the suit by the plaintiff and a release from any further actions against the defendant. There is almost always a condition that the settlement terms be maintained confidentially, and there is no admission of any liability on the part of the defendant. The settlement agreement is not filed with the court although the court is supposed to be informed that settlement has been reached.

*Offer of judgment.* Enacted in 1976, the offer of judgment provision<sup>19</sup> is a tool intended to promote settlement of lawsuits. At any point after a lawsuit is filed but no later than 30 days before trial, a plaintiff may file with the court clerk a written “offer of judgment” (OOJ) to the defendant offering to settle the claim for a certain sum. The defendant has 60 days after being notified of the OOJ, (as long as it is before completion of a trial) to consider and accept the offer. If accepted, the OOJ amount would be recorded as a stipulated judgment and the case closed.

However, if the offer is not accepted within 60 days, it is considered rejected. After trial, if there is a plaintiff’s verdict, the judge checks to see if the plaintiff made an unaccepted offer of judgment and in what amount. If the plaintiff’s verdict award is greater than or equal to the offer of judgment made by the plaintiff to the defendant, the judge adds 12 percent annual interest to the award amount. The interest is applied back to the date of the original lawsuit filing if the OOJ was filed within 18 months after the case was filed. For an OOJ made later than 18 months after the case was filed, the interest is computed from the OOJ file date.<sup>20</sup>

The defendant may also make an OOJ no later than 30 days before trial, which the plaintiff has 10 days to accept. If the plaintiff accepts the OOJ, a judgment is entered against the defendant for the amount of the offer and for costs accrued at the time the defendant made his offer. The risk to the plaintiff in not accepting is that unless any plaintiff verdict award is more than what the defendant offered, the plaintiff will not recover costs accrued after the offer, and will have to pay any defendant’s costs accrued after the offer was rejected.

**Jury trial.** In civil cases involving over \$250 in damages, either party can choose to have a jury trial, meaning the facts will be decided by a jury as opposed to a judge. Although only a small number of medical malpractice lawsuits get to the trial stage, typically a jury trial is selected. During trial, evidence in the form of witnesses, including expert witnesses, and exhibits is presented by both sides. As discussed earlier, the plaintiff needs to establish through that evidence that a breach of the appropriate standard of care occurred, and that breach caused his or her injury, by the preponderance of the evidence.

*Damages.* By statute, both parties are allowed during closing arguments to state a lump sum amount for past and future economic and noneconomic damages they believe is warranted

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<sup>19</sup> C.G.S. Sec. 52-192a

<sup>20</sup> Pre-October 1, 1981, if the plaintiff recovered an amount equal to or greater than the sum set out in the OOJ, the court added 12 percent interest to the amount recovered, computed from the time the offer was filed.

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by the facts of the case. An attorney may also suggest to the jury a math formula on which to base a verdict amount. However, the judge is required to instruct the jury that any sums noted by the lawyers are not facts, but argument, and that any award amount determination is solely within their role. Juries are further instructed that if they find liability, they are to determine what is “fair, just and reasonable compensation.”

**Post-verdict.** Many actions can be taken after the verdict to affect the final resolution of case. If the verdict is for the defense, meaning negligence was not established, the plaintiff always has the option of an appeal if reasonable legal grounds exist.

If the verdict is for the plaintiff, with a damage amount, several things can happen. First, in some cases, prior to the verdict but after the trial starts, parties can enter into what is called a “high/low” agreement. In this arrangement, the parties agree to a maximum amount the defendant will pay and a minimum amount the plaintiff will receive, *regardless and in lieu of* a jury verdict outcome that is above or below the agreement.

Second, after a plaintiff verdict, it is still possible for the parties to agree on a settlement that is different from the award amount. This can occur in cases where the verdict amount exceeds insurance coverage, and the plaintiff is willing to accept the insurance amount, or to avoid an appeal. Third, the parties can request the court to order either a remittitur (reduction) or additur (addition) of the verdict. There is no evidence either of these motions is often made. Fourth, parties can agree on periodic installment payments to pay for a verdict, which can reduce the burden on the party paying out the money. This option does not appear to be used often.

Many of these actions that alter what a plaintiff will really receive, notwithstanding a jury award, occur on a confidential basis. Thus the public that might read about a verdict award in the newspaper will never know if the award amount was ever actually paid.

### **Plaintiff Attorney Compensation**

There is a long practice in certain types of civil cases for plaintiff attorneys to work on a contingency basis, meaning an attorney only receives a fee if the plaintiff wins. Customarily, the common attorney fee is one-third of the amount of damages won in the case. In 1986, as part of Tort Reform I, in a stated attempt to increase the amount of money actually going to the plaintiffs in larger verdict cases, the legislature enacted a “sliding scale” contingent fee schedule.

Under that law, an attorney and client, for a claim or civil action to recover damages for a personal injury, wrongful death, or property damage, may enter into a contract for the lawyer’s fee to be paid contingent upon and as a percentage of either an award or settlement, in the following sliding scale amounts:

- 33 1/3 percent of first \$300,000;
  - 25 percent of next \$300,000;
  - 20 percent of next \$300,000;
  - 15 percent of next \$300,000; and
  - 10 percent of any amount that exceeds \$1,200,000.
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However, the provision may be waived by a plaintiff. In a 1992 case addressing the fee cap, the superior court judge ruled the cap was a private benefit for anybody filing a tort action, and as such could be waived by that person.<sup>21</sup>

The case was sparked by a wife wanting to sue a chemical manufacturer for the permanently disabling damages her 37-year old husband allegedly suffered due to toxic chemical exposure at work. The person sought representation from a well-known plaintiff's litigation firm. A firm attorney told her that because toxic tort claims were so complex, it wouldn't be economically feasible for him to take the case under the cap restrictions. In her decision, the judge noted the plaintiff had made a compelling case that the statute was unconstitutional, noting many other states in which similar statutory limits on attorneys fees had been declared unconstitutional (although not all). The constitutional question did not need to be addressed, though, because of the private benefit theory.

The judge cited the "general rule...that rights granted by statute may be waived unless the statute is intended to protect the general rights of the public rather than private rights." and noted other statutes relating to litigation have been construed by the courts as conferring a private right that may be waived (e.g., the statute of limitations in tort cases and the right to a jury trial.) The judge noted as the fee cap was intended to increase the portion of a judgment or settlement actually received by a plaintiff, it was a private right only for persons filing tort action. Finally the judge noted that during the enactment of the law, the proponents of the bill acknowledged the law would establish a private benefit that could be waived.

In practice, it does not appear unusual for plaintiffs' lawyers to seek waivers in medical malpractice cases on the grounds of case complexity and the investigation and discovery expenses involved. At least some that do also include the case expenses in the amount contingent upon a recovery, meaning a lawyer must absorb the expenses if there is no win. The legislature, of course, since the 1993 court decision could have amended the law to make it nonwaivable, but has not. Many believe such a change would likely be quickly challenged on constitutional grounds.

## **Damages**

A basic tenet of tort law is to compensate a person for any injuries and other negative results from the actions of a negligent person. The compensation goal is to make the person whole again, the position the person would be in "but for" the negligent act. Damages is another word for the money awarded to a plaintiff in a negligence suit.

The main type of damages awarded in medical malpractice cases, as in all personal injury cases, is compensatory damages. The intent is to "compensate" the injured person for losses caused by another's negligence, or to "restore the injured party to his original position." There are two types of compensatory damages: economic and non-economic. As defined under Connecticut statutes since 1987:

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<sup>21</sup> In re Estate of Pasquale Salerno 42 Conn. Supp 526 (1993)

- *economic damages* are compensation for pecuniary losses including but not limited to the cost of reasonable and necessary medical care, rehabilitative services, custodial care and loss of earnings or earning capacity; and
- *non-economic damages* are compensation for all nonpecuniary losses including but not limited to physical pain and suffering and mental and emotional suffering.

Many people concerned about rapidly rising medical malpractice premium increases cite the unpredictability of jury decisions about non-economic damages as a chief driver of those increases. Even though non-economic damages are only determined separately in cases that actually go to trial, which is a very small number of cases, there is a belief that the possibility of what a jury might decide affects settlement decisions also. Thus although settlement amounts are not broken into economic and noneconomic damages, they are affected by the distinction. Appendix A provides more detail about how non-economic damages are viewed under Connecticut case law.

**Guidance given to jury about damages.** Through a medical malpractice trial, testimony will be given about what a person’s life was like before the injury, what activities he or she pursued, what the person’s family situation is, and how those things were changed by the injury. Since 1989 by statute, attorneys are allowed to state their evaluation of damages in final argument, but if that happens, the judge is required to instruct the jury that the attorneys’ statements are not actual evidence, and the jury alone is to determine damages.

**Judicial review of jury awards.** The Connecticut Supreme Court has established the standard by which a judge is to review the size of jury awards: “The only practical test to apply...is whether the award falls somewhere within the necessarily uncertain limits of just damages or whether the size of the verdict so shocks the sense of justice as to compel the conclusion that the jury were influenced by partiality, prejudice, mistake, or corruption.”<sup>22</sup>

**Plaintiff collateral sources.** Under current Connecticut law, certain types of money received by a plaintiff from sources unconnected to the medical malpractice claim may serve to reduce any damage award owed by a defendant. The “collateral source” rule in tort law refers to how sources of money a plaintiff might receive from third parties to cover the effect of an injury alleged to be caused by any personal injury case (including malpractice) should be treated. For example, if a person claims an injury was caused by malpractice and sues for damages including medical care expenses, he or she might also have health insurance that will cover the medical care needed to address all or at least some of the damages.

Under common law, the fact that a plaintiff might have another source of money that would mitigate the damages caused by the tort was not admissible in court. Under the 1986 – 1987 tort reform acts, the Connecticut legislature altered the common law rule. Now, once liability is admitted or determined through trial and damages are awarded, the judge is to reduce the amount of the award by the total of all amounts paid to the claimant from all collateral

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<sup>22</sup> McKirdy v. Cascio, 142 Conn. 80, 86 (1955)

sources available (with some exceptions). After trial, the judge seeks information from the claimant about any collateral sources. The statute makes clear that in malpractice cases, any collateral sources are to reduce *economic* damages.

*Collateral source definition.* A collateral source is defined as any payment made to the claimant by any person as compensation for personal injury or wrongful death, attributable to the incident giving rise to the cause of action. It may include a payment from any health or sickness insurance, automobile accident insurance that provides health benefits, and any other similar insurance benefits (except life insurance benefits available to the claimant), whether purchased by him or provided by others or from any group contract or agreement to provide pay for or reimburse the costs of hospital, medical, dental, or other health care services. Collateral sources do not include amount received by a claimant as a settlement.

**Alternative resolution mechanism: medical malpractice screening panel.** In 1977, legislation was enacted creating a Medical Malpractice Screening Panel to hear medical malpractice claims and make findings of liability before a trial, if all parties agreed to submit the claim to the panel for its review. As explained by a Senate proponent of the bill, "...to the extent that we can screen out frivolous claims or see settled legitimate claims as soon as possible in that process we are going to save money, we are going to save money on premiums and we are ultimately going to save money in the cost of health care in Connecticut."<sup>23</sup>

The statute remains on the books today, but by all accounts the panel has never been used. The screening panel was "established within" the Insurance Department, and was to consist of a pool of doctors and lawyers suggested by the Connecticut State Medical Society and the Connecticut Bar Association. From this pool, ad hoc panels for specific cases could be drawn (two doctors and one lawyer).

After a hearing process, if the ad hoc panel unanimously makes a finding on liability, that finding is to be admitted to any subsequent trial on the case, and the jury decides how much weight to give it in its deliberations. Otherwise, the proceedings of the panels are confidential.

## **Findings and Recommendations**

### ***Connecticut: Many Proposals Already in Place***

Many proposals have been made to solve the premium increase problem by reducing the costs to insurance companies by focusing on aspects of the claims resolution process (i.e., the tort system). The American Medical Association supports several tort reforms as tools to reduce litigation and its costs. Many of these reforms were adopted by the states during the mid-1980s, during the last medical malpractice crisis. Appendix B lays out each of these mechanisms and the AMA position on each, comparing what California and Connecticut have in place. California is used because its 1975 tort reform legislation (Medical Injury Compensation Reform Act (MICRA)) is promoted by many as a model approach. As Appendix B shows, Connecticut has almost all the reforms in place the AMA supports, more so than California in terms of number. *For example, Connecticut has: 1) a certificate of good faith requirement, unlike California; 2) a*

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<sup>23</sup> Proceedings of the Senate, April 28, 1977, p.1445

*more restrictive statute of limitations for claims involving minors; and 3) more defendant-friendly versions of the rules of joint and several liability and comparative negligence.*

*Connecticut departs from the AMA and California in two significant ways: 1) Connecticut has no cap on non-economic damages; and 2) even though the state has an attorney fee schedule in statute, many plaintiff's attorneys, relying on a 1993 superior court decision, receive client waivers of the schedule.*

### **Cap on Non-Economic Damages**

**Intent of caps.** The main stated intent behind proposals to place caps on non-economic damages in medical malpractice cases is to affect rates in two ways: 1) inject stability into the ratemaking process (i.e., estimating how much potential loss for which to reserve) by removing a significant element of uncertainty—what a jury might award for non-economic damages; and 2) in light of the size of some non-economic awards, decrease the amount an insurer is liable to pay. It is important to keep the two purposes separate. For the sake of stability, the fact that there is a cap is more important than the size of the cap. To actually reduce the potential payout, the size of the cap is clearly as important as its existence.

**Cap status in other states.** Damage caps with varying characteristics are in place in 25 states as of December 2003. This past year, the U.S. Congress considered legislation to establish a national cap for certain damages for medical malpractice cases. Although most caps restrict non-economic damages, there is wide variance among the caps as to: 1) whether they apply to all personal injury cases versus just medical malpractice cases; 2) whether they also cap punitive damages or total damages; 3) the actual amount of the cap; 4) whether the cap is per claim or per defendant; 5) whether the cap is a fixed amount or increases over time; 6) any exemptions to the cap's application; and 7) what other mechanism they are tied to (i.e., a patient compensation fund).

*When caps were adopted also varies. The earliest was in 1975, several were enacted in the mid-1980s, and a few states have just enacted the provisions. Further, damage caps are just one of many "tort reform" tools promoted and adopted in states over the years. These reforms generally are intended to reduce what a respondent must pay in damages and to resolve cases earlier in the process.*

All these factors are mentioned to indicate there are many difficulties in attributing insurance rate levels to the institution of caps. In addition, how insurance is regulated can have an impact on insurance rates.

Below is a summary of the current status of caps across the United States:

- Five states currently have \$250,000 caps on non-economic damages for medical malpractice cases.
- Ten states currently have higher caps on non-economic damages for medical malpractice cases, with other variations.

- Six states have caps on non-economic damages for personal injury cases, including medical malpractice claims.
- Four states limit liability of health care practitioners who participate in a state compensation fund that covers any excess liability.
- 25 states have no caps on damages. (See Appendix C for more detail)

Two main questions are posed when evaluating caps. The threshold question is whether caps actually lower insurance premiums. If the answer is yes, the next inquiry is about the implications of imposing a cap in light of other policy interests.

### ***Do Caps Decrease Medical Malpractice Insurance Rates?***

*Logically, placing a limit on the amount of recovery should lower rates, all other factors staying the same.* As estimated losses are a key factor in determining rates, if an insurer knew that non-economic damages could be no more than \$X (i.e., the amount of the cap), and assuming past experience was that non-economic damages were often higher than the cap, those estimated losses would be lower, thereby requiring less premium to cover. How much of a decrease in losses would affect premiums is dependent in part on how other indemnity-related costs, like defense costs, might also be affected. Also, any potential decrease assumes the current rates are adequate.

*Prospectively determining cap impact on rates and the amount of that impact, though, is a complicated exercise.* The timing of any impact can be an unknown. If a cap went into effect in Connecticut in 2004, for example, what would that mean? It would only apply to claims made after the cap was in place. In theory, for those claims to which the cap would apply, the reserves attributable to that claim should reflect the presence of a cap. A cap would not affect any claims on the books prior to its effective date, so that any changes in reserves for “non-capped” claims would have to be reflected in premiums.

Further, some believe that unless there is a requirement to reduce rates upon the passage of a cap (as Connecticut did with its worker compensation reforms in 1991), insurers will not reduce rates. Also, if the cap was challenged as unconstitutional as has happened in other states with mixed outcomes, a prudent insurer would not reduce reserves as much. Finally, many also believe that a cap on non-economic damages would lead to changes in emphasis on economic damages. The actuarial firm, Milliman USA, in its analysis of the projected effect of capping non-economic damages in Pennsylvania, noted many of these uncertainties:

A cap on non-economic loss can have certainly additional effects that we did not consider in the analysis. It is possible, for example, that jury awards and settlements for economic loss will increase to partially offset the cap on non-economic loss, or that the percentage of defense verdicts will decline. Legal arguments might be devised to narrow the types of damages subject to the cap, or to define new forms of damages that are outside the limitations on non-economic loss. It is possible that certain types of lawsuits or damages may be exempted (either by statute or court decision) from the award cap. As a final example,

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greater care might be taken by plaintiffs to carefully define and fully list all elements of economic loss, if the possibility exists to use non-economic damages as a catch-all for ill-defined damages. All these items could act to decrease the savings realized by this type of tort reform. In our model we assume that no such events would occur.

The Connecticut Medical Insurance Company told the program review committee at its September hearing that if a \$250,000 cap went into effect in 2004, the planned rate of increase in its 2004 rates would be reduced by 10 percent. (e.g., if the rate of increase was to be 24 percent, with a cap, the rate of increase would only be 14 percent over 2003 rates.)

ProSelect, in a written response to the legislative medical malpractice work group noted: “Moreover...even if meaningful tort reform were to be enacted today, we would not be able to represent that we could reduce our premiums in the near future. Our long term exposure to risk and the possibility of catastrophic losses means that we would have to see how the reforms play out before we could quantify our savings and re-price our products.”

Cap proponents argue that the experience of states with caps proves that caps lead to reduced insurance rates. Appendix D summarizes many of the commonly cited reports on the issue of caps, and committee staff comments are made where pertinent. As Appendix D shows, methodological problems are presented in studies attempting to show the nature of the cap impact.

### **Selected Connecticut Award Data**

Committee staff reviewed medical malpractice plaintiff verdict awards made in Connecticut in the years 1998 through 2002, based on data submitted by the three largest medical malpractice insurers in the state during that period.<sup>24</sup> The data are limited in that it cannot be represented these are all of the medical malpractice plaintiff awards in Connecticut in that time period, but they certainly represent the great bulk. Committee staff did not audit the data for accuracy, although by comparing information from other sources, they were able to identify and correct some errors. These data represent the best compilation of Connecticut award data for medical malpractice cases of which committee staff is aware.

The data contain 43 lawsuits in which the plaintiffs were awarded verdicts during the five years, 1998-2002. Table II-2 shows the verdicts were spread evenly among four of the five years with 2000 standing out. Thirty-seven of the cases involved 14 different specialties (in six cases, specialty information was not provided.)

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<sup>24</sup> One of the three insurers had no plaintiff verdicts in that time period.

Table II-2. Plaintiff Verdicts Per Year in Medical Malpractice Lawsuits from Three Insurers						
Year	1998	1999	2000	2001	2002	Total
No. of Verdicts	7	8	12	8	8	43

Source: LPR&IC analysis of 43 medical malpractice plaintiff verdicts awarded in 1998-2002 (reported to CID by the three largest medical malpractice insurers in CT in 2003).

As Figure II-2 shows, the 43 awards totaled \$54.5 million dollars in the aggregate (not including any offer of judgment interest), made up of \$9.5 million in economic damages (21 percent) and \$45 million in non-economic damages (79 percent).

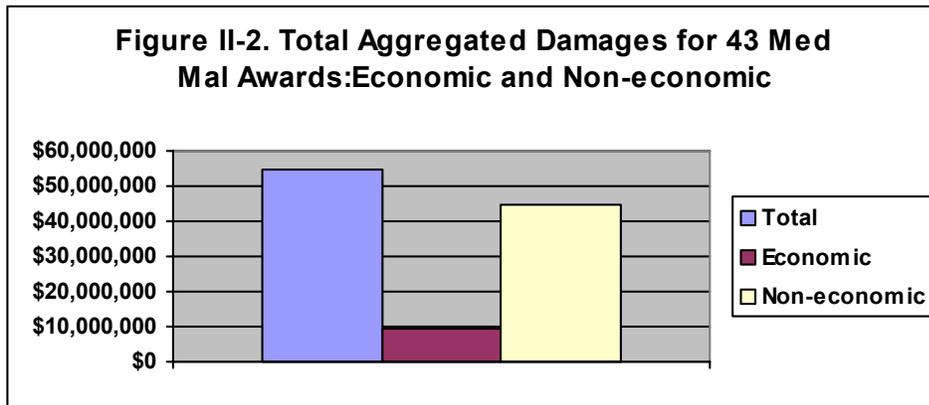
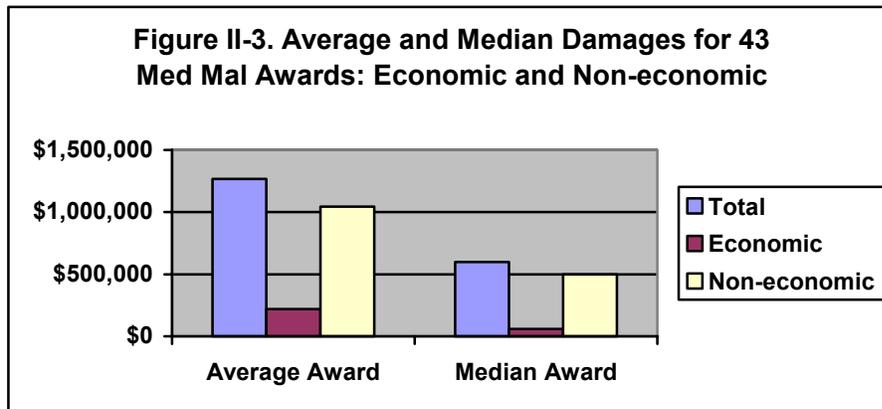


Figure II-3 shows the average total award amount, \$1,266,348, with an average economic damage amount of \$220,927 and an average non-economic damage amount, \$1,045,420. In comparison, the median total award

amount was \$600,000. The difference between the average and the median amounts indicates the wide spread of individual award amounts. The 43 individual awards ranged from a low of \$30,040 to a high of \$8,120,000. Fifty percent of the awards were \$600,000 and below; the top 25 percent ranged from \$1.8 million to \$8.1 million.



All 43 awards had noneconomic damages although three awards had no economic damages. The non-economic amounts ranged from a low of \$15,000 to a high of \$7,808,000.

**Application of offer of judgment interest.** *Thirteen of the 43 verdicts also had interest added to them under the offer of judgment (OOJ) statute. The total amount of OOJ for all 13 was \$8,586,539, at an average per verdict of \$660,503. The lowest interest amount was \$22,017 while the highest was \$1,982,400. In two of these cases, the OOJ amount was over 100 percent of the original award—178 percent and 110 percent.*

**Awards in context.** The award amounts discussed so far are what the jury awarded in each case. However, the awards need to be put in context.

- *One-third of the 43 cases involved two defendants, with one involving three. Thus the award amounts in those cases would apply to more than one person, meaning more than one person (and insurance policy) would be liable for the award.*
- *Although it is not known how much of the total awards described above were actually paid, the individual insurance companies were asked how much they actually paid for their insureds, as compared to their portions of the awards. In total, what the insurers actually paid was 72 percent of the total award amount.*

**Impact of cap on awards.** If there were a cap of \$250,000:

- 16 awards for which non-economic damages were under \$250,000 would be unaffected; and
- 27 non-economic awards over \$250,000 each would decrease in the aggregate by \$36,461,500, an average decrease of \$1,350,426 to the claimant with a median decrease of \$750,000.

If there were a cap of \$500,000, 21 cases or one-half of the cases from the 43 case data pool, would experience a reduction.

## **Cap Pros and Cons**

There are a number of reasons for and against caps. The primary ones can be summarized as follows.

### **Pros**

- Adds predictability to the rate making process
- Based on Connecticut's experience, would save money for insurers
- If savings passed to physicians, medical malpractice rates should be lower
- Would probably have a dampening impact on settlement amounts and perhaps encourage earlier settlement, all reducing costs to insurers

## Cons

- Sets medical malpractice cases apart from every other type of personal injury case in which the plaintiff has the facts of his or her case determined by a jury, which includes the level of damages that occurred
- Provides relief to health care providers (and their insurers) determined negligent by arbitrarily singling out a few injured patients
- Singles out the health care access issue triggered by medical malpractice rates from the other access issues for uninsured and underinsured citizens
- Is a regressive measure in that it would have a disproportionate impact on injured persons with lower economic damages

*While the committee believes that a cap (depending on the size) would have a beneficial impact on medical malpractice rates, determining how much of an impact is essentially speculative, with CMIC's actuaries citing a possible 10 percent reduction to any rate increase for one year based on a \$250,000 cap. Even that positive effect may prove ephemeral due to adjustments in the way damages are presented in claims, a caution noted by actuaries. Obviously, a \$250,000 cap would have the biggest impact because it is the lowest amount being proposed.*

*However, that potential benefit disrupts integral components of our current civil litigation system, i.e., the jury as fact-finder and the validity of non-economic damages. Indeed, cap proposals can be viewed as a tacit acknowledgement that the current litigation system does not work. Instead of structural changes to better achieve the goals of compensation and deterrence, caps only provide a piecemeal approach that negatively impacts the injured party only. Recognizing that modern day medicine and the traditional tort system are at such odds that the underlying goals of compensation and deterrence are not being met, instead of caps, efforts should focus on developing a more effective and broad-based patient-centered safety effort, with all the necessary emphasis on individual accountability.*

Because of the above, the program review committee does not recommend a cap on non-economic damages as a way to address the immediate problem of high medical malpractice insurance rates. *Instead, to respond to the immediate high premium rate problem for physicians, especially those in high-risk specialties, the committee believes a direct premium assistance fund approach is a more targeted solution.* This fund would be temporary, pending further work on more structural changes, discussed later in the report.

## Recommendation

**1. A Medical Malpractice Liability Insurance Premium Assistance Fund shall be established within the Office of the Treasurer. The revenue for the fund shall come from the following sources:**

**an annual charge to all licensed physicians of \$100 annually (13,000 x \$100=\$1,300,000);**

**an annual charge to all hospital of \$5,000 (31 x \$5000=\$155,000); and**

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**an annual fee to all attorneys licensed of \$50 (32,106 X \$50 = \$1,605,300).**

**The initial fund revenue of \$3,060,300 shall be used to provide financial assistance.**

**Any licensed Connecticut physician currently providing direct patient care and indemnified by a Connecticut licensed insurance company in the specialty areas determined by the Department of Insurance, who is not employed by a health care facility that indemnifies him or her, may apply to the department for financial assistance to pay his or her premium.**

**The fund shall be administered by the Department of Insurance and the program regulations required below shall be developed under the emergency provisions of the Uniform Administrative Procedure Act.**

**The fund is specifically dedicated and shall be used exclusively for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to physicians in the state who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner of insurance by regulation and meet the criteria established by this recommendation.**

**To carry out this program, the commissioner of insurance shall certify classes of physicians by specialty or subspecialty, whose average medical malpractice premium as a class, on or after August 31, 2003, is in excess of the amount per year as determined by the commissioner per regulation. In certifying classes eligible for the subsidy, the commissioner, in consultation with the commissioner of the department of public health, may also consider if access to care is threatened by the inability of a significant number of physicians in a particular specialty or subspecialty, to continue practicing in a geographic area of the state.**

**To be eligible for a subsidy from the fund, a physician shall have received a medical malpractice liability insurance premium increase in an amount as determined by the commissioner by regulation, upon renewal on or after January 1, 2004, from the amount paid by that physician in calendar year 2003.**

**The amount of the subsidy shall be an amount as determined by the commissioner by regulation of the increase from the preceding year's premium, except that no physician shall receive a subsidy greater than an amount determined by the commissioner by regulation, in a single year.**

**Prior to a physician receiving a subsidy, the commissioner shall make a determination that the premium charged by the insurance company to the physician seeking the subsidy is a legitimately determined premium, so as not to provide a windfall to the insurance company.**

**A physician who has received disciplinary action from the Department of Public Health shall not be eligible for a subsidy.**

**The commissioner may reduce the amount of the assessment in the subsequent years of the assessment if the commissioner shall determine that sufficient monies are available in the fund to permit a reduce assessment and still meet the purposes of the fund.**

**The fund shall expire June 30, 2007 unless re-established by the legislature.**

### **Offer of Judgment Provision**

The offer of judgment provision described earlier in this chapter applies to civil actions involving contracts or recovery of money. Its intent is to “encourage pre-trial settlements by penalizing a party that fails to accept a reasonable offer of settlement...” Essentially, if an offer is made by the plaintiff of a certain amount to settle a case, and the defense does not accept the offer, if there is a plaintiff verdict for an amount equal to or greater than the original offer, the court will add to that award 12 percent annual interest from either the day the offer was filed or back to when the complaint was filed (depending on when the offer was made).

When first enacted in 1976, the interest rate was 6 percent, which was changed to 12 percent in 1979. In 2001, the length of time the defense has to consider the offer increased from 30 to 60 days. Three concerns are expressed by the insurers and defense bar about the current interest provision:

- *The 12 percent rate is extremely high in today’s market, and leads to some severe results.*
- Its application in medical malpractice cases is difficult because of the length of time it can take to know all the facts of a case in order to make an informed decision about settlement.
- As fashioned now, the defense must pay for delays that it has no control over.

*Although more commonly referred to as pre-judgment interest in other states, the offer of judgment provision is a common concept used by other states to encourage settlements.* Some states do not allow pre-judgment interest in tort cases, on the theory that the potential recovery is so unpredictable, it is not fair to make someone pay interest on an amount no one could have figured out in advance. In some states, pre-judgment interest is limited to economic damages on that theory. In some states, the application of interest is up to the discretion of a judge or jury.

Most states base their rate of interest on a commonly recognized interest rate plus 1 to 4 percent. Some states like Connecticut have set interest amounts:

- 12 percent : Massachusetts, Rhode Island, Connecticut, and Wisconsin;
- 10 percent : New Mexico, South Dakota, and Utah; and
- 8 percent: North Carolina.

## Recommendation

**2. C.G.S. Sec. 52-192a shall be amended to require a plaintiff or his attorney, 60 days before an offer of judgment is proffered, to provide defendants with an authorization for medical records that meets federal Health Information Privacy Protection Act (HIPPA) requirements and a disclosure of any and all standard of care expert witnesses.**

**The rate of interest shall be amended to the five-year Treasury bill plus two percent on January 1 of each year.**

## Pre-Suit Mechanisms

Connecticut has a few provisions already on the books intended to screen out weak or resolve strong medical malpractice cases early in the litigation process. The first of the next two recommendations proposes amending the good faith certificate requirement, while the second suggests a replacement for the voluntary screening panel enacted in 1977 that has never been used.

**Certificate of good faith.** Connecticut's certificate of good faith was established in 1986 and only applies to medical malpractice cases. The statute currently suggests, but does not actually require a plaintiff's attorney to procure a written opinion from a health care provider as the basis for the attorney's good faith belief that his client received negligent care.

*In its discussions with attorneys, the program review committee through its staff learned there are varying beliefs as to what is required under the statute. Without anyone outside of the plaintiff's side actually viewing a written opinion, it is quite possible that lawsuits are being filed lacking the necessary medical review envisioned by the statute.*

Under the certificate statute, the written opinion is to come from a similar health care provider as defined in another section of the statute (i.e., C.G.S. Sec. 52-184c).

## Recommendation

**3. The statutes shall be amended to require that a written opinion from a similar health care practitioner, in which the health care practitioner is identified along with his or her qualifications, and is signed by the health care practitioner, be provided along with the good faith certificate under seal, and it shall be reviewed by a judge no later than 30 days after filing. If the judge finds the certificate insufficient due to the failure of the health care practitioner's qualifications meeting the requirements of C.G.S. Sec. 52-184c, the judge shall so inform the parties, and allow the plaintiff to resubmit one more certificate, with a sufficient written opinion, within 30 days.**

**Pre-suit mediation.** As described earlier in this chapter, Connecticut established the Medical Malpractice Screening Panel to hear medical malpractice claims and make findings of liability before a trial. The intent was to provide a mechanism for an early review of a claim by objective third parties, with the risk that a unanimous liability finding could be introduced at trial if a case proceeded that far. All parties had to agree to submit the claim to the panel and perhaps because of that requirement, the panel has never been operationalized.

*A common complaint heard by the program review committee from both plaintiff and defense lawyers is that they cannot get the other party to talk about the case early in the claim process. Medical malpractice cases can differ in terms of complexity, and any opportunity for resolving a case earlier rather than later keeps costs down and, importantly, provides relief to a negligently injured person faster.* The recommended mediation option below would be triggered by the request of just one party.

## **Recommendation**

**4. C.G.S. Section 52-192a shall be amended to make pre-suit mediation available to any party to a medical malpractice case who so requests as follows:**

**No less than 30 days prior to filing a civil action claiming negligence on the part of a health care provider, the claimant shall send written notice to the health care provider containing a brief description of the claim and a certificate of good faith as required under subsection (a) of this section. The applicable limitations periods should be tolled as of the date that the notice is sent by the claimant. This tolling period shall be in addition to other tolling periods.**

**Within 30 days of the date the notice is sent to the health care provider, either the claimant or the health care provider may contact the Office of the Chief Court Administrator of the Judicial Branch to request non-binding, pre-suit mediation. If any party to the proposed action requests mediation, all parties shall be required to participate in the mediation. The chief court administrator may assign a judge of the superior court to serve as the mediator for the matter, or the chief court administrator may assign two Connecticut-licensed attorneys, one whose practice consists primarily of representing plaintiffs in medical malpractice actions and one whose practice consists primarily of representing defendants in medical malpractice actions, to serve as mediators for the matter. The chief court administrator may develop a list of attorneys to serve as mediators by sending notice to members of the bar. The attorneys serving as mediators shall receive no compensation for their services.**

**A party to the mediation shall provide copies of relevant medical records within 30 days of receiving written request for such records from any other party.**

**The mediation process under this section shall be deemed to be settlement negotiations for evidentiary and confidentiality purposes. In addition, any findings or recommendations of the mediator or mediators shall be confidential and shall not be admissible in any other court proceeding.**

**Suit must be filed within 60 days of the original notice sent by the claimant or within 30 days of the date of the completion of the mediation process or within the applicable limitations period, whichever is later. The mediation process shall be completed within 120 days of the date of the original request for mediation. The mediator(s) shall provide written notice to the parties of the completion of the mediation for purposes of computing the applicable limitations period.**

**C.G.S. Section 38a-32 through 33 (the medical malpractice screening panel) shall be repealed.**

### **Attorney's Fees**

As described earlier in this chapter, attorney fees in Connecticut are currently subject to a statutory sliding scale limit, although the fee schedule is commonly waived by clients of some plaintiff firms under the authority of a 1993 superior court decision. Under the law, an attorney and client, for a claim or civil action to recover damages for a personal injury, wrongful death, or property damage, may enter into a contract for the lawyer's fee to be paid contingent upon and as a percentage of either an award or settlement, in the following sliding scale amounts:

- 33 1/3 percent of first \$300,000;
- 25 percent of next \$300,000;
- 20 percent of next \$300,000;
- 15 percent of next \$300,000; and
- 10 percent of any amount that exceeds \$1,200,000.

Attorney fees can be a significant cost in the claims resolution process for both plaintiffs and defendants. Eleven other states have some kind of plaintiff attorney contingency fee schedule. Four states limit fee recovery to a percentage of the award; in three states, the limit is one-third, and in the fourth state, 50 percent. Some states with schedules provide for exceptions in certain circumstances. For example, under the New York fee schedule statute, a plaintiff's attorney may apply to court for greater compensation in extraordinary cases in which the lawyer believes he or she was not adequately compensated. The plaintiff and other affected parties receive notice and have an opportunity to be heard on the matter. If a judge agrees with the attorney, the judge may allow the attorney a reasonable amount of compensation higher than the fee schedule would allow.

*Based on interviews conducted by its staff, the program review committee finds there is considerable confusion about the status of the attorney fee statute 10 years after the waiver decision. While it is true there was discussion about the waivability of the fee provision during the 1986 legislative debate, one of the proponents who acknowledged the fees could be waived also indicated that if there were a legal dispute between a client and his or her lawyer as to*

payment, “that waiver voluntarily informed or whatever, would most likely be void as against the now public policy of the State of Connecticut.”<sup>25</sup>

*It would seem appropriate for the legislature to revisit the attorney fee statute and state clearly how the legislature intends the statute to work.* If the legislature agrees with the superior court case, the statute could be amended making it clear the fee scale is waivable. If the body believes the fee schedule should apply to all cases, it should make that clear. The program review committee recommends, based on the language of the statute and no affirmative action by the legislature to the contrary, that the legislature make it clear the intent was to be mandatory

## **Recommendation**

**5. C.G.S. Sec. 52-251c shall be amended to make clear that the fee schedule is intended to be mandatory.**

## **Alternative Mechanism**

Two primary functions of the tort system in the medical malpractice arena are to provide compensation to injured patients and to promote patient safety by deterring injurious medical care. Many have pointed out the general dissatisfaction over the tort system’s inability to promote high quality health care and distribute compensation to patients who suffer injury caused by negligence. Two studies of hospitalizations, one in New York and the other in Utah and Colorado, are widely cited in support of that conclusion.

**Studies.** The New York study found “adverse events” occurred in 3.7 percent of hospitalizations and 27 percent of those events were due to negligence. Thus, about 1 percent of hospital errors were because of negligence. When the researchers tracked the hospitalizations with claims filed they found only 47 patients filed a claim (of the 7,743 cases reviewed). Based on their review, the researcher’s found only eight of the claims involved actual negligence (of the 306 cases of actual negligence or 3 percent). Of those eight, only half received any compensation. On the other hand, 19 of the 47 claims that were judged not to have any negligence resulted in an indemnity payment.

Similarly only 2.5 percent of the patients who were injured due to negligence in the Utah and Colorado study filed a malpractice claim. The studies have been subject to some methodological criticism, but the question remains as to why the studies would not provide stronger support for deterrence and appropriate compensation.

**Impediments.** Other barriers exist to the legal system providing a strong deterrent effect, including the use of insurance to mitigate the effect of any monetary loss due to negligence and the fact that premiums are not generally experience related. Experience rating is complicated because of the difficulty of developing a highly predicative rating formula for individual physicians. In addition, many costs of medical malpractice are “externalized” – that is costs of

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<sup>25</sup> Proceedings of the House of Representatives , Thursday, May 1, 1986, p. 5833

errors accrue to other payers including private medical insurers, government health insurance programs, and income support programs.

**Patient safety.** Furthermore, many observers have pointed out that the tort system does not encourage the development of patient safety initiatives. The malpractice environment dampens efforts to secure physician cooperation because of at least the perception, if not the reality, of increased exposure to medical malpractice liability. In particular, the Institute of Medicine's report, *To Err is Human*, has highlighted the factors that hobble solutions to medical error, notably: the failure of the medical system to learn from error (in part because of practitioner's reluctance to report them), and the focus on individual errors rather than more systemic causes of error.

**Alternatives.** A number of reforms efforts have been proposed that seek to address the inefficiencies of the tort system and encourage patient safety efforts. For example, two states have implemented limited no-fault compensation systems where victims of severe neonatal injury are compensated for their injury without regard to provider negligence or fault. In addition, enterprise liability is another reform that may have some merit. Under this model, liability is shifted from the individual physician to the hospital or under some scenarios a health maintenance organization (HMO). These larger institutions become liable for the doctors who practice in their facilities. The concept of enterprise liability could be considered in conjunction with or separate from a no-fault system. The advantage of enterprise liability is that it promotes the idea of a system view of medical error. This system provides a built-in incentive for hospital to improve patient safety systems.

*It is acknowledged that the entire replacement of the tort system is unrealistic and may not even be desirable in some cases. However, some type of voluntary system that allows for a no-fault administrative system should be reviewed to begin a transition away from the current unwieldy system. For example, a no-fault system that is targeted to specialties that have a high degree of risk because of the nature of what they do is a realistic consideration. Both obstetricians and neurosurgeons have to pay the highest premiums for medical malpractice insurance. Continued increases in their premiums will eventually impact access. Assessing the advantages of a different framework to address some of the most severe and costly types of medical injuries by restructuring the compensation system is appropriate.*

Fundamental issues have to be thoughtfully considered and ultimately decided by the legislature for such an administrative system to be realized. These include: how fully informed and freely given consent by patients to opt-out of the tort system is assured; how program eligibility would be determined; how funding would be decided to ensure long-term viability; what funding sources should be used; how such a program would be structured and managed; what types of benefits should be provided; how physician actions should be reviewed; how appropriate measures can be taken to ensure insurance discounting occurs; and how the program's impact would be measured. *Although, proper consideration and resolution of such issues were not workable within the timeframe of this report, the program review committee believes a review of an alternative dispute resolution mechanism is a natural second step to the recommendations made here.*

## **Recommendation**

**6. A multi-stakeholder taskforce shall be appointed to determine the feasibility of developing systemic alternatives to the current tort system, including an enterprise liability system and a no-fault approach to medical malpractice.**



# Chapter Three

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## Insurance Pricing

Fundamentally, insurance combines the risks of individuals into a group and uses the funds contributed by members of the group to pay for losses. Ratemaking is the process for determining the price or premium for an insurance product<sup>26</sup>.

A basic difference between insurance pricing and setting prices in other industries is the price for insurance is based on a calculated prediction. When an insurer sells a policy, the ultimate development and cost of any claims related to that policy is unknown at the time the price is set. Actual costs occur after a premium is set. The prospective losses are estimated based on past experience, which may or may not be the same in the future. Uncertainty about the probability and severity of a claim combined with the length of time it takes to settle a claim for medical malpractice makes pricing difficult and complex.

### Principal Elements in Pricing

Generally speaking, there are two sources of funds for insurers (aside from the initial capital provided by investors to start a company): policyholder premiums and return on investments. Insurers need funds for three purposes: pay for losses; pay for expenses; and provide for profit and contingencies (or surplus). Thus, there are four determinants of insurance premiums: expected claims (loss) costs; expenses; profit and contingencies; and investment income.

A description of the four principal factors is provided below but, in general, losses, expenses, and profits or contingencies are added and investment income is subtracted to get a projected price. A summary of the Connecticut Medical Insurance Company's (CMIC) 2003 rate filing submitted to the Insurance Department is also presented in Table III-1 in order to highlight the pricing concepts. The table calculates the rate for each anticipated covered physician on an average basis and then multiplies that rate by the number of anticipated insureds to arrive at a total premium.

**Claims and loss costs.** The *pure premium* is the amount included in the rate for the payment of losses as well as the loss adjustment expenses – that is, the expenses directly related to particular claims such as attorney fees to defend a claim. The cost to pay claims is the largest component of the premium.

A company that is new to Connecticut will typically use a combination of data sources including data submitted by established companies (such as CMIC), its own data from other states, or national data to establish loss experience. This estimation could end up varying substantially from its eventual actual (or “ultimate”) experience.

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<sup>26</sup> The term rate is used interchangeably with premium. In certain cases in the insurance industry, rate refers to the price per unit of coverage (e.g., per \$1,000 of coverage) with the total premium equal to the rate per unit of coverage times the amount of coverage purchased.

*CMIC pure premium.* The pure premium is calculated based on the average expected losses and loss adjustment expenses. In CMIC’s case, actuaries estimate a range of losses (low, midpoint, and high) based on three different actuarial methods (i.e., reported indication, paid indication, and frequency/severity method), which examine the company’s historical losses, in some cases over a decade. The results of the three methods are averaged producing an average low, an average high, and an average midpoint. For simplicity, the table below reflects the recommended average midpoint change because historically CMIC has selected this option for proposed rate changes.

<b>Table III-1. Calculations in Establishing an Average Rate: CMIC 2003 Rate Filing</b>			
<b>Factor</b>	<b>Sub- Amount</b>	<b>Amount</b>	<b>% of Final Rate</b>
Average Pure Premium		\$26,064	
Reinsurance		3,603	
Average Adjusted Pure Premium		\$29,667	127%
Total Expense Loading		\$3,204	14%
ULAE Loading <sup>1</sup>	390		
General and Administrative Expenses	1,607		
State and Federal Taxes	1,207		
Discounts (Off-Balance)		5,477	23%
Total Costs		\$38,348	
Investment Income Reduction		(7,478)	(32%)
Surplus Income Adjustment		(2,080)	(9%)
Indicated Average Manual Rate		\$28,790	
Discounts (Off-Balance)		(5,477)	(23%)
<b>Indicated Average Collected Rate</b>		<b>\$23,313</b>	<b>100%</b>
Number of Insureds		2,800	
Total Premium		\$65,276,400	
<sup>1</sup> Unallocated Loss Adjustment Expenses Source: CMIC rate filing dated November 28, 2002, and LPR&IC calculations			

This amount is adjusted for the mix of different classes (specialties) of doctors, reductions due to year in practice (most doctors receive a discount for the first four years of

practice), different policy limits that are purchased, and losses paid on behalf of insureds who have died, become disabled, or retired. So, as reflected in the table, the *average* pure premium is \$26,064. When reinsurance costs are added, which are the amounts paid by an insurance company to a re-insurer to cover losses above a certain amount, the total rises to \$29,667. Altogether losses and loss adjustment expenses (pure premium and reinsurance costs) represent the largest component of total costs (77 percent) and the final collected rate (127 percent).

**Expense loading.** General and administrative costs related to pricing, underwriting and distribution of policies as well as overhead expenses (e.g., rent, employee benefits, and travel) are included in an expense loading.

*CMIC expense loading.* The expense factor for CMIC’s filing represents 8 percent of the total costs and 14 percent of the final collected rate. Included are costs for: unallocated loss adjustment expenses, which cover claims overhead expenses; general and administrative expenses; taxes; and discounts. Rate discounts can be given to insureds for different reasons, such as partaking in risk management programs and participation in a group practice.

**Investment income.** Investment income consists of interest, dividends, rents, and similar regular income received from the invested assets held by a company. Statutory restrictions limit the amount and types of investments Connecticut-based insurers can make. For example, a company may not invest more than 5 percent of its assets in the stocks of any one institution. In addition, the National Association of Insurance Commissioners (NAIC) rates the quality of each investment based on the information detailed in each insurance company’s annual report (from 1, “highest quality” to 6, “in or near default”) to assist state regulators in assessing the financial condition of a company.<sup>27</sup>

The lag time between when a premium is paid and when claims are paid is known as the claims “tail.” Medical malpractice insurance is considered a long-tailed line of business because a large portion of claims is paid a number of years after the coverage period. Premiums should reflect the ability of an insurer to earn interest on premium dollars before claims are paid. As interest rates rise and fall, the amount of premium charged will be affected. Similarly, as the claims tail gets longer, the amount of premium an insurer needs for loss payments declines because more investment income will be earned before claims are paid. This concept of adjusting claims costs by the amount of expected investment income is referred to as discounting, where the expected claims costs are multiplied by a discount factor (or present value factor) to reflect the time value of money.

*CMIC investment income.* The impact of earning interest on the premium before claims are paid is reflected in the interest income reduction. In this case the assumed rate of return is 7.5 percent resulting in about a 32 percent reduction in the final rate.

**Profit and contingencies (or surplus).** Because claims costs are uncertain and companies are not able to retroactively adjust premiums, insurers need to hold capital or surplus for excessive losses or expenses (contingencies). Surplus is the accumulated amount of money

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<sup>27</sup> NAIC is a voluntary organization of all state insurance commissioners that develops model laws and regulatory practices and promotes uniform financial reporting by insurance companies.

left over after all income is collected and expenses are paid on an annual basis. An adequate amount of surplus is important to an insurance carrier because it is considered a safety net for unexpected or underestimated claims costs and is a significant component of A.M. Best's rating criteria.<sup>28</sup>

In addition to building surplus for contingencies, an insurer typically must offer investors a return on their investments, in order to obtain capital. Profit can be an explicit item in the rate in for-profit companies. Should losses be less than anticipated, that money becomes available for building surplus or paying a dividend.

*CMIC profit and contingencies.* The company, being a mutual or nonprofit insurer, has not included an amount for profit in its rates. The closest CMIC had to a profit component was an expense loading called "Surplus Replacement" that was used to build surplus. The initial capital investors in CMIC were paid back from surplus funds. The company has not included this type of expense in its rate filings since 1999.

In 2003, CMIC decided to continue a practice started in 2000 of dedicating interest income from its accumulated surplus to reducing (or subsidizing) the overall rate increase. In 2003, this amounted to \$2,080 or 9 percent of the final collected rate. Typically, the interest income would be available to increase the accumulated surplus or could be paid out to policyholders in the form of dividends. The company has paid dividends totaling \$31.5 million between 1991 and 2001. Most of those dividends were derived from better than expected loss results, discussed later in Chapter Six.

**Manual and collected rates.** The outcome of the above calculations results in a "manual" and "collected" rate. The average manual rate reflects the anticipated average loss and expense costs of CMIC's group of insureds. The average collected rate is the manual rate less certain discounts discussed above. Thus, the actuarially calculated manual rate for 2003 was \$28,790 and the collected rate was \$23,313. Compared to the 2002 manual and collected rates of \$17,018 and \$13,781 respectively, the 2003 rates are 69.2 percent higher.

However, while the company's actuaries recommended an average mid-point rate change of 69.2 percent, CMIC ultimately chose to implement an overall 35 percent increase in rates. To make up the difference, CMIC increased premiums for high-limit policies, increased physicians' corporate premiums, and reduced or eliminated discount programs. Although the company submitted documentation supporting an overall rate change of 69.2 percent developed on an average basis, the actual rate change for each specialty ranged from 10 percent to 72 percent. How the average rate change results in individual differences by specialty is discussed below.

## **Individual Premiums**

Once an overall rate increase is established, it must now be converted into an individual premium. First it is important to understand that individual rates are influenced by risk classification and underwriting policies.

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<sup>28</sup> A.M. Best is an insurance rating agency that assesses financial solvency and other financial measures to establish a "grade" for insurance companies.

**Risk classification.** Insurers will estimate expected losses for different buyers and charge a premium that varies according to expected claim costs. This process of grouping together consumers with similar characteristics is known as risk classification. For medical malpractice the classification rates are based on medical specialties and procedures performed. The grouping of specialties within each class may vary with each insurer.

The outcome of the risk classification process is essentially a weighting by specialty. This means the premiums will be higher in obstetrics and general surgery than for internal medicine because of the nature of the procedures performed by each specialty and associated losses. Individual risk classifications are reviewed on a regular basis by CMIC, based on its own experience and evaluated against nationwide comparative data provided by the company's actuaries.

**Underwriting.** Each insurer uses selection standards to determine whether a specific applicant in a given class will be offered coverage. The overall process of assessing the expected claims costs for buyers, determining the applicable rate, and deciding what coverage to offer is known as underwriting. Class rates and underwriting standards generally differ across insurers.

*Individual rate increase.* After an overall average rate increase has been established by CMIC, it then determines rate increases for each class. This iterative, multi-step process involves the use of loss data by specialty and knowledge of existing market conditions. Generally, to calculate class rates CMIC will take the following steps.

- CMIC removes any doctors from its analysis who are no longer insured, along with any practitioners that represent an anomaly, i.e., they are experiencing a much greater deviation than expected from the norm in terms of losses.
- CMIC analyzes a rolling five-year average of losses by class along with outstanding open claims
- CMIC arrays the classes of insureds by loss experience -- from low to high -- and select the class with the closest to the average loss experience (recall the rate increase is based on an average). Then the average increase is applied to this class. Depending on the mix of specialties (that is, the number of doctors in each class), those below would generally receive a lower increase and those above a higher increase. The total amount of premium expected to be collected from one year to the next cannot be more than the average increase requested in the rate filing.
- Finally, CMIC examines the results and make adjustments based on market considerations. The company has to balance loss experience with some consideration as to what competitors are charging by specialty.

Individual class rates may be modified by prior loss experience of some individual applicants, referred to as experience rating. For individual physicians or group practices that experience higher than expected losses, CMIC has three options in developing a particular rate that is different from the manual rate. It may:

- assess a surcharge for a number of years as a probationary period until there is a sufficient amount of improvement in the experience;
- require a large deductible backed up by a letter of credit; or
- simply not renew a client.

CMIC customers may appeal rates or non-renewal decisions to a board appointed underwriting committee. The company also maintains a risk management unit that can provide risk management services such as procedural/safety audits and remedial training to its customers.

Various discounts may also be offered by different companies for participating in risk management programs, raising deductibles, having a “no loss” record, or having a group practice insure with one company.

## Insurance Department Oversight

Insurance companies selling medical malpractice insurance are regulated by the Insurance Department because this type of coverage is considered property/casualty insurance. The regulation begins at entry into the Connecticut market with license requirements. Once licensed, a company must abide by certain financial strictures and comply with numerous reporting and review mandates. Finally, the rates charged by a company for medical malpractice insurance must be approved by the department, along with the forms of policies and contracts used. This chapter focuses on the initial licensing process and rate regulation.

### Licensing

All insurance companies doing business in the state of Connecticut must be licensed by the Insurance Department. A primary purpose of licensing is to determine that a company has the wherewithal, both in terms of financial solvency and management, to operate a legitimate insurance business that provides Connecticut consumers the insurance coverage for which they paid. If the license applicant is a company organized in another state (termed a foreign company), information based on its home state experience is required.

The information required from a new applicant seeking to write medical malpractice insurance includes:

- a certified copy of its charter or articles of association;
- a valid license from its state of domicile (if a foreign company);
- a statement of its financial condition, including, for each line of insurance, proof it has the minimum amount of capital and/or surplus funds required by state statute:

Liability insurers (e.g., medical malpractice) must have a minimum of \$500,000 in capital and \$500,000 in surplus for a stock insurance company; \$1,000,000 in surplus for a mutual insurance company;

- evidence of an orderly pattern of growth in its marketing territories, including adequacy of equity resources;
  - experience in marketing and servicing policy holders in other jurisdictions;
  - biographical information about company directors and officers;
  - most recent form 10K (if regulated by the SEC);
  - a copy of an actuary opinion certifying the loss and loss adjustment expense reserves;
  - audit reports for last two fiscal years;
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- annual NAIC statements for the preceding two years (along with an annual statement of any parent or subsidiary insurer); and
- the most recent examination report done by its home state insurance department (for a foreign company).

Licenses must be renewed each May, but the license renewal process is minimal.

## Rate Regulation

Medical malpractice rates charged by insurance companies in Connecticut are regulated under the “file and use” method. A company must file a proposed rate change with the insurance department before the effective date of the change for approval by the commissioner. The company does not have to wait for approval to charge the rates after the proposed effective date. If the rates are disapproved though, the company must stop using them.

A company seeking a rate change must file documents with the insurance department that explain the proposed rate change, including classification manuals, rate schedules, and how the new rates would apply to different classifications. As explained in Chapter Three on insurance pricing, the proposed rate change application computes an average rate, and then applies that rate in a weighted manner to the various specialties covered depending on their relative risk assessments (relativities). Included in the rate proposal will be an actuarial evaluation of the needs of the company relative to losses it must cover.

The insurance department reviews rate filings to ensure they meet the statutory criteria that the rates are not excessive, inadequate, or unfairly discriminatory. The statutory definitions of those terms are set out below.

- An **excessive** rate requires a finding that: A) the rate is unreasonably high for the insurance provided; or B) a reasonable degree of competition does not exist in the area with respect to the classification to which the rate is applicable.
- An **inadequate** rate requires a finding that: A) the rate is unreasonably low for the insurance provided and continued use of the rate would endanger the solvency of the insurer; or B) such rate is unreasonably low for the insurance provided and the use or continued use will have the effect of destroying competition or creating a monopoly.
- **Unfairly discriminatory** means an insurer cannot charge a significantly different rate for two people who are classified as the same type of risk. Risk classification systems are allowed as long as they are based on actuarially sound loss data.

In assessing a rate proposal, the department is to consider to the extent possible:

- past and prospective loss experience within and outside the state;
- a reasonable margin for underwriting profit and contingencies;
- past and prospective expenses both country-wide and those specially applicable to the state;
- investment income earned and realized by insurers both from their unearned premium and loss reserve funds; and
- all other factors, including judgment factors, deemed relevant within and outside the state.

The department may also consider dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to the policyholders, members or subscribers.

Both the excessive and inadequate standards contain an element related to market competitiveness, although tests for competitiveness are only found in the statutes related to the personal risk market. There, competition is presumed and if the personal risk market is competitive (e.g., homeowners insurance), the insurance commissioner may not find rates excessive.

During the study, insurance department personnel told committee staff they were not aware of any medical malpractice rates ever determined excessive or inadequate. The department staff indicated any concerns they might have are handled through informal discussions with a particular company, with changes to rate proposals as needed.

### **Findings:**

Based upon committee staff interviews with CID staff, an examination of rate filings and rate trends, and review of relevant literature, findings about the rate review process, as well as the department's oversight follow below.

- *The commissioner and other department staff who review rate filings have stated the medical malpractice insurance market in Connecticut is not competitive. In 2002, one company wrote 41 percent of the total medical malpractice premiums and the top two companies wrote 59 percent of the premiums.*
- *A non-competitive market does not serve the interests of consumers, especially those like physicians who are required to purchase medical malpractice insurance. Increased regulation of the marketplace can be justified in order to mitigate market imperfections, such as a lack of price competition.*
- *Other states have stronger regulatory frameworks for setting medical malpractice rates than Connecticut. Twenty-one states have some form of*

prior approval of rates for medical malpractice insurance. This means the commissioner must review the rates before they go into effect. Some of these states allow for consumer comment and participation in the prior approval process. A number of states require a finding of a non-competitive market by the commissioner first and/or when proposed rates exceed a certain percentage increase before prior approval is required.

In Connecticut, prior approval of rates is required for title and residual market insurance, as well as credit property insurance. Personal risk insurance in Connecticut is subject to prior approval if the commissioner finds the market is noncompetitive (medical liability insurance is regulated as a commercial line). In 2003, the insurance commissioner in California, through a prior approval process, reduced a rate hike from 15.6 percent to 9.9 percent for the state's second largest medical malpractice carrier (SCPIE Indemnity Company) due to a consumer-based challenge. Subsequently, the state's largest medical malpractice provider (NORCAL Insurance Mutual Company) reduced its proposed increase by 70 percent when it was challenged through the prior approval process.

- *No medical malpractice rate filing in Connecticut in recent memory has been found to be excessive or inadequate.* While the insurance department has stated it works informally with carriers to either clarify or question assumptions contained in rate filings, it has not initiated any changes to rate filings, formally or informally, that have resulted in a revision or reduction in rates.
- *Recent history in the medical malpractice insurance marketplace, on both the national and state level, has exhibited two contrasting trends – growing insolvencies and reported excess reserves.* On the one hand, a number of insurance companies with business in Connecticut have become insolvent. Many market observers have attributed those insolvencies to underpricing and competitive excesses.<sup>29</sup> That is, insolvencies were the result of not pricing insurance adequately to reflect costs.

On the other hand, as detailed in Chapter Six, medical malpractice insurance carriers have reported excess reserves in recent years. A key component of loss reserves are incurred losses, which include projections for payments for claims that have been filed but not yet paid as well as those claims that an insurer expects to be filed but have not yet been filed. This information is used to assess the company's financial condition and to develop new rates. There can be considerable discretion in determining incurred losses. On the

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<sup>29</sup> See for example, *Medical Malpractice Premium Data Summary*, Department of Banking and Insurance, State of New Jersey and *U.S.P/C Industry's Profitability Continues Downward Slide Despite Recent Premium Growth*, Insurance Journal, November 19, 2003.

national level, throughout the 1990s medical malpractice carriers have collectively reported excess in reserves. In 1999, for example, \$200 million in excess reserves were reported for the medical malpractice line of business. The Connecticut Medical Insurance Company has reported an excess amount in reserves every year, except one, between 1990 and 2002. While predicting appropriate reserve levels is challenging, consistently reporting excess reserves indicate premiums may be too high.

- *The insurance department does not maintain adequate information to gauge market competition.* It does not know how many medical malpractice insurance carriers are available to doctors in specific specialties; to other types of health care providers; or to health care facilities.
- *The insurance department does not have a clear and complete picture of the premiums charged in the medical malpractice area.* While the department approves a basic rate structure, including total premium, and the classification system for medical malpractice insurance carriers, it does not know the amount of premium charged to insureds due to the practice of surcharging or discounting by insurance carriers. Medical malpractice premium pricing is not typically experience-based. The extent to which malpractice history factors into premium pricing is not clear.
- *The medical malpractice insurance market is changing and the insurance department has limited or no regulatory oversight over some of these newer risk mechanisms.* Medical malpractice policyholders have increasingly turned to alternative risk mechanisms, such as captives and risk retention groups. A captive is a company established to insure the risks of a parent organization and affiliated companies. Captives are typically, but not exclusively, domiciled outside of the United States. Risk retention groups (RRGs) are a variation of a captive and are regulated under federal law. Except for those RRGs in existence before 1985, they must be chartered under and conform to the laws in whichever state they are domiciled. Similar to traditional insurance companies, the state in which an RRG is located is responsible for providing solvency oversight. Neither Connecticut nor the federal government exercise regulatory oversight over other captives.

#### **Recommendations:**

- 7) Prior approval of medical malpractice insurance rates shall be required if the commissioner determines the market for medical malpractice is not competitive or an insurance carrier requests a rate increase or decrease of 15 percent or more.**

Specifically, no later than October 1 each year, the commissioner shall determine if a competitive market exists for medical malpractice insurance. That determination shall apply to all rate changes filed on or after January 1 of the succeeding year. The commissioner shall consider relevant tests of competition pertaining to market structure, market performance, and the opportunities to obtain insurance from competing insurance carriers. These tests may include, but are not limited to: the size and number of insurers actively engaged in the market, both in general and by doctor specialty; whether there are enough carriers to provide multiple options to physicians and medical facilities; market concentration and changes in market concentration over time; the extent to which any insurer or group of affiliated insurers controls all or a significant portion of the market; ease of entry into the market; and underwriting restrictions. The commissioner may make a determination of market competitiveness at any other time, after appropriate notice, if the commissioner determines the market has changed significantly since his or her prior determination.

If the commissioner determines a noncompetitive market exists or a carrier requests a rate increase or decrease of 15 percent or more, the commissioner shall notify the public of any application for a rate change, within five business days of filing, and the commissioner shall accept public comment for 30 days after public notice regarding any proposed change. In addition:

- a public hearing on the proposed change may be requested by a consumer or his or her representative within 45 days of public notice; or
- the commissioner may hold a public hearing regarding the rate change on his or her own motion; or
- in the absence of a request for a public hearing by a consumer or his or her representative, the commissioner may approve or disapprove a rate without a hearing, within 60 days of filing, consistent with the standards in C.S.G. Sec. 38a-665 pertaining to excessive, inadequate, or unfairly discriminatory rates.

The commissioner shall require every insurance carrier to enclose a notice in every policy renewal or premium bill informing policyholders of the opportunity to request a hearing upon application of rate changes by insurance carriers during a noncompetitive market. The commissioner shall maintain on an on-going basis a database containing information about the competitiveness of the medical malpractice marketplace derived from the information gathered above, including premiums charged by physician specialty and number of physicians insured under alternative risk mechanisms. The commissioner shall utilize any relevant information collected by any other state department or agency that would assist in determining the degree of competition that exists and how physicians are insured.

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**In a competitive market, the existing “file and use” method of rate review for medical malpractice insurance, under C.G.S. Sec. 38a-676, shall apply.**

- 8) Any foreign captive insurer (i.e., chartered and formed under the laws in another jurisdiction) that provides medical malpractice insurance in Connecticut shall be required to obtain a certificate of authority from the insurance commissioner before doing business in Connecticut. The company shall provide such information as the commissioner deems necessary (and is not inconsistent with federal law) to ascertain whether the captive insurer will be able to meet its policy obligations before a certificate of authority is issued. The captive insurer shall be required to report annually to the commissioner sufficient financial information to demonstrate, to the commissioner’s satisfaction, that such insurer is operating in sound financial condition. If the commissioner determines the captive insurer is not operating in sound financial condition, the commissioner may revoke its certificate of authority.**



## Physician Oversight

### Introduction

It is the mission of the Department of Public Health (DPH) to protect the health and safety of the people of Connecticut. One way the department, along with its associated professional boards, achieves that mission is through the regulation of health professionals, including determining their licensing eligibility, evaluating their performance, and enforcing sanctions for wrongdoing.

The purpose of an effective physician disciplinary system is to protect citizens from illegal, negligent, and incompetent medical practice. The responsibility for physician discipline in Connecticut is shared between the Department of Public Health and the Connecticut Medical Examining Board. The department is responsible for many functions related to the licensure and discipline of physicians, while the board advises the department on licensure issues and makes final disciplinary decisions based on the findings of hearing panels composed of board members and other members of the public.

This chapter presents an overview of the physician disciplinary process along with activity measures based on the department's annual reports for the last five years. In addition, an analysis of physicians with multiple discipline and medical malpractice issues from data maintained by DPH and the federal government since 1990 is presented. Further, the committee provides information about the outcomes of investigations and makes several findings critical of the physician disciplinary process. Finally, eight recommendations are presented aimed at strengthening the overall process, adding resources, and improving communication about the process and its outcomes to complainants and the public.

### Structure of Medical Examining Board

From the outset, it is important to understand the final administrative authority for disciplinary actions against physicians is the Medical Examining Board. The department can investigate and recommend action but it falls under the board's authority to discipline a physician. The board is located within DPH for administrative purposes, but acts separately from the department. The board is composed of 15 members appointed by the governor and confirmed by the General Assembly. The membership consists of nine physicians, one physician assistant, and five public members. It is a statutory requirement that of the nine physicians, five must be practicing in the state, one must be a full-time faculty member of the University of Connecticut School of Medicine, one must be a full-time chief of staff at a general hospital, one must be an osteopath, and one must supervise one or more physician assistants.

## Disciplinary Process<sup>30</sup>

The physician disciplinary process is outlined below. In short, complaints are reviewed and assessed by the department, and when warranted selected cases are investigated. Cases typically will be dismissed, settled through a negotiated consent order, or decided after a full evidentiary hearing. Overall, a review of department data, detailed below, reveals:

- most complaints that led to investigations involved physician incompetence or negligence;
- probation was the type of sanction most often used; and
- the settlement of cases was usually reached through negotiated consent orders.

**Table V-1. Physician Discipline Cases Opened, Closed, and Actions Taken, 1998-2002**

Year	Complaints & Medical Malpractice Payment Notices Received	Cases Opened & Investigated (Petitions)	Cases Closed For Lack Of Evidence by DPH			Number of Cases with Disciplinary Action by Board*	Total Number of Sanctions
			Total	Opened in Current Year	Opened in Prior Years		
1998	N/A	240	287	124	163	48	58
1999	559	251	168	68	100	34	49
2000	489	227	172	44	128	51	73
2001	463	197	197	49	148	39	41
2002	471	295	179	80	99	53	53
Average	496	242	201	73	128	45	55

\*Includes interim consent orders and consent order modifications (which do not start as complaints) but does not include cases dismissed by the board. Some cases contain more than one disciplinary action. Some agreements involving rehabilitation are not considered final actions and are not reviewed by the board.

Sources: PH, *Report of Legal Office Regarding Physician Actions*, 1998-2000 and OLR, except complaint total from correspondence to committee staff from DPH 12/4/03, and medical malpractice payment notices from DPH database.

*Activity summary.* Table V-1 provides a summary of the activities of the department and medical board with regard to physician discipline over the last five years. It can be noted:

- the investigations unit received an average of 496 complaints and notices of medical malpractice payments involving physicians since 1999;
- the average annual number of petitions or cases opened was 242 over the five-year period or about 50 percent of complaints received each year;
- an average of 201 cases were closed each year;

<sup>30</sup> Program review committee staff would like to acknowledge the assistance provided by the Office of Legislative Research in compiling some of the annual report data and a portion of the background information in the first part of this chapter. Any errors or omissions, however, remain the responsibility of program review committee staff.

- the average number of cases resulting in a disciplinary action over the last five years was 45 per year or 18 percent of the cases opened (and 9 percent of the complaints and medical malpractice notifications received); and
- on average, 55 sanctions were imposed each year. (Some cases resulted in more than one sanction.)

Cases closed for lack of evidence means that at the end of an investigation the allegation could not be substantiated, the alleged conduct was not substantiated, the alleged conduct occurred but did not violate the standard of care, the alleged conduct could not be proven because of an uncooperative or unavailable witness, or there was insufficient evidence.

**Complaints.** There are several possible sources of information about physicians received by DPH that may be referred to as complaints, and requiring review to determine if statutory requirements have been identified as a concern. The Practitioner Investigations Unit (“investigations unit”) of the Bureau of Health Care Systems of DPH reviews and screens complaints for possible further investigation. The various information sources include:

- the public;
  - any physician, hospital, and state or county medical society, which must file a petition within 30 days when they have “any information that appears to show that a physician is or may be unable to practice medicine with reasonable skill or safety...”;
  - health care facilities within 15 days when they terminate or restrict a physician’s privileges (typically only hospitals report);
  - physicians within 30 days when another state takes a disciplinary action against them;
  - entities that make medical malpractice payments on behalf of a physician (usually an insurance company). (While malpractice payments are not considered formal complaints, certain records may be reviewed by DPH for possible further investigation); and
  - hospitals and freestanding ambulatory surgical care centers that must report “adverse events” to DPH under a recently passed state law (C.G.S. Sec. 19a-127n). Adverse events are injuries caused by or associated with medical management and result in death or measurable disability. The adverse events reporting law is primarily aimed at institutional quality of care concerns, though an individual practitioner may be implicated in an event. The reports are reviewed by the department’s health care facilities licensing unit for possible physician incompetence or negligence issues, which, if suspected, are referred to the Practitioner Investigations Unit.
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**Initial screen.** Complaints are subject to a two-step initial screening process by the investigations unit. First, the unit will evaluate complaints and reject those not within its jurisdiction and those complaints considered so minor they can be handled administratively (e.g., when a physician has not reported information required under the physician profile law).

The investigations unit will refer a complaint to another governmental agency if it involves the jurisdiction of that agency. Other agencies may include the Department of Consumer Protection, the various state's attorneys, the federal Drug Enforcement Administration, the Department of Social Services, or the Department of Children and Families. Joint investigations with other units within DPH, such as the Division of Health Systems Regulation, are also possible

*Petitions.* The second step involves the remaining complaints that are considered petitions – these are complaints about a licensee that are serious enough to warrant some level of investigation. These petitions are assigned petition numbers, which allows tracking by DPH. The extent of information gathering conducted in this second step of the initial screening process will vary depending on the nature of the underlying complaint/petitions, as well as the extent to which additional information is needed to make an appropriate initial evaluation.

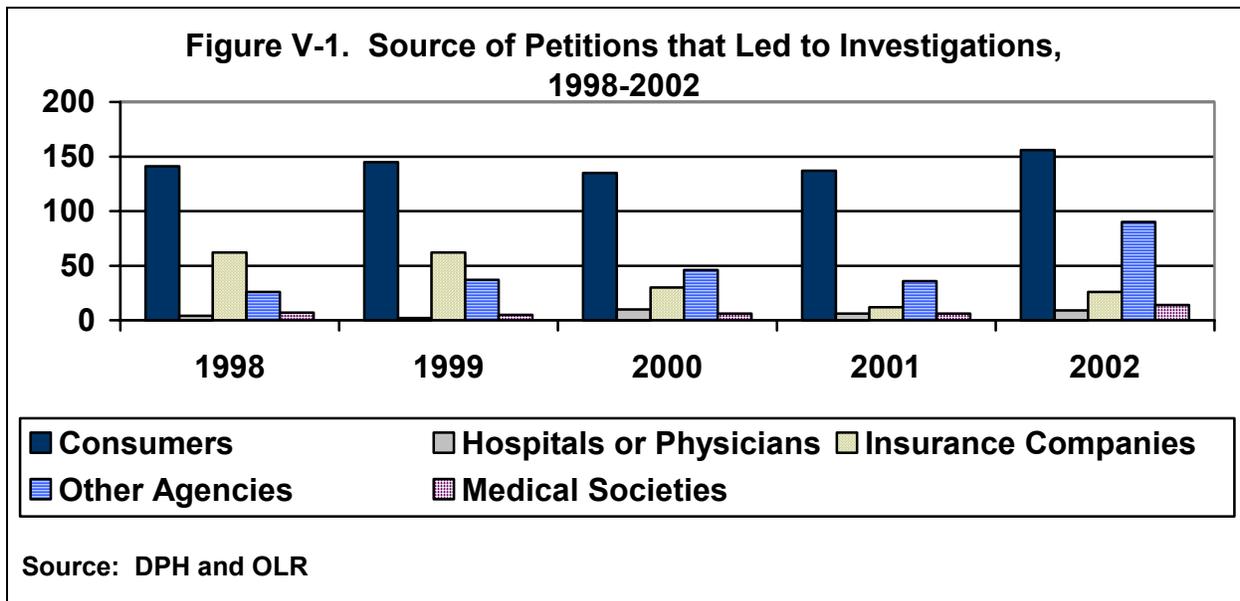
No formal criteria, formula, or guidelines exist to determine the extent to which a petition should be investigated. The investigations unit exercises discretion and utilizes its clinical expertise in evaluating the petition against applicable state and federal law and standards of practice. The department reports that it will usually fully investigate petitions involving malpractice or negligence, except in certain reviews involving medical malpractice payment notifications.

*Medical malpractice payment notifications.* With regard to the decision to pursue investigations based on medical malpractice payment notifications, the investigations unit relies on staff judgment in the application of a number of informal factors to make this assessment. Some of the specific factors, used by the unit to screen malpractice awards and settlements, include:

- existence of prior disciplinary actions and complaints against the licensee;
- past malpractice history;
- medical malpractice payments with high verdict or settlement amounts;
- whether the licensee is currently licensed;
- length of time from the date of the incident to the date of DPH notification;  
and
- severity and scope of injury (for example the removal of the wrong body part is considered a high severity event).

One of the more critical factors in the investigation staff's evaluation of medical malpractice payment notifications is the amount of time that has passed from the date of the incident. If a significant amount of time has passed and the unit is unaware of any other actions or malpractice allegations against the physician, it usually will not further investigate a case. In contrast, if the department were notified about a new case with the same fact pattern as an old case, it would investigate the former.

While the unit does not have a dedicated physician resource, it does have access to clinical expertise within the department for initial consultation purposes. The investigations unit, though, has not consulted with physicians in the department in the last year.



*Source of petitions.* Figure V-1 shows the number of petitions that were investigated by the department over the last five years, broken out by source. Consumers represent by far the largest source of petitions (nearly 60 percent). Reports from insurance companies regarding medical malpractice payments accounted for 16 percent of the total, while 19 percent of the reports came from other state agencies (e.g., the departments of social services, mental retardation, children and families, and the offices of the state's attorneys and attorney general). Reports from hospitals, physicians, and medical societies accounted for the remaining 6 percent.

*Types of allegations.* Petitions identify many different types of wrongdoing. The Medical Examining Board is authorized to take action against a physician, including license revocation, for any of the following reasons (C.G.S. Sec. 20-13c):

- physical illness, including deterioration due to aging, mental illness, or emotional disorder;
- alcohol or drug abuse;
- illegal, incompetent, or negligent practice of medicine;

- possessing, using, prescribing, or distributing controlled drugs, except for medically proper purposes;
- misrepresentation or concealment of material facts in obtaining or reinstating a license;
- failure to adequately supervise a physician assistant, maintain professional liability insurance, fulfill any obligation of the National Health Service, or provide information for DPH's physician profiles;
- performing magnetic resonance imaging or administering anesthesia without proper accreditation, or failing to provide evidence of that accreditation; and
- conduct that draws into question the ability of the practitioner to practice safely and effectively.

By far the most frequent allegation was physician incompetence or negligence, which comprised about 75 percent of the complaints over the last five years. Drug and alcohol abuse (5 percent) and improper business practices (4 percent) were next.

<b>Table V-2. Allegations By Type, 1998-2002</b>					
<b>Allegation</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>
Incompetence/negligence	191	205	162	150	196
Substance abuse-drugs	11	4	16	1	14
Substance abuse-alcohol	1	5	3	5	4
Other drug-related	2	2	7	6	6
Sexual misconduct	6	3	7	4	5
Unlicensed practice	2	1	3	1	4
Fraud/deceit	1	1	2	4	5
Mental illness	4	2	4	4	6
Business practice	8	8	5	9	14
Medical records	1	4	3	1	4
Illegal conduct	1	1	3	2	12
Professional ethics	9	8	9	5	9
Probation violation	2	3	0	0	3
Lack of cooperation	0	1	0	1	12
Unsanitary conditions	0	0	2	1	4
Patient abuse	0	0	0	0	2
Scope of practice	0	0	1	1	0
Other	0	3	0	2	3
<b>TOTAL</b>	<b>239</b>	<b>251</b>	<b>227</b>	<b>197</b>	<b>303</b>
Source: DPH, <i>Report of Legal Office Regarding Physician Actions, 1998 - 2000</i> and OLR					

**Investigation process involving negligence/malpractice.** After performing the initial screening and determining if a complaint should be investigated further, the investigator will request and review records, conduct interviews, and obtain sworn statements regarding the allegations contained in the complaint. The investigations unit has reported that in most cases involving negligence/malpractice, the investigator will contact a physician who practices in the same specialty area to review the case in a redacted format and render an opinion regarding incompetence or negligence.

Except in very rare circumstances involving complicated cases, consultants work on a volunteer basis. No reimbursement is provided to consultants for reviewing records, writing reports, providing testimony, or appearing at hearings. Investigators are required to search for consultants, with the appropriate credentials, as part of their work. In some cases, a member of the board, with pertinent expertise, may be asked to give an opinion on a case. The member may not participate in any subsequent hearing for that case.

The expert is asked to determine if a “standard of care” appropriate for the specialty has been violated. Standard of care is what a reasonably prudent doctor is expected to provide to a patient seeking care – professional services with the degree of skill and learning commonly applied in Connecticut by the average, prudent, reputable physician.<sup>31</sup> This is a key determination in whether the case moves to further prosecution.

When the investigation is complete, the investigator will transfer the case to the supervising Nurse Consultant, who oversees the Practitioner Investigations Unit, to determine if there is sufficient evidence for the case to proceed. State statutes require a determination that “probable cause exists to issue a statement of charges” (C.G.S. Sec. 20-13e(a)) for a case to be prosecuted. As discussed above, in cases alleging negligence or incompetence, the department seeks a consultant’s opinion affirming the standard of care has not been met.

If the unit finds the standard of care has not been met, the case is referred to DPH’s legal office. The department has 18 months from the date the petition is filed to conclude if probable cause exists, but according to the department, the average length is six months.

With the exception of cases involving substance abuse or mental illness, the investigation is confidential and remains confidential until a statement of charges is issued or 18 months has expired from the time the petition was filed. In the case of substance abuse or mental illness, if the department determines that the physician is an appropriate candidate for participation in a rehabilitation program, the petition remains confidential as long as the practitioner complies with the program requirements and successfully completes the prescribed program.

*Investigators and caseload.* The Practitioner Investigations Unit has nine investigators reviewing or investigating about 400 cases and complaints at any given point in time. (This unit is also responsible for investigating all 59 health care professions licensed by the department, including physicians). About half of those cases and complaints involve physicians. Investigators, who are trained to manage investigations of all licensure categories, include an

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<sup>31</sup> This is the same standard used to determine if a doctor is negligent in a civil suit, except the civil suit standard is nationally based.

Investigations Supervisor, two nurse consultants, five Health Program Associates, and one Health Program Assistant. Each investigator is assigned about 45-50 cases each at any given point in time. In 2002 the unit had 11 investigators, each handling about 36 cases at a time.

**DPH legal office.** If probable cause exists, DPH's Legal Office will assign an attorney to the case and take action consistent with the procedures outlined in the Uniform Administrative Procedures Act (UAPA). Thus cases that reach this point are prosecuted through the administrative hearing process.

*Compliance conference.* The licensee will be issued a compliance letter notifying him or her there is a pending case and that the licensee has an opportunity to meet with the department at a compliance conference before an administrative hearing. The purpose of the compliance conference is to:

- allow the respondent an opportunity to demonstrate that he or she did not breach the standard of care or engage in inappropriate behavior;
- explain the adjudication process; and
- provide for an opportunity to negotiate a settlement.

If agreement is reached between the department and the licensee, the legal office drafts a consent order or other agreement to be signed by the parties. Both a consent order and any other agreement contain enforceable terms and conditions. These agreements are presented to the Medical Examining Board for approval. The board can:

- approve the order, which takes effect immediately, and the case is concluded;
- reject the order and recommend dismissal of the case;
- send the case back with recommendations for modifications of the order; or
- schedule the case for a hearing.

Under certain circumstances, the department can hold an investigation in abeyance and enter into an agreement that allows the licensee the ability to complete a confidential program of rehabilitation for substance abuse or mental illness issues. As it is not considered a final action, the board does not review or approve this arrangement.

Over the last year, the board has rejected five of the department's proposed consent orders. In two cases, the board wanted more information, in another two cases the board rejected the consent orders outright and no disciplinary action was taken, and in one case the board wanted to increase the fine that the department was proposing. Two cases were rejected with no disciplinary action: one involved a billing concern and the other a standard of care issue.

*Statement of charges.* If an agreement is not reached between the department and the licensee, a "statement of charges" is issued. The statement of charges outlines the allegations against a licensee (respondent).

*Summary suspension.* If it is determined the licensee is a clear and immediate danger to the public health, the department may request the Connecticut Medical Examining Board to summarily suspend the practitioner's license pending a hearing. In addition, if appropriate, the department may request summary suspension for a licensee who meets the other statutory criteria, such as having been convicted of a felony or the subject of a disciplinary action in another jurisdiction. The department can prepare and bring the motion for summary suspension expeditiously when it believes it needs to move against a licensee.

In these cases, a hearing on the merits of the complaint is typically scheduled within two weeks. In lieu of a summary suspension, the practitioner may be offered an interim consent order in which he or she agrees to have his or her license suspended for a period of time.

**Administrative hearing.** The statement of charges is filed with the board, which must refer the case to a hearing panel within 60 days of receipt of the charges. A hearing panel has three members that consist of at least one member of the board and one member of the public. Hearing panels are appointed by the chairman of the board from a list compiled by the commissioner. The panel conducts the hearing and is supported by an assistant attorney general who advises the board on matters of law.

A staff attorney from DPH's legal office presents the case on behalf of the department. Both sides may present expert witnesses and cross-examine each other's witnesses.

The panel members decide matters of fact. This means they may decide whether certain actions occurred or did not occur, and whether actions were proper or improper based on the evidence provided. The panel will also suggest an appropriate penalty.

**Final decision.** The hearing panel is required to file a proposed decision with the full board within 120 days of receiving notification of the hearing, unless extended by the board for good cause. The full board reviews the panel's final proposed decision and may adopt, modify, or remand the case for further review or for the collection of additional evidence. The final decision of the board is called a memorandum of decision.

<b>Table V-3. Medical Examining Board's Forms of Action</b>					
<i>Form</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>
Memorandum of Decision*	11	3	5	10	7
Consent Order/Agreement	22	21	26	16	28
Interim Consent Order	2	2	0	2	3
Consent Order Modification	4	3	2	3	3
Summary Order	5	3	8	3	2
Voluntary Surrender	4	2	10	5	8
Agreement not to Renew/Reinstate	0	0	0	0	2
<b>Total</b>	<b>48</b>	<b>34</b>	<b>51</b>	<b>39</b>	<b>53</b>
*does not include 2 dismissals in 2002 Source: DPH, <i>Report of Legal Office Regarding Physician Actions, 1998-2000</i> and OLR					

*Forms of action.* There are several types of actions the medical board can take as illustrated in Table V-3. The board may take action through a memorandum of decision or approve the recommendations made by the department in the form of consent orders, interim consent orders, consent order modifications, voluntary surrenders, and voluntary agreements not to renew. Over the last five years, most of the board's actions have involved consent orders/agreements (along with interim consent orders and modifications), followed by memoranda of decision.

*Type of sanctions.* State statutes provide the board with a range of defined disciplinary sanctions ranging from revocation or suspension of licenses to requiring continuing education and assessing civil penalties. Table V-4 shows the types of disciplinary actions that have been imposed from 1998 through 2002. Probation, therapy, and civil penalty are the three most common forms of discipline. The severest forms of discipline (i.e., revocation, suspension, and voluntary surrender) occur in about eight cases, on average, per year.

<b>Table V-4. Types of Disciplinary Actions, 1998-2002</b>					
<i>Type</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>
<b>Revocation</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>
<b>Suspension</b>	<b>4</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>1</b>
<b>Voluntary Surrender</b>	<b>4</b>	<b>2</b>	<b>7</b>	<b>5</b>	<b>8</b>
<b>Restricted</b>	<b>0</b>	<b>1</b>	<b>7</b>	<b>4</b>	<b>5</b>
<b>Civil Penalty</b>	<b>6</b>	<b>4</b>	<b>11</b>	<b>8</b>	<b>10</b>
<b>Probation</b>	<b>17</b>	<b>18</b>	<b>16</b>	<b>10</b>	<b>10</b>
<b>Rehabilitation</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>1</b>	<b>0</b>
<b>Education</b>	<b>5</b>	<b>8</b>	<b>9</b>	<b>2</b>	<b>3</b>
<b>Therapy</b>	<b>11</b>	<b>10</b>	<b>12</b>	<b>7</b>	<b>5</b>
<b>Reprimand</b>	<b>5</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>8</b>
<b>Stay</b>	<b>3</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Cease &amp; Desist</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Negative Finding</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>
<b>Remove Finding</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>
<b>Agreement not to Renew/Reinstate</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
<b>Dismissed</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>
<b>Total*</b>	<b>58</b>	<b>49</b>	<b>73</b>	<b>41</b>	<b>53</b>
*Some doctors were subject to more than one disciplinary action within one case. Total does not include dismissed.					
Source: DPH, <i>Report of Legal Office Regarding Physician Actions, 1998-2000</i> and OLR					

**Communication with petitioners and licensees.** Petitioners are notified at various points in the process about the progress of their cases, including receipt of the complaint and the determination that the department either has no jurisdiction or that an investigation has been opened. The department will notify petitioners of the outcome of the department's review of

cases at whatever point in the process each case ends. Similarly, licensees are notified when cases have been opened against them, when the nature of the allegations has been determined, and at other points in the process as the cases proceed.

The timing and outcome of a case determine the amount of information a petitioner is allowed to access about the investigation. Statutes maintain physician investigations as confidential for 18 months. If within the 18 months after the investigation is opened, the department determines that no probable cause has been found, the case is closed and is never publicly available under the state's freedom of information law. If probable cause is found, the confidentiality ends when the case is open and over 18 months old, or when a statement of charges is issued. The only exception is for those cases involving substance abuse or mental illness, in which case the files remains confidential.

### **Physicians with Multiple Licensure Actions**

In order to analyze physicians with multiple licensure actions, committee staff examined both the National Practitioner Data Bank (NPDB) Public Use Data File and DPH's petition and physician profile database. The NPDB file contains information about adverse licensure actions, clinical privileges, professional society membership, Drug Enforcement Administration reports (all referred to as "adverse actions"), and medical malpractice payments received by the NPDB concerning physicians and other health care professionals since 1990.

The analysis below is limited to only licensure actions taken against Connecticut physicians. It should be noted, NPDB and DPH databases do not match for licensure actions or medical malpractice payments. There are a number of potential reasons for this including:

- for medical malpractice payments, NPDB does not require a report to be made if an individual is making a payment from personal funds, but the state does require this payment to be reported to DPH;
- fines levied as licensure actions are not reported to NPDB unless the fine is accompanied by other licensure actions; DPH records all fines as licensure actions;
- the date when reports are received by DPH and NPDB could be different and may put the same incidents in different years for each database;
- NPDB includes licensure actions imposed by other states and DPH's database does not; and
- required reporters may not be reporting the same information to both databases or that information may be incorrectly entered.

Results from both databases are important for their own purposes. The DPH database provides information to the department about Connecticut physicians for regulatory purposes, as well as

providing the basic information for the publicly accessible physician profiles.

**Table V-5. Number of Licensure Actions per Year, NPDB and DPH, 1990-2003**

<i>Year</i>	<i>NPDB</i>	<i>DPH</i>	<i>Difference</i>
1990*	7	32	25
1991	29	31	2
1992	32	24	8
1993	38	30	8
1994	44	35	9
1995	66	38	28
1996	50	33	17
1997	48	26	22
1998	54	35	19
1999	42	26	16
2000	63	40	23
2001	9	28	19
2002	7	36	29
2003**	3	19	16
<b>Total</b>	<b>492</b>	<b>433</b>	

\* began in September and not all cases would be reported for that year  
 \*\* 2003 is only partial year for both databases  
 Source: LPRIC analysis of NPDB and DPH databases

The NPDB retains adverse action and malpractice payment information about doctors in a nationwide network that is accessible to licensing agencies and employers of health care professionals. Some of the NPDB information is available to the public, but names of physicians are not part of that public data file. While data in the NPDB are presented for comparison purposes, the main focus of the analysis that follows is on the DPH database.

First, the number of cases having licensure actions recorded in each database was compared. Table V-5 shows the number of cases having licensure actions recorded each year by DPH and NPDB. The NPDB reports 59 more cases than DPH. Since 2001, NPDB

has reported significantly fewer cases than the DPH database and fewer than NPDB had reported in previous years.

**Table V-6. Number of Doctors by Licensure Cases, NPDB and DPH, 1990-2003**

<i>Number of Cases</i>	<i>NPDB Number of Doctors</i>	<i>DPH Number of Doctors</i>	<i>Difference</i>
1	160	298	138
2	73	51	22
3	26	8	18
4	12	1	11
5	3	1	2
6	2	0	2
7	1	0	1
8	2	0	2
10	1	0	1
<b>Total</b>	<b>280</b>	<b>359</b>	

Source: LPRIC analysis of NPDB and DPH databases

The number of doctors that have multiple licensure cases in each database is displayed in Table V-6 (above). Of the 359 doctors with licensure actions, by far most physicians (83 percent) had only one case.

- In combination with the totals displayed in the previous table, the DPH database shows the department had 433 cases where it took action against 359 doctors (multiple actions were possible), while the NPDB shows that 492 cases resulted in actions taken against 280 doctors since 1990.
- In the DPH database, 17 percent of the doctors (with an action) had more than one licensure case, while the NPDB data shows 43 percent of the doctors had more than one case.
- 201 of the 359 doctors with licensure actions cited in DPH's database are currently licensed; 25 of those doctors have had two licensure cases, and one has three cases.
- A total of 33 doctors since 1990 have had their licenses revoked by DPH, while 60 doctors voluntarily surrendered their licenses. Thus, 93 of the 359 doctors with licensure actions resulted in the loss of license.
- Overall, the most common reason for revocation (10 out of 33 doctors) was incompetence/negligence, while the most common reason for voluntary surrender (18 of 60) was substance abuse.

*License status of physicians with the most cases.* The licensure action history and license status of the practitioners in the DPH database with three or more actions (10 practitioners) and in the NPDB with five or more actions (nine practitioners) were also reviewed.

- While several practitioners had multiple reasons indicated for disciplinary action the predominate reason was substance abuse; four of the nine in the NPDB and six of the 10 in the DPH database had either drug or alcohol abuse or both as a reason. Incompetence or negligence was the next most-cited reason.
- One doctor in the DPH database and two in the NPDB have probation cited as the last action taken. The rest of the physicians have had their licenses revoked, voluntarily surrendered their licenses, or lapsed their licenses and agreed not to renew.

## Physicians with Multiple Medical Malpractice Payments

<b>Table V-7. Physicians with Multiple Medical Malpractice Payments</b>		
<i>Number of Payments</i>	<i>Number of Doctors DPH</i>	<i>Dollars Reported to DPH</i>
1	1,394	\$463,460,429
2	270	304,658,689
3	69	56,864,228
4	25	30,691,021
5	7	14,623,643
6	4	10,450,426
7	2	2,748,000
8	1	2,839,475
9	1	726,841
11	1	2,475,500
<b>Total</b>	<b>1,774</b>	<b>\$889,538,252</b>
Source: LPRIC analysis of DPH database		

Medical malpractice payments were reviewed in terms of number reported to the NPDB and DPH, as well as the number of payments per doctor and the amount of those payments. Since 1990, the NPDB file revealed 1,936 payments were made on behalf of 1,470 doctors, while DPH data showed 2,342 payments were made for 1,774 doctors. Table V-7 shows, for doctors with a payment, the number of payments made per doctor and the amounts of those payments in the DPH database. A total of 380 doctors have two or more medical malpractice payments and 110 have three or more.

Committee staff reviewed the disciplinary history and licensure status of physicians with the most reported payments to DPH and NPDB. There were nine doctors with six or more reported payments in the DPH database and eight doctors in the NPDB file. Table V-8 summarizes the results of the

committee staff analysis of DPH data.

- According to DPH data, three of the nine physicians with six or more payments had a licensure action. Two of the three actions resulted in a fine and the third resulted in probation with a restriction on the license.
- No revocation of licenses was reported for this group of doctors with six or more payments and no licensure action was taken against the physician with the highest number (11) of reported payments.
- Similarly, NPDB reported three of the nine doctors with six or more payments had some licensure action against them. The penalty for two physicians indicated a censure or a reprimand and one had a suspension of his/her license. The physician with the most payments (nine) did not have any licensure actions reported. Total dollars reported to NPDB over the time period was \$692 million, which was a difference of nearly \$200 million less than the dollars reported to the DPH database. It is unclear why the federal database should be so significantly less than state data.

<b>Table V-8. License Status of Physicians with the most Medical Malpractice Payments, DPH data, 1990-2003</b>					
Number of Payments	6	7	8	9	11
Number of Doctors	4	2	1	1	1
Dollar Amount	\$ 10,450,426	\$ 2,748,000	\$ 2,839,475	\$ 726,841	\$ 2,475,500
Licensure Status	All Current	All Current	Current	Non-renewal	Non-renewal
Licensure Disciplinary History	2 physicians disciplined: 1 MD had 2 petitions, one was dismissed and one resulted in fine; the other MD had 9 petitions, 8 dismissed and 1 resulted in a consent order w/ fine and reprimand	None	None	1 petition resulted in a consent order w/ probation and restriction on license	None
Source: LPRIC analysis of DPH database					

*Investigations based on payment notices.* Committee staff also reviewed the trends in medical malpractice investigations resulting from medical malpractice payments and the outcome of those investigations since 1994. Table V-9 shows the outcome of those investigations.

- According to the DPH database, from 1997 through 1999, a total of 599 payment notifications were received and 178 cases (30 percent) were opened. From 2000- 2002, 450 payments were received and 70 cases were opened as petitions (16 percent).
- The total number of medical malpractice payment notifications received by DPH between 1994 and 2002 was 1,638. Of that number, 414 cases were opened as petitions (25 percent) and 46 disciplinary actions were taken (3 percent of total received).

- Of the 46 actions taken the most prevalent actions were: fines (11), probation (10), and remedial education (7). No licenses were revoked. (As noted above, fines unaccompanied by other licensure actions are not reportable to NPDB.)

<b>Table V-9. Outcome of DPH Malpractice Investigations, 1994-2002</b>										
	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>Total</i>
Dismissed	10	25	78	55	60	40	55	32	13	368
Fine	0	0	1	1	0	1	6	1	1	11
Probation	2	0	0	0	2	3	1	0	2	10
Remedial Education	0	0	0	0	2	3	1	0	1	7
Voluntary Surrender	1	3	1	0	0	0	0	0	0	5
Reprimand	1	0	0	0	0	1	2	0	1	5
Warning Letter	0	1	2	0	0	0	0	0	0	3
Therapy	0	0	0	0	0	0	1	0	0	1
Suspension	0	0	0	1	0	0	0	0	0	1
Stayed Suspension	0	0	0	1	0	0	0	0	0	1
Restriction	1	0	0	0	0	0	0	0	0	1
Negative Finding	0	0	0	0	0	0	1	0	0	1
<b>Total</b>	<b>15</b>	<b>29</b>	<b>82</b>	<b>58</b>	<b>64</b>	<b>48</b>	<b>67</b>	<b>33</b>	<b>18</b>	<b>414</b>

Source: DPH, Letter to program review committee staff, 4/02/03

## **Findings:**

### **Physician Discipline**

- *On average, the Department of Public Health receives 496 complaints and notifications of medical malpractice payments involving doctors per year.*
- *About half (243) of those complaints and notifications result in an investigation, and 45 investigations (18 percent of the investigations or 9 percent of the total complaints) result in a disciplinary action.*
- *About 8 cases, on average (17 percent of cases with an action or 2 percent of total complaints), end in a severe disciplinary action (i.e., loss of license).*

- *Over the last 6 years, the proportion of cases investigated by DPH as a result of a review of malpractice payments has dropped in half (from 30 percent to 16 percent).*
  - *Relatively few doctors with multiple licensure actions remain in practice; however, physicians with multiple medical malpractice payments tend not to have licensure actions taken against them.*
  - *The physician disciplinary system is primarily complaint driven – depending mostly on public complaints. The process can be fairly characterized as largely reactive, not proactive. Public protection could be enhanced if the department proactively identified physicians who lack the requisite skills and qualities to effectively perform their jobs.*
  - *The Department of Public Health does not maintain any formal initial screening guidelines for determining which complaints are to be investigated. This is the point at which the majority of cases are selected out of the process.*
  - *No budget is provided, and rarely is a consultant paid, to determine if standards of care have been violated. Standard of care determination is an essential component of a case involving incompetence or negligence. Many problems are attributed to a reliance on a volunteer system of experts.*
    - *The investigations unit has reported that investigators devote a considerable amount of time trying to find an appropriate expert willing to volunteer his/her time to reviewing a case and possibly testifying at a hearing.*
    - *The legal unit has reported instances of experts backing out of cases when they get to the hearing stage due to their reluctance to appear at a public hearing.*
    - *The department has also reported a reluctance to prompt consultants who have not been timely in performing a review because they are not being paid by the department and have other work responsibilities.*
  - *There are no formal disciplinary guidelines to assist the department in its negotiations with a licensee or the board in its decision-making process. The purpose of guidelines is to provide consistent and equitable discipline in cases dealing with similar violations.*
  - *The department does not typically find out about a malpractice issue that has been litigated or a malpractice case that has been settled until a payment has been made. As cited above that time period is on average is at least five years from the date of the incident, and in many cases even longer. In the meantime, a potentially impaired physician could continue to practice and cause additional harm without any knowledge by DPH. The department is reluctant to investigate a case based solely on a malpractice payment notification, years after an incident, even though if notified earlier it would have conducted an investigation.*
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- *Committee staff have been told that doctors employed by hospitals are often initially named in lawsuits and involved in a pending malpractice matter but are eventually dropped from suits as a case proceeds. Hospitals make a payment on behalf of a doctor's negligent actions but the payment is made under the aegis of the hospital. The identity of the doctor is masked and the payment is never reported to the state or the NPDB.*
- *Several victims and families of patients who have alleged medical malpractice and have petitioned DPH have cited a lack of communication with the department over the progress and status of a pending case before DPH. A problem often mentioned was the lack of a satisfactory explanation as to why a case was dropped by DPH. Under current law, the investigatory file of a case that does not result in a disciplinary action and is concluded in less than 18 months is not a public record.*
- *Department disciplinary and medical malpractice payment data are not crosschecked with NPDB for consistency or completeness.*

### **Other Areas**

- *The Department Of Public Health does not know how many doctors are actually involved in patient care, the actual number of doctors practicing under each specialty in patient care, or the trends in physician employment in Connecticut. The department cannot track doctors who are limiting their specialty or changing specialty, such as obstetrician/gynecologists limiting practice to gynecology. Monitoring and publishing trends in physician employment and the availability of physician specialties are fundamental elements to the department being the state's leader in public health policy and advocacy.*
- *High quality health care requires physicians to be adequately trained so that care will be delivered consistent with current professional knowledge and practice. If physicians are not well-versed in the standard of care, medical errors are more likely. Connecticut is one of only 10 states that do not require continuing professional medical education for physicians, according to the American Medical Society. Board certification is often cited as a reason for the lack of continuing education requirements. However, certification does not necessarily impose stricter education mandates; it determines through testing that a physician has knowledge at that point in time. Board certification requirements for continuing education, which are determined by individual physician specialty boards, are inconsistent. Some specialty boards have begun to introduce or refine the requirement but have grandfathered existing "diplomats" (i.e., members), by excluding them from the requirements. In addition, board certifications are typically for extended periods of time (usually 10 years). According to the American Board of Medical Specialties, about 2,900 physicians in Connecticut, or less than half of those involved in patient care, are board-certified*

## Recommendations

9) The Department of Public Health shall establish a policy of funding for physician consultants for physician investigations. The department shall develop cost estimates for the payment of consultants and report to the legislative committees having cognizance over public health matters.

10) With regard to the disciplinary screening and investigation process, the Department of Public Health:

- shall develop formal written initial screening guidelines for physician-related complaints, including medical malpractice payment notifications. The department shall develop and report meaningful reasons for why cases are dropped from the process in a summary format in the department's annual report entitled, *Report of Legal Office Regarding Physician Actions* required under C.G.S. Sec 20-13i;
  - shall develop a formal written prioritization system so investigations may be conducted in order of priority, and report outcome and timeliness of actions by priority under C.G.S. Sec. 20-13i;
  - shall adopt written guidelines for broadening the scope of investigations, if deemed appropriate following screening, beyond the incident report or complaint that prompted the investigation. Those criteria for investigatory practices should include: sampling a large portion of patient records to identify patterns of care; reviewing office practices and procedures; reviewing performance and discharge data from hospitals and managed care organizations; and interviewing additional patients and peers;
  - shall adopt necessary procedures so that all investigations recommended for closure by the department, without any action, shall be reviewed by a panel of both public and professional members of the Medical Examining Board for concurrence;
  - shall develop a proactive system of markers to identify licensees warranting possible evaluation, in order to provide greater public accountability. This shall include but not be limited to: health status/age of licensee; number of complaints and malpractice claims/settlements/judgments; frequent changes in location; changes in area of practice; adverse actions by professional organizations, HMOs and licensing boards; failure to recertify in board specialty; inability to
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**obtain liability insurance in the regular insurance market; and physicians whose practice is not subject to peer review. It is understood any one action in one of these areas would not necessarily warrant an evaluation by DPH; and**

- **shall implement these changes by December 31, 2004.**

**11) There shall be established a multi-stakeholder task force, by September 1, 2004, to develop disciplinary guidelines to assist the Medical Examining Board in the physician disciplinary process. In each final action, the board shall provide evidence of how it applied the guidelines in memoranda of decisions, consent orders, and consent agreements. Deviation from the guidelines may be permitted when the board determines that clearly evident mitigating factors or other facts before the board warrant such a deviation. The board shall identify the reasons for the deviation in each case. The guidelines shall be developed by December 31, 2004. The guidelines shall include, but not be limited to:**

- **identification of each type of violation;**
- **a minimum and maximum penalty for each type of violation;**
- **additional optional conditions that may be imposed by the board for each violation; and**
- **identification of factors the board shall consider in determining if the maximum or minimum penalty should apply.**

**12) The Department of Public Health shall consider improving communication with petitioners by stating explicitly in writing why a case does not proceed based on changes in the screening guidelines recommended above and allow the victim or family, in the case of death, access to the consultant review for those cases that are evaluated and fail to meet the probable cause standard.**

**13) The Department of Public Health shall track and report annually on the number of physicians by specialty who are providing patient care and identify and develop the information necessary to create an inventory of actively practicing physicians in Connecticut by December 31, 2004. The department's physician license renewal form shall contain, and each licensed physician shall provide, the name of the insurance company through which a physician is insured and the policy number. The department shall assess the physician inventory every three years and such assessment shall include, but not be limited to: the number of doctors licensed by specialty, the number of doctors involved in patient care by specialty in Connecticut, projections for physician employment, identification of insufficient supply of specialists, and identification of any barriers to meeting physician workforce needs.**

**14) The Judicial Branch shall provide notification to the Department of Public Health of all medical malpractice lawsuits filed with the courts within 30 days of their filing, indicating all doctors who are named. The health department shall track the**

**doctors involved in lawsuits for purposes of determining if investigation for possible licensing actions are warranted.**

**15) By December 31, 2004, the Connecticut physician profile shall contain any information on malpractice payments and adverse actions taken in other states against Connecticut licensed physicians. The department shall use NPDB data for the source of this information, and the department shall adopt the practice of regularly crosschecking DPH records with NPDB data for consistency and accuracy.**

**16) Requirements for physician re-licensure shall be amended to include a minimum of 40 hours of continuing education every two years. The department shall determine acceptable required content guidelines as well as the minimum number of hours per year needed. In addition, a multi-stakeholder task force shall be convened to examine the feasibility of developing a physician re-licensing examination. The task force shall be appointed by September 1, 2004, and shall report to the legislature by February 1, 2005. The task force will examine:**

- if a periodic test for re-licensing based on determining an acceptable level of clinical competence, for both knowledge and skills, would benefit public safety and health;**
- the appropriateness of such a test for all physicians or class of specialties;**
- how such a test would be administered;**
- at what time intervals in a physician's career should such a test be administered;**
- what type of preparation would be necessary and could be made available to physicians;**
- how failure of the test should be handled, and how many retakes would be allowed; and**
- how much such a re-licensing process would cost.**



### Data Analysis

This chapter examines trends in premiums paid by physicians for medical malpractice insurance and the factors believed to contribute to premium increases. This includes incurred and paid losses, interest income, reinsurance, and reserves. In addition, overall profitability is examined. Where possible and applicable, aggregated data for all medical malpractice insurance carriers in Connecticut are compared to the nationwide experience. Where national data may be incomplete, supplemental analysis from authoritative and reliable sources is provided.

The experience of the Connecticut Medical Insurance Company (CMIC) is also presented to provide context and to augment trend information when statewide aggregate data are unavailable. CMIC, a mutual insurer, is in the unique position of being the single largest medical malpractice carrier in Connecticut (with about 41 percent of market share and 2,800 doctors insured of the estimated 7,000 in Connecticut), while at the same time only doing business in Connecticut.

The analysis, based on the data gathered and presented in detail below, shows:

- Premiums paid by physicians for medical malpractice coverage in Connecticut have increased recently, but the extent of increase varies by specialty and insurer.
- After a drop in 1998, total premiums earned by medical malpractice carriers in Connecticut increased 54 percent from 1998 to 2002. Nationally, the increase in earned premium was 25 percent over the same time period.
- Insurance carrier losses for medical malpractice in Connecticut, when measured on both a paid and an incurred basis, have increased more than the national experience. Nationally, over the last 12 years, incurred losses increased an inflation-adjusted 97 percent, but the increase was over 340 percent in Connecticut. Nationally, paid losses have increased 68 percent over the last 12 years, while in Connecticut the increase was 112 percent.
- Both premiums earned and losses for medical malpractice carriers are higher in Connecticut than the nation as a whole on a per capita basis.
- Frequency, or the number, of medical malpractice claims has been fairly constant in Connecticut.

- In Connecticut, the average “severity” of claims, measured as the dollar amount per claim, has increased 115 percent on an inflation-adjusted basis since 1991.
- Medical malpractice carriers have allocated the majority of invested assets to bonds. Investment income has declined, but this decline has been relatively minimal.
- The cost of reinsurance, additional coverage that insurance companies buy to protect themselves from excessive losses, has increased.
- Excess reserves have helped keep premium rates low in the past but insurers report the excess has been depleted.
- Profitability in the medical malpractice insurance line has declined in Connecticut more than the national experience and more than all insurance lines as a whole.

## **Base Premiums**

### **Medical malpractice rates have increased recently, but the extent of the increase varies by specialty and insurer.**

Figures VI-1 and VI-2 illustrate changes in base premiums charged by carriers of medical malpractice insurance in Connecticut for internal medicine, general surgery, and obstetrics/gynecology.<sup>32</sup> (These three specialties are selected because they generally represent low, medium, and high-risk specialties.)

These figures are based on annual surveys conducted by the publication Medical Liability Monitor (MLM) for the years 1996 through 2002 and data provided by the Connecticut Insurance Department for 2003. A few qualifications of the data are necessary.

- MLM data are not a complete survey of all insurance carriers offering medical malpractice insurance each year.
- Base premium rates will vary from what an individual doctor is charged based upon potential discounts or surcharges for which the doctor is eligible or liable.

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<sup>32</sup> Premium rates are based on annual rates for claims-made policies with a coverage limit of \$1 million per incident and \$4 million per year except The Doctor’s Company which provides a \$1 million per incident and \$3 million per year policy.

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- It is difficult to convey the magnitude of price changes in premiums because the data do not fully capture how many doctors are affected in particular specialties. For example, the highest rate quoted in 2003 in Connecticut for OB/GYN malpractice insurance is more than \$120,000, but that company insures fewer than 20 OB/GYNS. On the other hand, one of the largest OB/GYN group practices in Connecticut, with about 150 doctors, has experienced a rate increase of about 73 percent -- from about \$55,000 per physician in 2002 to about \$95,000 in 2003. In addition, the survey does not include doctors insured by captives or alternative providers.

The committee finds the MLM survey data, despite its limitations, and in combination with data available at the insurance department does provide an indication of the direction of change that has occurred in the traditional medical malpractice insurance market.<sup>33</sup>

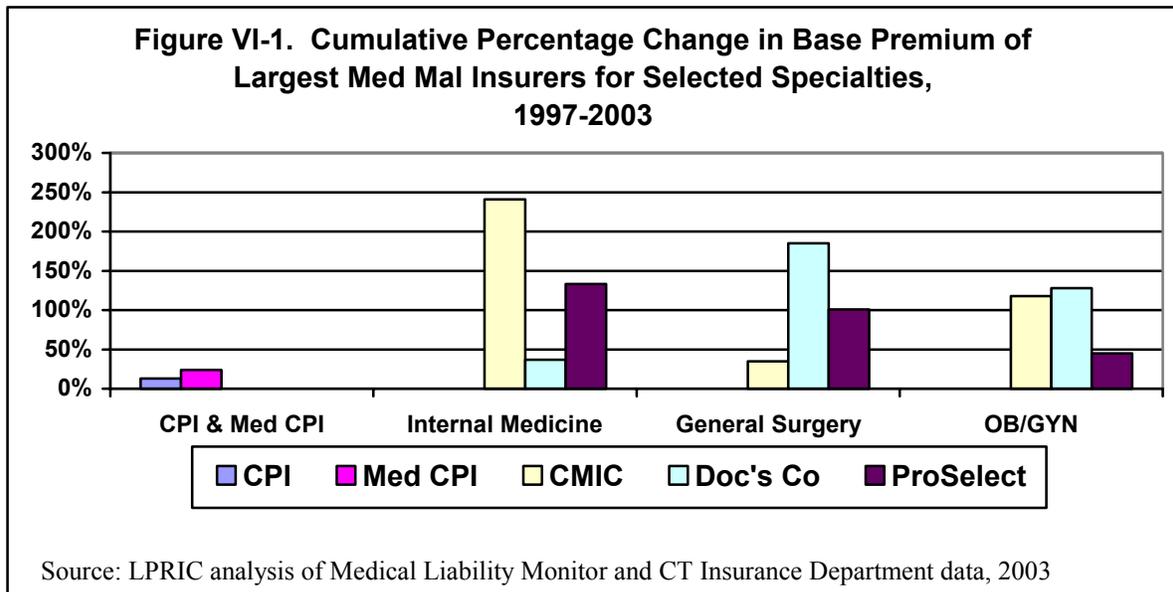


Figure VI-1 presents the percentage increase in the base premium of the largest medical malpractice insurers in Connecticut between 1997 and 2003 for three specialties and provides a comparison to the consumer price index (CPI) and the index for medical costs (Medical CPI). In summary, the figure depicts that:

- Over the last six years, premiums increased between 37 and 241 percent for internal medicine, 35 and 185 percent for general surgery, and 45 and 128 percent for obstetrics/gynecology depending on the company.

<sup>33</sup> LPRIC staff believe the inclusion of MLM data is justifiable for the Connecticut experience because the current largest medical malpractice providers in Connecticut are represented in most of the years depicted and discounts, while not reflected in the premiums, would serve to reduce already low rates in the earlier years compared to current rates. Insurance carriers have indicated the level of discounting has recently been reduced.

- Over the same time period, the cumulative CPI and Medical CPI have increased 13 and 24 percent respectively.
- In comparison, rate increases in the 1990s were considerably smaller. For example, CMIC’s cumulative rate increase from 1993 through 1997 was about 12 percent for these three specialties, not including discounts or dividends. From 1997 through 1999, CMIC insureds *on average* experienced either no rate change or a reduction in their premium, not including dividend payments.
- The premiums do not include the most recent rate filing by the carrier ProSelect, which is requesting a 30 percent overall increase in rates effective November 1, 2003. Other Connecticut carriers that have recently filed for rate increases include: The Medical Protective Company (29.1 percent overall increase effective 8/1/03), and Truck Insurance Exchange (57.3 percent overall increase effective 12/1/03).

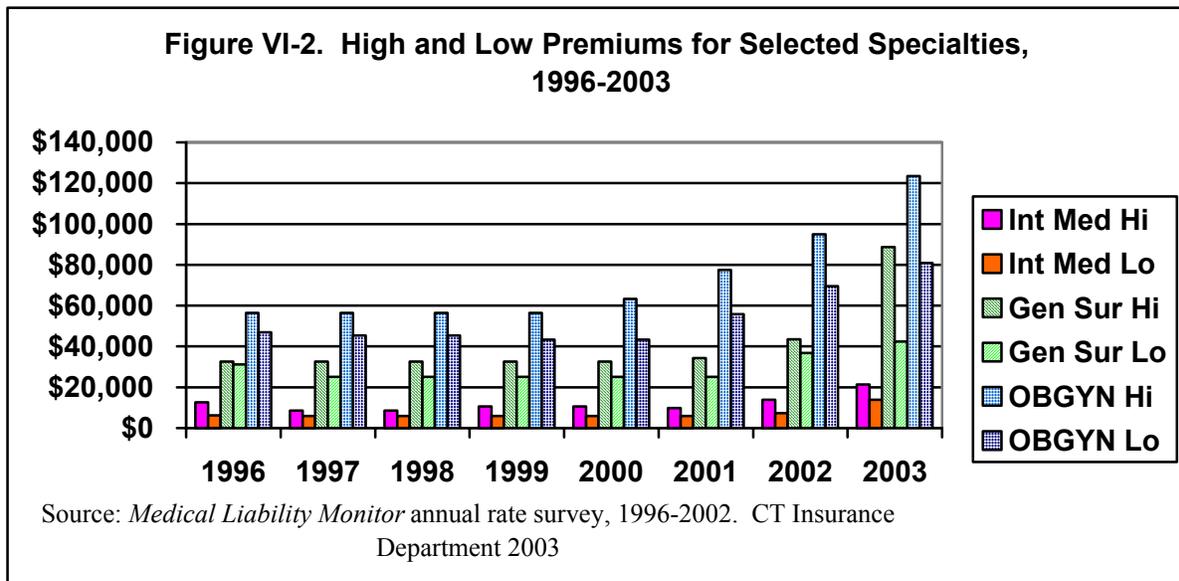
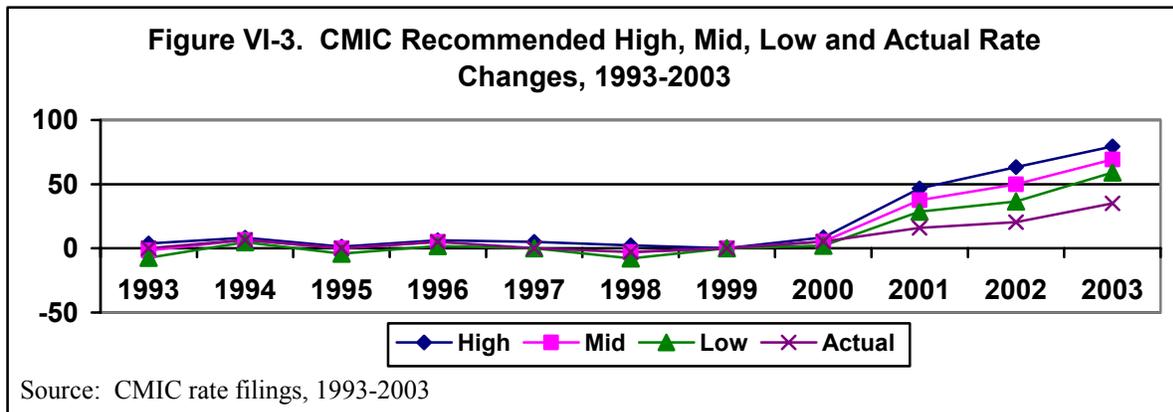


Figure VI-2 shows high and low premiums for selected specialties from 1996 through 2003. It illustrates the variability among different insurers and different specialties, as well as the year-to-year variability in premium. As expected, rates vary greatly across specialties. Based on the survey data, the highest rate for an internist in 2003 is about \$21,000; an obstetrician’s highest rate is about \$120,000. The differences in rates, according to insurers, mirror the costs associated with each specialty’s malpractice claims. It also shows the general premium trend for all specialties begins to increase noticeably in about 2001 and 2002. It can be noted between 1996 and 2003:

- the lowest rate paid by internists increased 133 percent, while the highest rate increased 150 percent;
- the lowest rate paid by a general surgeon increased 69 percent, while the highest rate increased 172 percent; and
- the lowest rate paid by obstetrician/gynecologists increased 87 percent, while the highest increased 119 percent.



The annual average rate increases, across all specialties, submitted by CMIC to the Connecticut Insurance Department from 1993 through 2003 was also examined as a way to measure change in premium. Figure VI-3 presents the high, midpoint, and low rate changes recommended by CMIC's actuaries and the actual rate changes selected by CMIC. From 1993 through 2000, there is very little difference between the three rates.

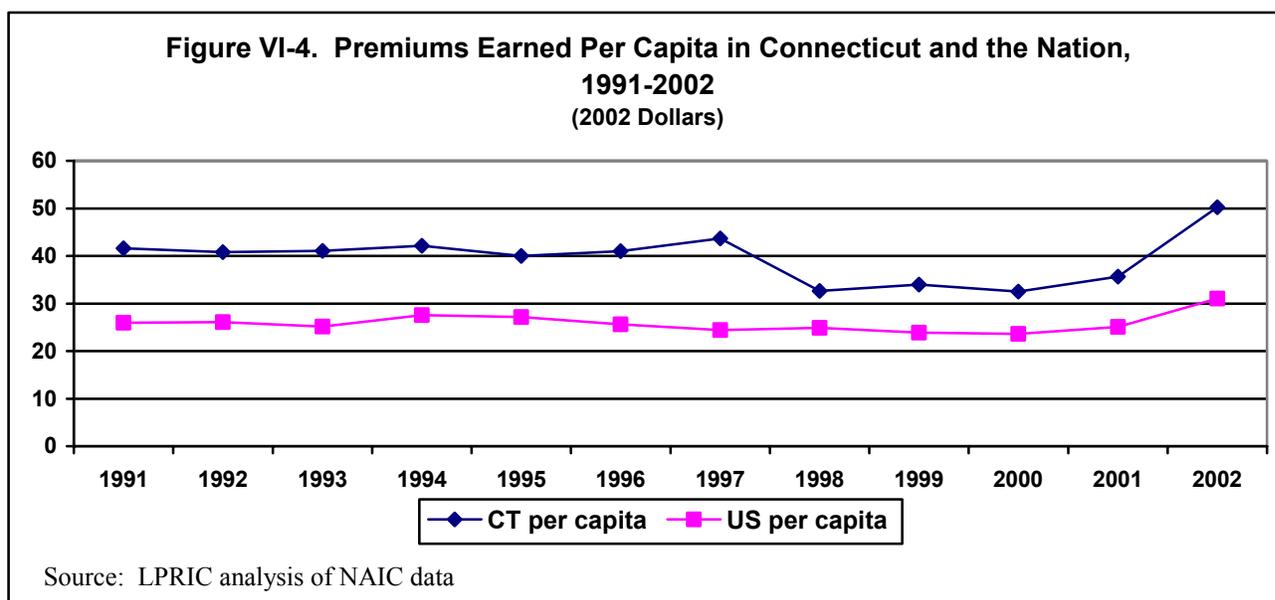
- In five out of the seven years from 1993 through 1999, CMIC submitted either no increase or a decrease in the average rate. In 1994, the average increase was 6.5 percent and in 1996, it was 5 percent.
- In five of the eight years from 1993 through 2000, CMIC selected the recommended mid-point change for each year. The exceptions were: 1993 -- the range was from about a 4 percent increase to a 7 percent decline and it selected no (zero) change; 1997 -- the range was from a high of a 5 percent increase to no (zero) change and it selected no change; and 1999 -- it did not file for a rate change.
- For each of the three years from 2001 through 2003, CMIC selected an average rate increase that was less than the lowest one recommended by its actuaries. CMIC reduced or eliminated discount programs to compensate for the difference.

## Premiums Earned

**After a drop in 1998, total premiums earned have increased significantly in Connecticut.**

Another way of analyzing premium trends is to examine the total premiums earned by medical malpractice insurance carriers as reported to the National Association of Insurance Commissioners. Insurers across the nation are required to report financial information annually to NAIC.<sup>34</sup> Insurance carriers collect premium before the coverage period. This premium is called the written premium. As the coverage period elapses, written premium becomes earned premium.

Figure VI-4 shows the trend in total earned premiums for insurance carriers in Connecticut and the nation for medical malpractice, adjusted for inflation and presented on a per capita (population) basis.<sup>35</sup> This allows for a valid comparison over time and across different geographical regions.



- Total earned premiums in Connecticut are consistently higher on a per capita basis than in the nation as a whole.
- Total premiums earned on the national level decreased 14 percent between 1994 and 2000. In 2001 and 2002, earned premiums rose 6 percent and 24 percent respectively.

<sup>34</sup> Self-insured entities are not included in the data

<sup>35</sup> Appendix E contains a comparison of premiums earned, losses incurred, and losses paid on an inflation-adjusted basis for the nation and Connecticut separately.

- Premiums in Connecticut have shown more much more variability and greater growth recently than the nation as a whole. After a period of little to no growth through 1997, there was a 25 percent drop in premium in 1998. However, from 1998 to 2002, premium grew about 54 percent. The largest single jump (41 percent) in that time period was between 2001 and 2002.

## Incurred and Paid Losses

### Both incurred and paid losses have increased.

Figures VI-5 and VI-6 below compare Connecticut to the nation for both incurred losses and paid losses after adjusting for inflation and are presented on a per capita basis (population) to provide an accurate comparison across time and among locations of different size.

*Paid losses* represent the amount of money actually paid out by insurance companies in a specified period of time. *Incurred losses* are an aggregate amount representing an insurance company's actual paid losses and changes in loss reserves for future payments of losses. An estimate of future losses includes not only an insurance company's initial estimates of ultimate losses for the current policy year but changes (if any) of estimates in ultimate losses made for prior policy years as well. Incurred and paid losses include both jury awards and settlement amounts. The "losses" do not include costs associated with losses, such as defense costs or any administrative expenses.

### Incurred Losses

#### Incurred losses have increased.

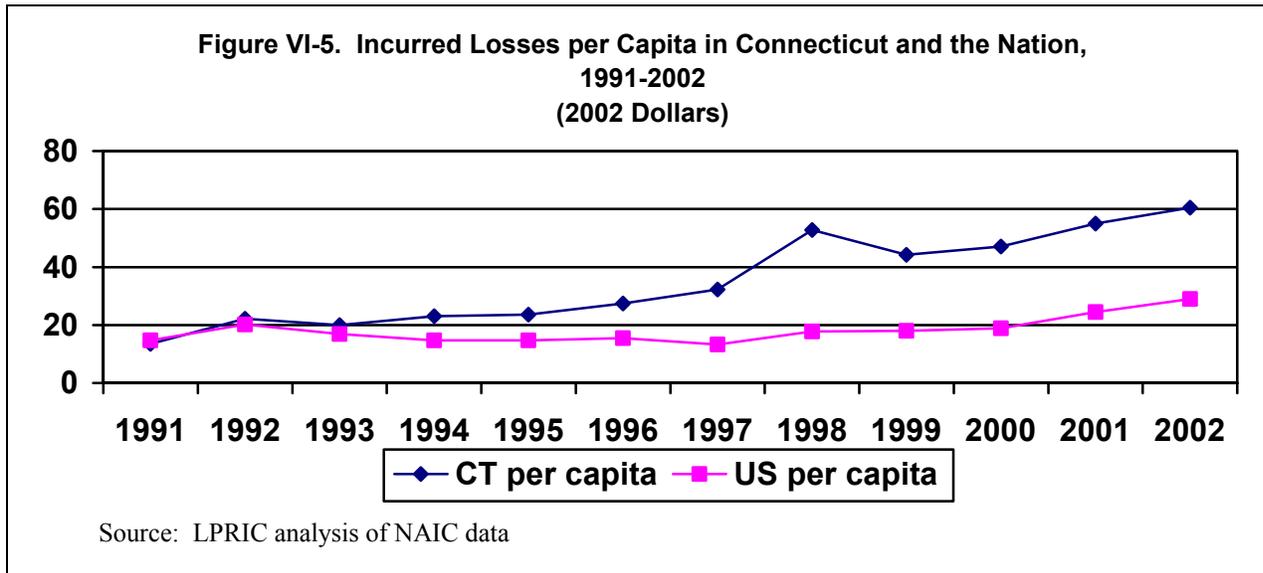


Figure VI-5 shows incurred losses per capita in Connecticut and the nation. The dollar amounts have been adjusted for inflation. The figure shows:

- Since 1992, losses incurred in Connecticut were consistently higher than in the nation as a whole.
- Nationally, there was a general decrease in incurred losses from 1992 through 1997. But from 1997 through 2002, incurred losses increased 119 percent. Over the last two years incurred losses increased 30 and 18 percent respectively. Over the 12-year period, incurred losses increased 97 percent.
- In Connecticut, the overall trend, from 1991 through 2002, has been a general rise in incurred losses – over 340 percent in the 12-year period. From 1991 through 1998, incurred losses increased 290 percent. In 1998 alone, incurred losses increased 64 percent and then decreased in 1999 by 19 percent. From 2000 through 2002, incurred losses rose again by 56 percent.
- In Connecticut, the average annual change in incurred losses has doubled over the last decade. The average annual change in incurred losses between 1992 and 1997 was 8 percent, while the average between 1998 and 2002 was 16 percent.

## Paid Losses

Paid losses have increased.

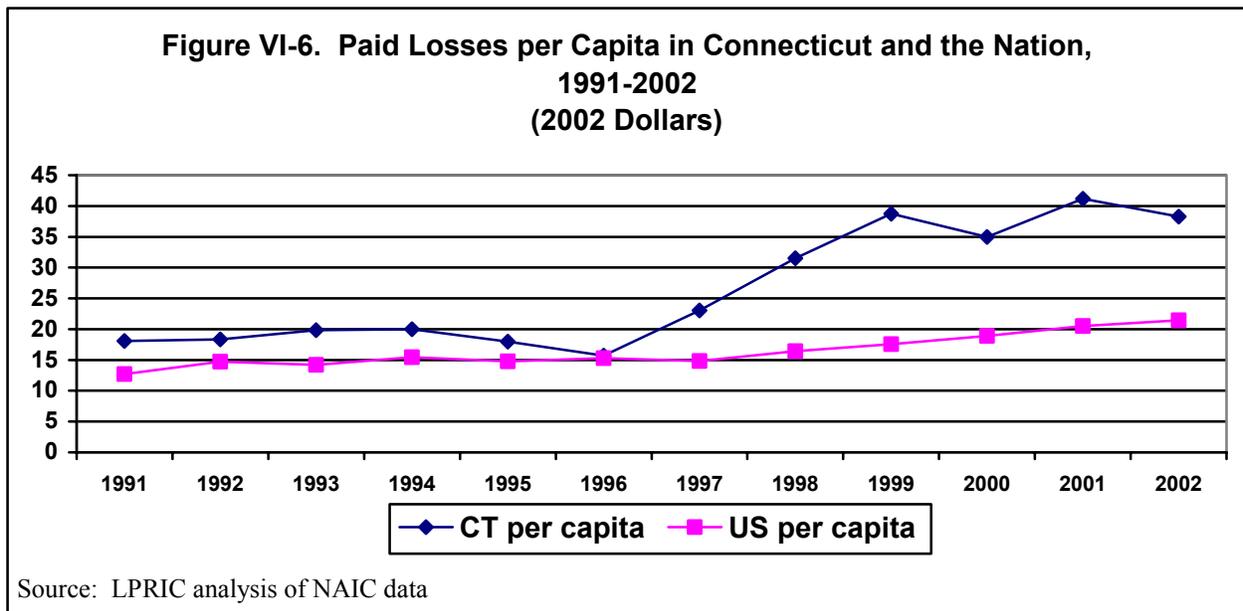
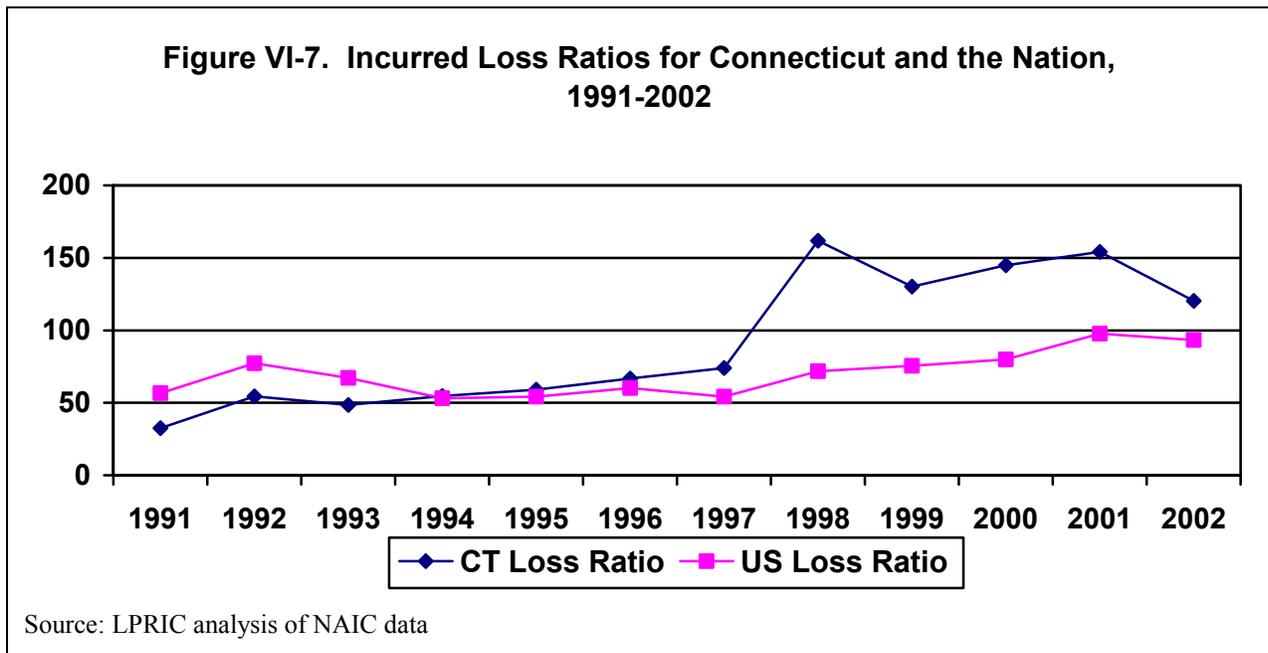


Figure VI-6 illustrates inflation-adjusted paid losses per capita in Connecticut compared to the nation for medical malpractice. It shows paid losses in Connecticut on a per capita basis are consistently higher than the national experience as a whole. In addition:

- Nationally, total paid losses between 1991 through 1996 increased 20 percent (the average annual change was about a 4 percent increase), while paid losses between 1997 and 2002 increased 45 percent (the average annual change was about a 6 percent increase). Total paid losses increased 68 percent from 1991 to 2002.
- In Connecticut, total paid losses between 1991 through 1996 decreased 13 percent (the average annual change was a 2 percent decrease). Even though there has been a slight decrease in 2002, total paid losses between 1997 and 2002 increased 66 percent (the average annual change was about a 18 percent increase). Total paid losses increased 112 percent from 1991 to 2002.

### Loss Ratio

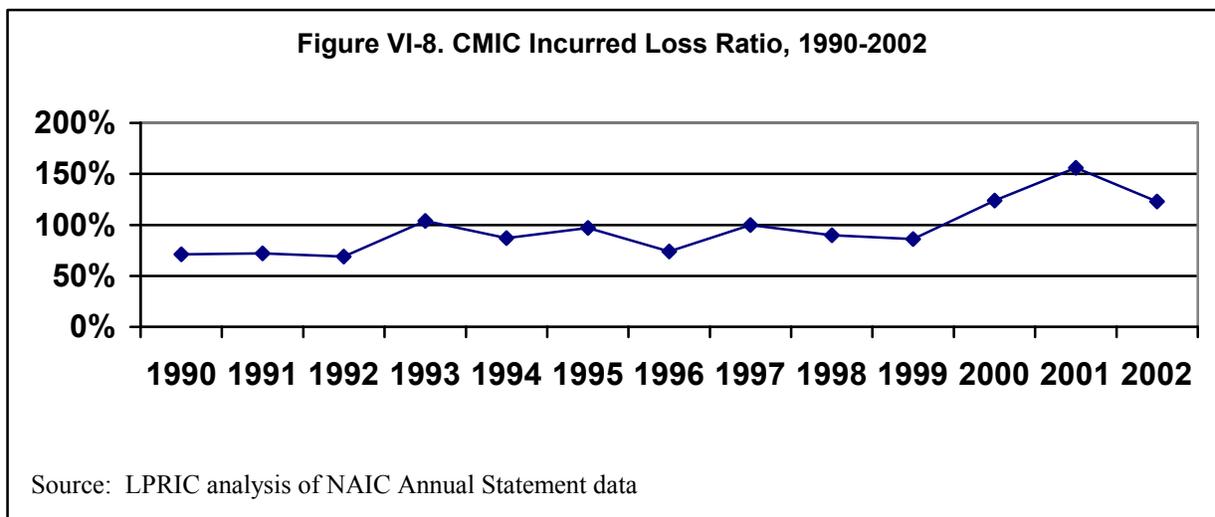
The loss ratio has increased since the mid-1990s.



The calculation of the loss ratio, presented in Figure VI-7 above, is a method of comparing incurred losses to premiums earned. It is one way of looking at the financial performance of insurance carriers. The loss figures do not include any other expenses besides paid claims.

A loss ratio greater than 100 indicates losses incurred exceed premium collected. Even so, an insurance carrier could still have made a profit through the investment of premiums, which is not reflected in this ratio. A ratio of less than 100 indicates premiums can pay for losses and other expenses or a profit. The figure shows:

- From 1991 through 2002, the national loss ratio remained below 100.
- Since 1997, the loss ratio in Connecticut has exceeded 100. While the ratio has dropped from a high of 162 in 1998, it was still at 120 in 2002.
- Until 1997, the loss ratios nationwide and in Connecticut took similar tracks; since then a significant gap has developed.

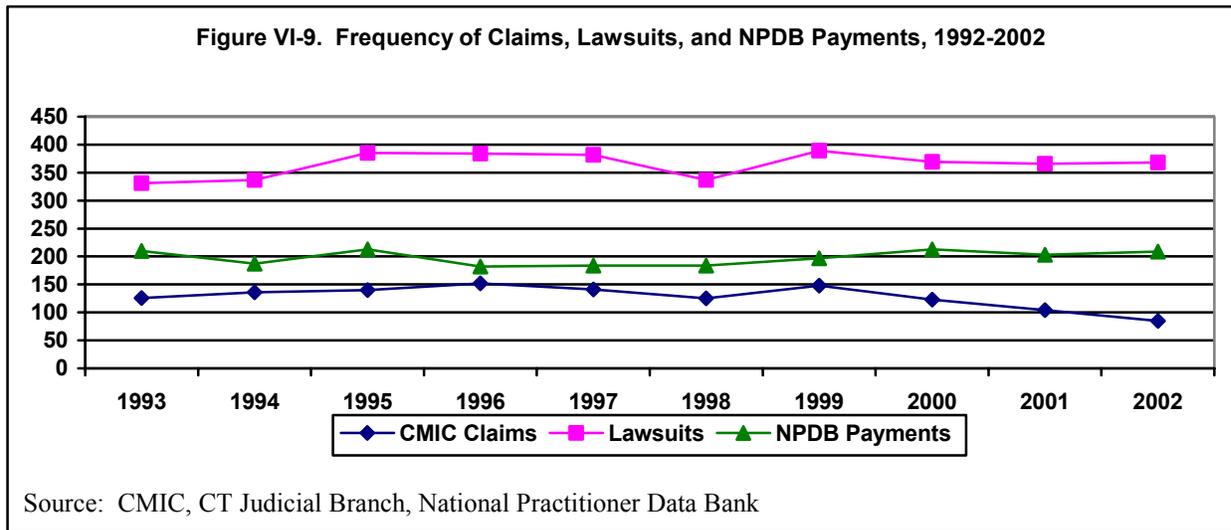


*CMIC incurred loss ratio.* Figure VI-8 shows the loss ratio for CMIC for 1990 through 2002. CMIC’s experience lagged a bit behind the aggregated Connecticut experience as noted in the previous figure. From 1990 through 1999, the loss ratio was just at or below 100. Between 1999 and 2001, the ratio climbed to 156, before declining last year to 123.

### Frequency and Severity of Loss

To understand the nature of losses and in order to try to address or reduce losses, it is important to assess the frequency and severity of medical malpractice losses. Frequency of loss measures the number of losses over a certain period of time, while severity of loss measures the magnitude of the loss per occurrence. Losses could increase with a rise in either or both of those conditions.

**Frequency of claims has been fairly constant.**



Because neither the state nor NAIC collect historical claims information on a state-by-state basis, no single source could indicate the total number of claims filed every year in Connecticut. To estimate the trend in frequency of claims in Connecticut over time, committee staff used three sources of information – the number of lawsuits filed in Connecticut annually, the number of claims filed with CMIC, and the number of payments reported to the National Practitioner Data Bank (NPDB) for Connecticut physicians. (A separate claims data collection effort was made by the committee for hospital data, with the Connecticut Hospital Association. The results are contained in Appendix F.) All medical malpractice payments made on behalf of a physician must be reported to the NPDB, except those by doctors who are self-insured.

Figure VI-9 presents the frequency of lawsuits filed in Connecticut, CMIC claims, and NPDB payments from 1993 through 2002 on an annual basis. It shows overall the number of claims has been fairly consistent.

- The number of lawsuits filed annually over the last 10 years has ranged from a low of 331 to a high of 382; the average yearly number of lawsuits has been 365.
- The number of NPDB payments per year has ranged from 184 to 213 over the last 10 years; the average has been about 200.
- The number of claims each year filed with CMIC has actually declined over the last four years from 148 to 85, with an average of 115.

Severity of claims has increased.

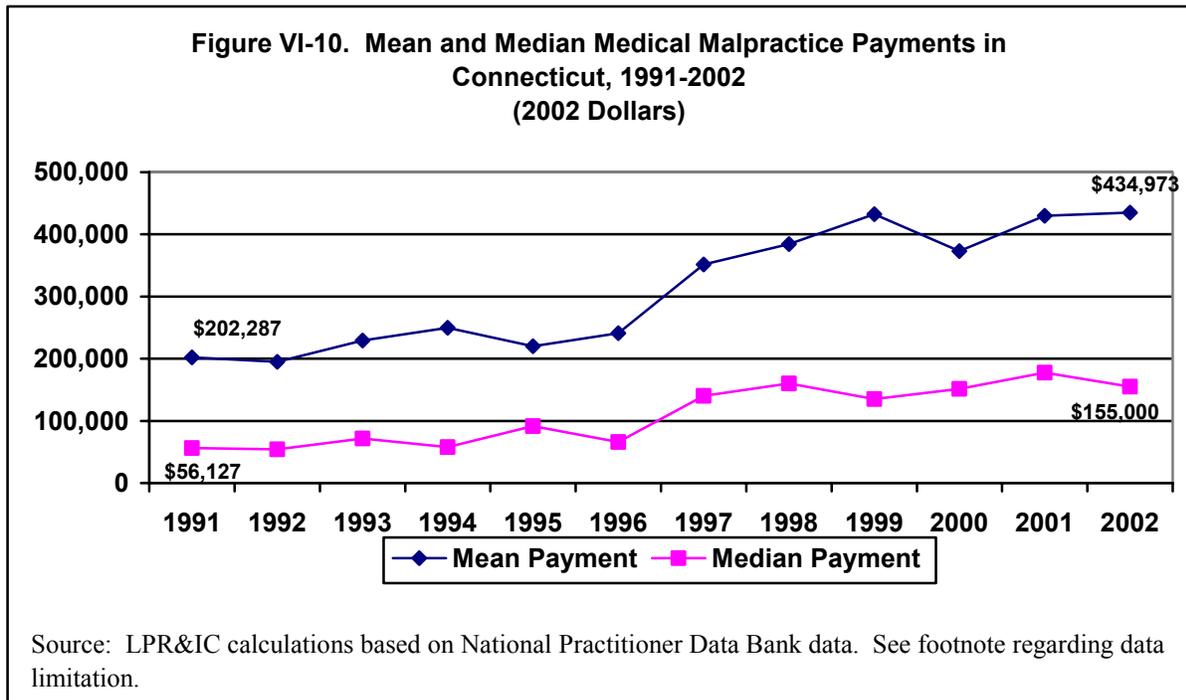


Figure VI-10 shows the mean and median (both inflation-adjusted) malpractice payments for Connecticut from 1991 through 2002 from the NPDB<sup>36</sup>. While a general increase can be noted throughout the time-period, the increase has been more severe over the last six years compared to the previous six years.

- The overall increase in mean payments from 1991 to 2002 was 115 percent, with the greatest increases occurring between 1996 and 2002. The mean payment from 1991 through 1996 increased 19 percent, from just over \$200,000 to \$240,000. However, it increased to \$435,000 in 2002 or 81 percent since 1996.
- Similarly, the overall increase in the median payment from 1991 to 2002 was 176 percent, with the greatest increases occurring between 1996 and 2002. The median payment from 1991 through 1996 rose from just over \$56,000 to \$66,000 (an 18 percent increase). From 1996 to 2002, the median increased to \$155,000 (or 135 percent).

<sup>36</sup> Note NPDB only reports first payment of multiple payment settlements, which would tend to understate the mean. However, 92 percent of payments in Connecticut were lump sum. Payments made by self-insured individuals are not reported nor are payments made on behalf of hospitals or corporations, which could affect the mean and median.

## Composition of Losses

If the severity of losses is one of the main driving components of premium increases, the next level of analysis requires an examination of the composition of those losses; for example, how losses are divided between jury verdicts and settlements, and further, how economic and non-economic damages are split.

**Data limitations.** National and state level comprehensive data, though, is lacking. As noted above, there are limitations on the federal data, and unfortunately, it is very difficult to assess these data independently because information on actual settlement and verdict amounts are very difficult to come by for several reasons. One reason is that settlement agreements between doctors (and their insurance companies) and plaintiffs are held confidentially. As most medical malpractice cases in which the plaintiff receives money are settled, this confidentiality custom obviously is a problem when trying to gather information. Even if the information were available, settlements are not usually broken down by economic and non-economic damages, frustrating further analysis.

In terms of verdicts, while this information is public, there are two major limitations. First, the judicial branch does not collect and compile data on verdict outcomes. Its automated case system is intended for case management purposes only, and while the fact that a case was resolved with a verdict for the plaintiff or the defendant is recorded, no verdict amount information is recorded for plaintiff verdicts.

**Table VI-1. Jury Verdict Outcomes in Four Connecticut Jury Trials (Hartford Judicial District)**

Case #	Return Date	Disposition Date	Total Damages	Economic	Non economic	Loss of Consortium
1 (death involved)	8/10/99	6/29/2001	\$1,017,817 (\$675,000)*	\$617,817	\$300,000	\$100,000
2	3/13/01	10/2/02	\$819,699	\$19,699	\$650,000	\$150,000
3	12/29/98	2/27/02	\$763,214	\$13,214	\$750,000	NA
4	6/27/95	6/29/00	\$61,957**	\$18,957	\$43,000	NA

\* Amount actually paid, based on high/low agreement made by parties during trial. Includes \$41,722 for loss of consortium for husband. Each defendant (M.D. and employer) paid ½, or \$337,500.

\*\* Amount owed by two doctors, one at 40% and the other at 60%.

Second, because of the way the judicial database is maintained (i.e., the database is purged periodically), it is not possible to even identify all medical malpractice cases resolved by verdict over a period of time, thwarting any effort to examine actual case files and collect award information. Further complicating data on award outcomes is, due to post-verdict activity or prior high/low agreements (discussed in Chapter Two), the verdict award is not necessarily what ends up getting paid by the insurers.

However, to begin to try to get an idea of what the data actually look like, program review staff identified all the plaintiff verdict cases in the database in one judicial district (Hartford), and reviewed four actual case files for verdict information. The result is illustrated in Table VI-1. Juries fill out forms in plaintiff verdicts that indicate their decisions on liability and damage amounts—what they conclude is “fair, just and reasonable compensation” for economic and noneconomic damages.)

Again, these case outcomes are not proffered as representative, but to begin to illustrate the variability of the outcomes. Obviously, the variability will be mostly based on the nature of the underlying claim.

**Table VI-2. CMIC Verdict and Settlement Data**

	1998	1999	2000	2001	2002
<b>No. of Settlements</b>	72	73	76	84	105
<b>Avg. Amt. Paid</b>	\$485,206	\$486,240	\$491,495	\$477,673	\$404,124
<b>No. of Verdicts for Plaintiff</b>	4 (25%)	7 (25%)	10 (38%)	8 (35%)	8 (50%)
<b>Avg. Amount of Award</b>	\$431,000	\$569,825	\$1,245,977	\$2,504,688	\$692,396
<b>Avg. Amount Paid**</b>	\$285,702	\$576,508	\$890,577	\$1,004,762*	\$445,672*
<b>Difference b/t Award and Paid</b>	\$145,298	(\$6,683)	\$355,400	\$1,499,926	\$246,724
<b>No. of Verdicts for Defendant</b>	12	21	16	15	8
<b>Total No. of Verdicts (Plaintiff and Defendant)</b>	16	28	26	23	16

\*Under negotiation

\*\*Further analysis would be needed to identify any further reductions in payouts

Source of Data: CMIC

**CMIC data.** CMIC provided the committee with data on its settlement and verdict outcomes. Table VI-2 provides information for a five-year period on settlements and verdicts. As shown, although there was a dip in 2002, the average amount paid for settlements has remained relatively constant. The average verdict awards, however, increased 61 percent from 1998 to 2002.

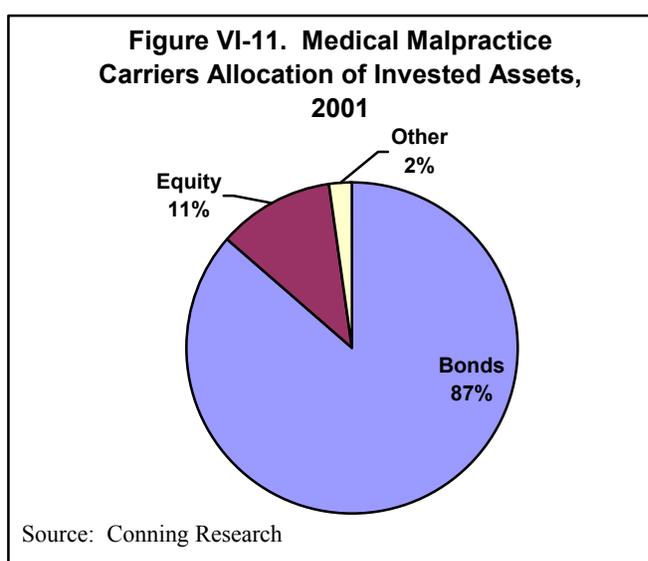
## Investment Income

**Medical malpractice carriers have allocated the majority of invested assets to bonds. Investment income has declined, but this decline has been relatively minimal.**

**Investment income.** Investment income is an important component of the insurance industry's financial operations. Because medical malpractice insurers collect premiums well before claims are paid, they have the ability to invest the premiums and earn investment income. This income, then, may be used to partially compensate for losses, possibly reduce premiums or increase profits. It has been asserted that insurance companies are raising rates to offset investment losses.

Investment income consists of interest, dividends, rents, and similar regular income received from the invested assets held by a company. While the investments can take many forms, statutory restrictions limit the amount and types of investments Connecticut-based insurers can make. For example, a company cannot invest more than 5 percent of its assets in the stocks of any one institution.

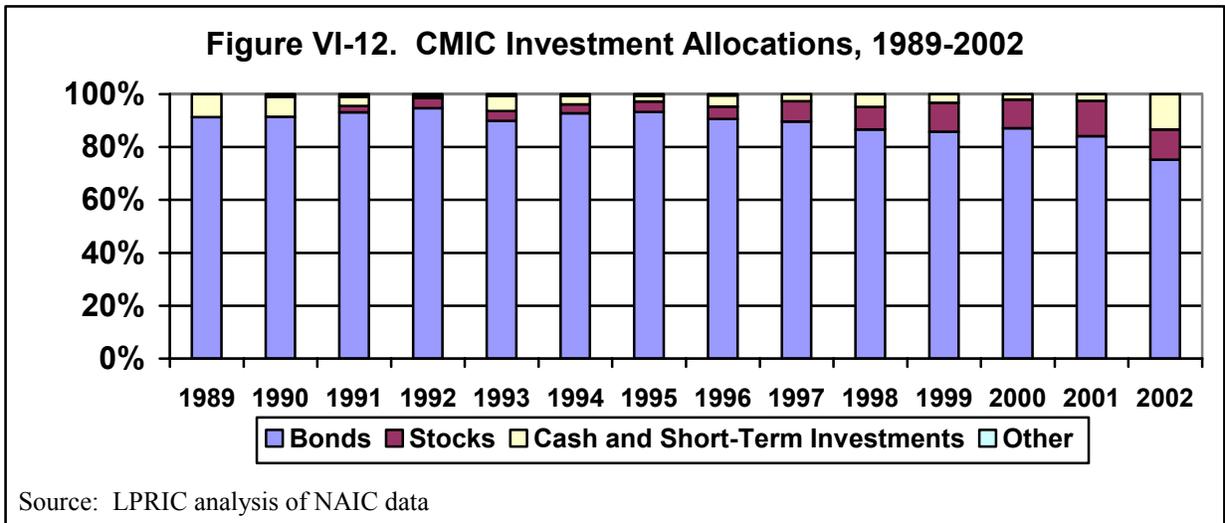
*Investment allocation.* A number of studies have examined the investment allocation of medical malpractice carriers. All have found these insurers are primarily conservative bond investors. For example:



- Figure VI-11 presents the results of an analysis of medical malpractice carriers' investments performed by Conning Research and Consulting in 2003. It found 87 percent of the invested assets were in fixed income securities and that number had not changed in the last five years. Moreover, the Conning study found medical malpractice

insurers were more conservative than the property-casualty insurance industry as a whole, which held 72 percent of its assets in bonds.<sup>37</sup>

- The U.S. General Accounting Office (GAO) examined the investments of the 15 largest medical malpractice carriers in the nation and reported similar results. It found the insurers “invested, on average, around 79 percent of their investment assets in bonds, usually some combination of U.S. Treasury, municipal and corporate bonds.”<sup>38</sup>
- The investment firm of Brown Brothers Harriman & Company found the amount medical malpractice companies invested in equities over the last five years was fairly constant - at just over 9 percent.<sup>39</sup>



*CMIC experience.* Program review staff analyzed the investment allocation of CMIC’s invested assets since 1989, and the results are presented in Figure VI-12. While CMIC has increased its investment in equities, the amount invested in high-grade investment bonds has never been less than 75 percent and has typically been at or near 90 percent.

*Rate of return.* Because malpractice carriers invest primarily in bonds, staff examined the rates of return for treasury securities as well as a recent analysis by GAO regarding investment returns. Figure VI-13 shows the yields for three, five, and 10-year treasury bills. It shows a general decline in rates from the mid-to-late 1990s through 2002. Specifically, the

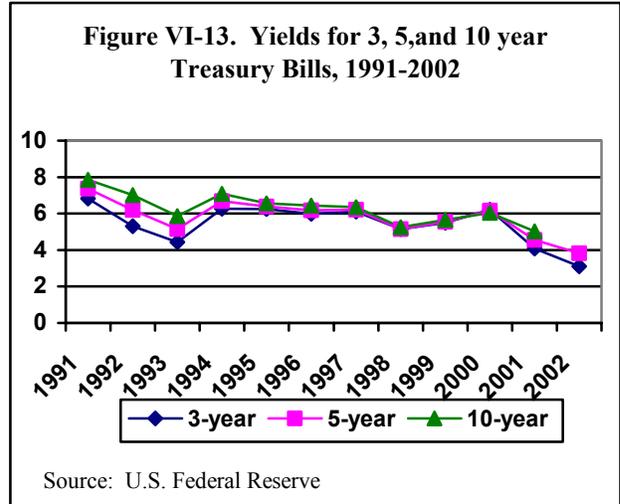
<sup>37</sup> Conning Research and Consulting, Inc., *Medical Malpractice, Anatomy of a Crisis*, 2003

<sup>38</sup> U.S. General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates* (Washington, D.C.) June 2003. pg. 24.

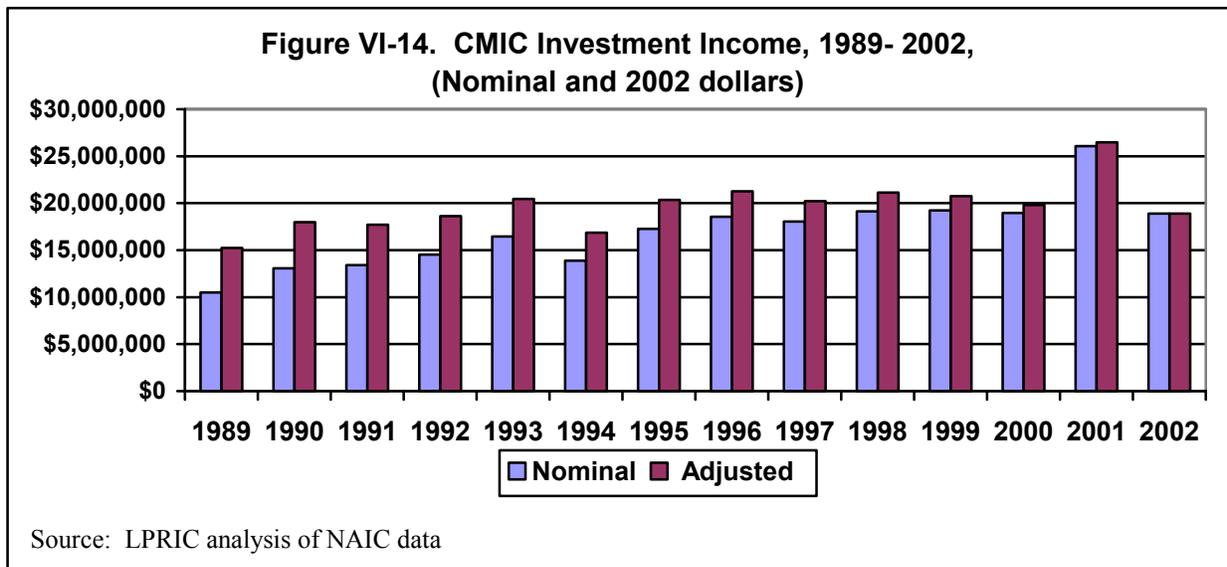
<sup>39</sup> Raghu Ramachandran, Brown Brothers Harriman, *Did Investments Affect Medical Malpractice Premiums?*, January 21, 2003

average rate declined almost by half from about 6.14 percent to 3.18 percent in 2002. Similar declines have been noted in municipal and corporate bonds.<sup>40</sup>

Similarly, GAO examined the investment returns of the 15 largest medical malpractice carriers in the nation and found “the average return fell from about 5.6 percent in 2000 to an estimated 4.0 percent in 2002. However, none of the companies experienced a net loss on investments at least through 2001... Additionally, almost no medical malpractice insurers overall experienced net investment losses from 1997 to 2001.”<sup>41</sup>



The General Accounting Office also calculated a rough estimate of the relationship between return on investment and premium rates. Using the experience of the 15 largest medical malpractice insurers, and holding all other factors constant, GAO found “a drop of 1 percent in return on investments would translate roughly into a 4.5 percent increase in premium rates.” Thus, the 1.6 percentage point drop in the return on investments experienced by the insurers between 2000 and 2002 would have resulted in a premium increase of about 7.2 percent over the two-year period.<sup>42</sup>



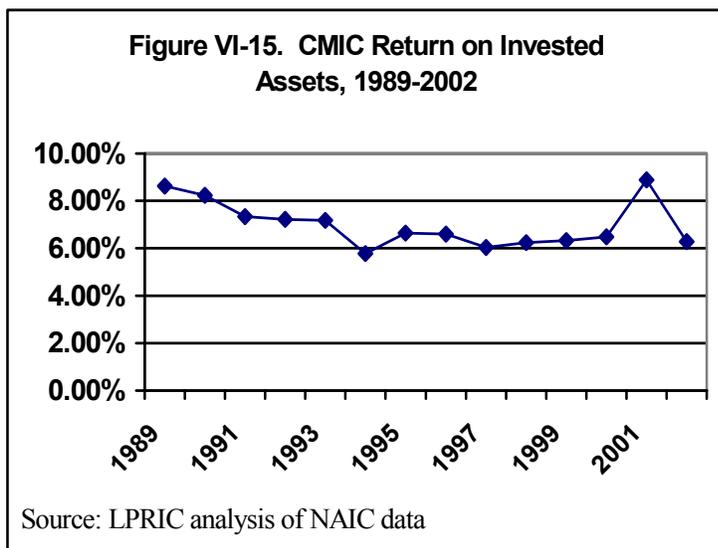
<sup>40</sup> GAO, pg 25

<sup>41</sup> Ibid

<sup>42</sup> Ibid, pg 27

*CMIC experience.* No rigorous state-by-state analysis of investment returns of medical malpractice insurers has been conducted. Part of the difficulty in doing such an analysis is obtaining the necessary data and properly allocating multi-state company data to particular states. Committee staff examined CMIC’s return on investments in terms of nominal and inflation-adjusted dollars and as a percent of return on total invested assets.

Figure VI-14 shows CMIC’s nominal and inflation-adjusted investment income for the period 1989 through 2002. There was a general increase of about 34 percent in investment income between 1989 and 1993 in inflation-adjusted terms. After a dip in 1994, the inflation-adjusted amounts remain fairly stable through 1999. Comparing 1999’s return to 2002, CMIC’s investment income declined about 9 percent in inflation-adjusted dollars.



In 2001, CMIC realized an unusual net capital gain due to the sale of stocks. If that asset were removed from the analysis, CMIC would still have realized a small increase in 2001.

Figure VI-15 shows CMIC’s percentage return on invested assets from 1989 through 2002. A general decline occurred between 1989 and 1994 (from 8.62 percent to 5.77 percent). In 1995, there was an increase to about 6.6 percent and, except for 2001, the rate remains within about 6.25 to 6.5 percent.

## Reinsurance

### The cost of reinsurance has increased.

Reinsurance is another expense component that contributes to the overall cost of premiums. Reinsurance is the coverage insurance companies purchase from other carriers in order to protect themselves from catastrophic loss. Thus, medical malpractice insurers are able to shift loss costs over a certain amount per claim to other carriers to help protect solvency.

A number of reports have commented on the increase in reinsurance rates on a national basis. Because severity of medical malpractice losses has increased, reinsurers bear a disproportionate share of the increase. In addition, reinsurance rates overall have increased because of the reinsurance losses related to the September 11, 2001 terrorist incidents.<sup>43</sup>

<sup>43</sup> See GAO pg. 32, Sanford pg. 7 and Statement of James D. Hurley, Tillinghast-Towers Perrin, before the Medical Malpractice Task Force of the Connecticut General Assembly, May 19, 2003, pg. 6.

The General Accounting Office reported in its study of medical malpractice premiums that some insurers have stated their reinsurance premiums increased in the range of 50 to 100 percent. However, the study went on to note: “One insurer estimated that while reinsurance rates had increased approximately 50 percent from 2001 to 2002, this increase had resulted in only a 2 to 3 percent increase in medical malpractice premiums.”

*CMIC experience.* Committee staff examined CMIC’s reinsurance costs. The following figures present CMIC’s reinsurance trend information based on reinsurance cost as percent of premium.

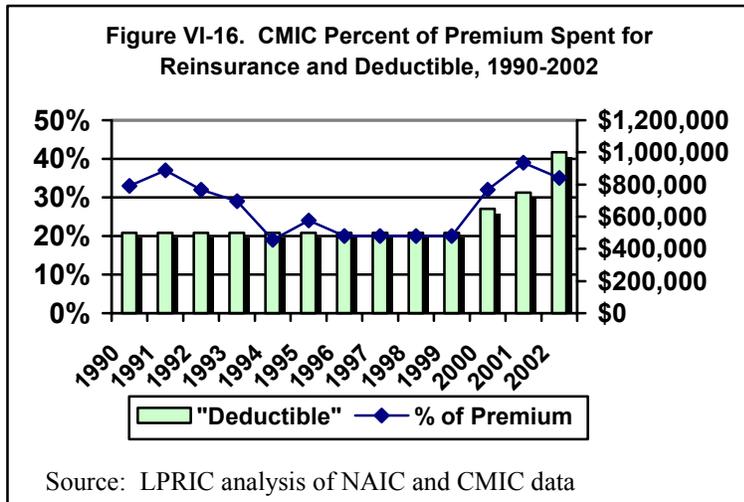


Figure VI-16 shows CMIC’s reinsurance costs as a percent of premium and its retention (or “deductible”) amount. A general decline in the percentage can be noted from 33 percent in 1990 to about 20 in 1994. This percentage holds steady until 2000. In 2000, the percentage jumped to 32 percent, and by 2002, it was 35 percent.

At the same time that rates were increasing, CMIC reduced its reinsurance coverage. Between

1992 and 2000, the dollar amount at which reinsurance coverage began was \$500,000; in 2000 it was \$650,000; in 2001, \$750,000; and by 2002, it was \$1 million. In 2003, CMIC reports it was raised to \$2 million. This means CMIC was paying an increasing amount of money for less reinsurance coverage and hence had less protection from high individual losses.

## Reserves

**Excess reserves have helped to keep premium rates low in the past, but insurers report the excess has been depleted.**

Because premiums are collected before claims are paid, insurers establish a reserve by estimating future losses and loss adjustment expenses. This amount is annually adjusted based on an assessment of settled claims, anticipated new claims, and associated loss adjustment costs.

Nationally, it has been reported insurance carriers overestimated the amount of losses associated with policies written in the late 1980s and early 1990s.<sup>44</sup> This became evident gradually as claims were settled. These excess (or “redundant”) reserves were reduced as actual payments were made and current year loss reserves were adjusted to reflect improved loss experience. This, in turn, lowered incurred losses and increased income and profits in the mid-

<sup>44</sup> GAO, pg. 28; Hurley, pg. 5

to late-1990s. These excess reserve amounts have also been credited with allowing insurers to keep premium rate increases low or flat while still making a profit.<sup>45</sup>

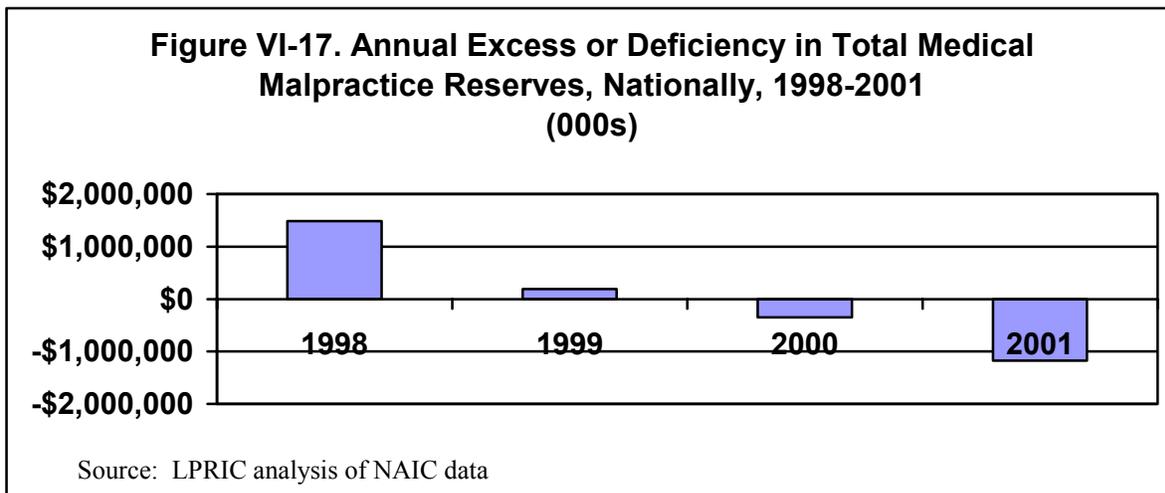
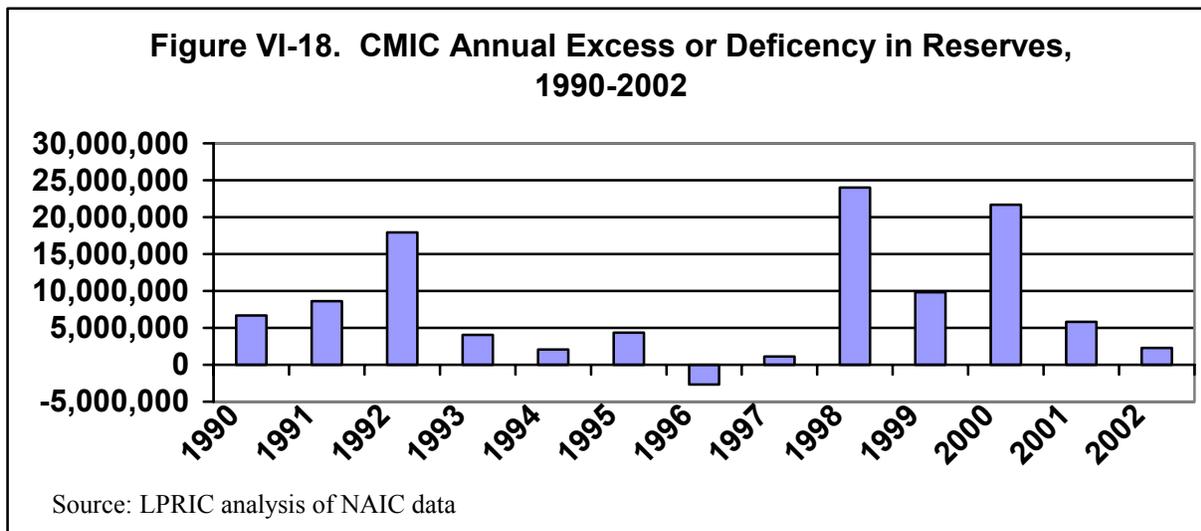


Figure VI-17 shows the cumulative annual excess or deficiency in total reserves for losses and loss adjustment costs reported by medical malpractice carriers nationally. In 1998, reserves exceeded ultimate expected losses by \$1.5 billion. By 1999, reserve redundancy dropped to about \$200 million. In 2000 and 2001, reserve estimates were deficient by \$350 million and \$1.1 billion respectively. The industry as a whole has subsequently increased reserves in 2000 and 2001, a trend projected to continue.<sup>46</sup>



*CMIC Experience.* Committee staff also analyzed CMIC’s reserves for losses and loss adjustment expenses. Figure VI-18 shows CMIC’s annual excess or deficiency in reserves. In contrast to national data, for each year except one (1996), CMIC reported an excess of reserves.

<sup>45</sup> GAO, pg 28.

<sup>46</sup> Hurley, pg. 5; Sanford, pg. 7; and Conning, pg. 13, regarding overall inadequacy of current reserves

The highest amount was in 1998, when \$24 million was reported. In 2002, CMIC reported about \$2.3 million in redundant reserves.

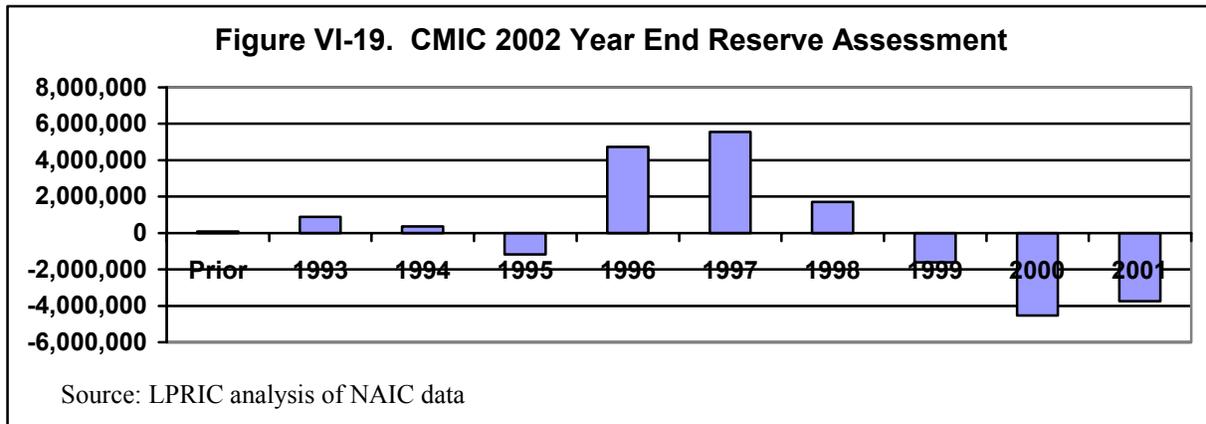


Figure VI-19 shows on a *cumulative basis* CMIC's 2002 year-end reserve assessment. This is the result of an annual assessment that measures the amount of excess or deficiency for each year in the last ten time periods. Each time period adds to the \$2.3 million illustrated in Figure VI-18 for 2002. It can be noted that the current estimates for the most recent years (1999-2001) are showing a deficiency. What is not known is whether these estimates will also prove to be in excess of what is ultimately paid out.

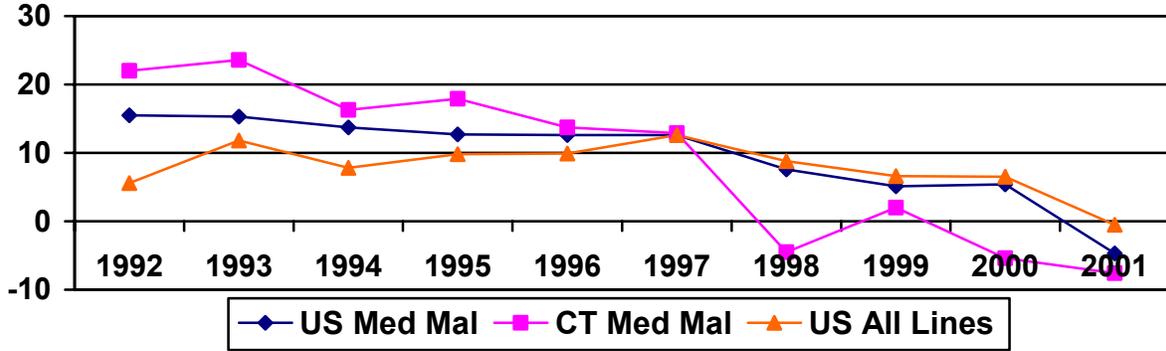
## Profitability

### Profitability in the medical malpractice line of insurance has declined.

Figure VI-20 shows a measure of profitability for Connecticut medical malpractice carriers compared to national medical malpractice carriers and to all insurance lines in the nation. Profitability of insurers can be measured in various ways. One standard is the net profit of medical malpractice carriers as a percent of net worth. Sometimes this is referred to as a return on equity or surplus. The figure shows:

- Nationally, medical malpractice profitability began to decline in the mid-1990s and declined faster after 1997.
- Although profitability in Connecticut has followed the same general pattern as the nation (high profits in the early 1990s), profitability overall in Connecticut has been more extreme than the nation. In the early- to mid-1990s, Connecticut was more profitable than the nation; after 1997, it has become much less profitable.
- Insurance lines as a whole were generally quite profitable (averaging about 10 percent) until 1997. Profits began to decline after that, and generally medical malpractice carriers have not experienced profits since 1997.

**Figure VI-20. Net Profit as a Percent of Net Worth for Medical Malpractice Carriers in Connecticut and the Nation and All Insurance Lines in the Nation, 1992-2001**



Source: LPRIC analysis of NAIC data

## **APPENDICES**

## Compensatory Damages: Economic and Non-economic

As noted in the main report, a basic tenet of tort law is to compensate an innocent person harmed by the negligent act of another, for the injury caused. The main type of damages awarded in medical malpractice cases, as in all personal injury cases, is compensatory damages. The intent is to “compensate” the injured person for losses caused by another’s negligence, or to “restore the injured party to his original position.” There are two types of compensatory damages: economic and non-economic. As defined under Connecticut statutes since 1987:

- *economic damages* are compensation for pecuniary (monetary) losses including but not limited to the cost of reasonable and necessary medical care, rehabilitative services, custodial care and loss of earnings or earning capacity; and
- *non-economic damages* are compensation for all nonpecuniary losses including but not limited to physical pain and suffering and mental and emotional suffering.

Prior to Connecticut’s Tort Reform I in 1986, there was no definition of compensatory damages in statute. In court decisions, compensatory damages pre-1986 were more commonly called “special” (now economic) and “general” (now non-economic). Special damages had to be specifically identified as to what medical care costs were and what lost income was, but, as a Connecticut court pointed out in 1963, ‘...general damages were distinguished from special damages in that the former are *natural and proximate* effects of [the] wrongful act charged and need not be specially alleged.’ (emphasis added)

Non-economic damages are not a new concept in civil litigation and have long been recognized as a legitimate damage component in personal injury cases. Issues over how to measure such damages, when should the jury’s decision be reviewed as excessive or inadequate, and what role a judge should take, are also not new. There have been relatively recent changes expanding recovery availability in the last several years, though, discussed below.

**Wrongful death cases.** When a person dies as a result of negligence in Connecticut, by statute since pre-1949, the estate of that person may recover from the negligent party “*just damages* together with the cost of reasonably necessary medical, hospital and nursing services, and including funeral expenses...” (C.G.S. Sec. 52-555) In 1976, the state Supreme Court held “just damages” mean:

- the value of the decedent’s lost earning capacity less deductions for [his/her] necessary living expenses and taking into consideration that a present cash payment will be made;
- compensation for the destruction of [his/her] capacity to carry on and enjoy life’s activities in a way he/she would have done had [he/she] lived; and

- compensation for conscious pain and suffering.<sup>47</sup>

The significance of the decision is the second element of damages. It identifies the concept of compensation for loss to a person of enjoyment of life, separate from compensation for any pain and suffering. The state Supreme Court acknowledged in its decision "...the assessment of damages in wrongful death actions must of necessity represent in a crude monetary forecast of how the decedent's life would have evolved." (citing other cases). (The Katsetos case noted a 1946 case, in which the issue of the proper valuation of damages based on the death of a housewife was at issue.)

Connecticut is in the majority of states where the loss of enjoyment of life element is a separate and distinct element of damages from pain and suffering; a minority of states consider the concept to be part of pain and suffering. In theory, because this separate basis of recovery exists, non-economic damages could be larger than otherwise. Connecticut has been described as showing a "progressive approach" regarding use of these damages in both personal injury and wrongful death cases "being the first jurisdiction to permit recovery for hedonic [loss of enjoyment of life] damages under the state wrongful death statute."<sup>48</sup>

Generally, the inexact nature of non-economic damages is well known, as a legal reference notes: "there is no exact standard by which [non-economic] damages can be measured in personal injury cases, because of the lack of equivalence between money and pain and suffering, fright, or humiliation, but money nevertheless is awarded as "compensation." The money to be awarded is, therefore, largely a matter for the jury to determine according to the facts and circumstances of each case. It must however be fair and reasonable and based on the facts disclosed rather than on sentimental or fanciful standards."<sup>49</sup>

*Loss of consortium in wrongful death cases.* Connecticut further added to the potential for increased damage recovery in 1989 in wrongful death cases. Prior to 1989, the spouse of a person who died as a result of medical negligence (or any other type of negligence) could not receive damages for his or her loss of consortium (e.g., loss of companionship). This was because common law did not provide for such a recovery. In 1989, the legislature made available a separate claim for damages for the spouse of a person who died under the above circumstance, applicable to any death on or after October 1, 1989.<sup>50</sup>

**Injury-no death cases.** Where there is personal injury but no death, the controlling damage statutes are different from the wrongful death statute. Although program review staff could not find a case specifically interpreting the definition of non-economic damages to include the same elements as "just damages" under the wrongful death statute, the separate concept of loss of enjoyment of life appears to apply to injury cases as well. In a 1988 state Supreme Court case, based on pre-tort reform law, the court upheld a \$9 million damage award based on a birth

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<sup>47</sup> Katsetos v. Nolan, 170 Conn. 637, 657 (1976))

<sup>48</sup> Hedonic Damages and the Admissability of Expert Testimony in Connecticut After Daubert v. Merrell Dow Pharmaceuticals, Inc. 15 QLR 235 (Summer 1995)

<sup>49</sup> 34 A.L.R. 4<sup>th</sup> 293 Section 2(a)

<sup>50</sup> C.G.S. Secs. 52-555a ,555b, and 555c

injury that left the plaintiff totally unable to care for himself, but with a life expectancy at age three of 68.1 years.<sup>51</sup>

In the decision, the Supreme Court said “ ...The jury was also entitled to assess Victor’s permanent injury and its effect on his capacity to pursue life’s enjoyments and it had the right to evaluate the pain and suffering that it concluded had resulted from Victor’s injury.” (This case is an example of both high economic and non-economic damages in a case where a person is injured and seriously disabled as an infant, but is expected to live a normal life-expectancy. Of the \$9 million, \$5,892,694 was for economic damages, two-thirds of the total award, while the remaining \$3,107,306 was for non-economic damages.)

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<sup>51</sup> Mather v. The Griffin Hospital, et al., 207 Conn. 125 (1988)

**APPENDIX B**

**Table 1. Liability Reform: Provisions Supported by the AMA and Status in California and Connecticut**

<b>Mechanism</b>	<b>AMA Position</b>	<b>California</b>	<b>Connecticut</b>
<b>Statute of Limitations (SOL)</b>	Optimal to have short but reasonable SOL permitting injured parties adequate time to pursue litigation w/o unreasonably subjecting providers to litigation	Action must be brought within 1 year after claimant discovers negligent act; no more than 3 years from date of injury. Actions on behalf of minors must be brought within 3 years from date of negligent act, unless the minor is under 6, in which case suit must be filed within 3 years or before the child turns 8, whichever is longer.	Action must be brought within 2 years from the date when the injury was first sustained, discovered, or in the exercise of reasonable care should have been discovered, except not more than 3 years from date of incident.
<b>Joint and Several Liability Rule</b>	Should be abolished; rule means all persons (joint tortfeasors) in a medical malpractice (med mal) case are each responsible for the whole damage award (joint) as well as their own portion (several) based on a calculation of degrees of fault. Rule intended to place onus of full recovery not on injured party, but on someone at fault. AMA says rule benefits claimant who can seek total compensation from “deep pocket” defendant, no matter degree of fault.	There is joint responsibility with exceptions: where comparative fault involved, liability is several for non-economic damages, meaning a defendant’s liability for non-economic damages is several only, limited to his percentage of fault.	In 1986, adopted a modified form of several liability; joint tortfeasors are generally only severally liable, but claimant can ask court for relief if after a year, any portion of damages has not been paid. Then the court must re-allocate unpaid portion to other parties based on their degree of fault. <sup>i</sup> <i>Unpaid economic and non-economic damages are re-allocated differently.</i>
<b>Contributory/Comparative</b>	Supports comparative negligence that prohibits a claimant who is	Follows a pure comparative negligence rule: a claimant’s	In 1986, adopted doctrine of modified comparative negligence. This means a

**APPENDIX B**

**Table 1. Liability Reform: Provisions Supported by the AMA and Status in California and Connecticut**

<b>Mechanism</b>	<b>AMA Position</b>	<b>California</b>	<b>Connecticut</b>
<b>Negligence</b>	partially at fault for an injury from seeking the entire amount of damages from a defendant.	negligence reduces his recovery but will never bar recovery	claimant's action is barred if his/her negligence exceeds the combined negligence of all defendants.
Limits on Attorney Fees	Supports reasonable limits on attorney fees to: help ensure the injured person gets fair share of awarded damages; and help discourage frivolous lawsuits by making it less lucrative to pursue meritless cases. Notes some states limit fees to percentage of total compensation, while other states apply sliding scale, and seems to support either.	For med mal cases, 40 percent of first \$50,000; 33 1/3 percent of next \$50,000; 25 percent of next \$500,000; and 15 percent of any amount that exceeds \$600,000. Applies to settlements, arbitrations, or awards.	For all personal injury cases, 33 1/3 percent of first \$300,000; 25 percent of next \$300,000; 20 percent of next \$300,000; 15 percent of next \$300,000; and 10 percent of any amount over \$1.2 million. (ruled waivable by 1993 superior court decision.)
Patient Compensation Funds	Supports funds to provide coverage to physicians in excess of other coverage. Funds benefit the medical community (often coverage physician has to provide lower than the common coverage of \$1 million/\$3 million); typically capitalized by physician surcharge.	No fund	No fund
Damage Caps	Supports caps on non-economic damages. Believes caps stabilize	\$250,000 cap on non-economic damages in medical malpractice cases	No cap

**APPENDIX B**

**Table 1. Liability Reform: Provisions Supported by the AMA and Status in California and Connecticut**

<b>Mechanism</b>	<b>AMA Position</b>	<b>California</b>	<b>Connecticut</b>
	liability insurance market, and strike a balance between compensating injured patients for damages impossible to quantify, and encouraging the availability of health care (also supports caps on punitive damages, which are not common in med mal cases).	damages in medical malpractice cases	
Mandatory Liability Coverage	Believes mandatory personal liability insurance as condition of licensure benefits both physicians and injured parties (But notes that in states that do not mandate, as practical matter, physicians are required to have such coverage to have hospital privileges or participate in managed care).	Only mandatory for physicians involved in claims related to outpatient surgical procedures	Has mandatory PLI
Periodic Payment of Damages	Believes periodic payment arrangement generally benefit physicians and insurers, who are sometimes required to pay huge verdicts that primarily benefit a claimant's beneficiary	For med mal cases that result in judgments of future damages in excess of \$50,000, either party may request the court to order periodic payments. Upon the death of the claimant, the court will modify any future damage award, except that awards for loss of	If both parties agree, periodic payments can be set up. If parties cannot agree, court orders lump sum. (For one year, after Tort Reform I and before Tort Reform II, if the parties did not otherwise agree, the part of an award over \$200,000 was to be paid in periodic

**APPENDIX B**

**Table 1. Liability Reform: Provisions Supported by the AMA and Status in California and Connecticut**

<b>Mechanism</b>	<b>AMA Position</b>	<b>California</b>	<b>Connecticut</b>
		future earnings will not be reduced by reason of the claimant's death.	payments.)
Collateral Source	Supports abolition of common law rule, which prohibits consideration of other compensation for person's injuries when deciding damage award (e.g., health insurance).	Evidence of receipt of payments in connection with injury admissible at trial.	Evidence of collateral sources not admissible at trial, but if plaintiff wins award, the judge will consider evidence of such payments and reduce the award as warranted (The AMA prefers this approach to where collateral source evidence is provided to jury to consider in its decision.
Pre-Trial Screening Panels	Believes mandatory pre-trial screening panels discourage frivolous lawsuits as they are a prerequisite to litigation	No	Voluntary screening panel; never used
Affidavit of Merit	Believes affidavits of merit help eliminate frivolous lawsuits which burden the court system, and can save defendants the costs of litigation	No requirement	For med mal cases, a good faith certificate must be filed with complaint. The certificate is a document signed by an attorney that says he/she has made a "reasonable inquiry as permitted by the circumstances to determine..there are grounds for a good faith belief..there has been negligence in the care or treatment of the claimant." (not clear if written opinion of an physician qualified as expert is required).

**APPENDIX B**

**Table 1. Liability Reform: Provisions Supported by the AMA and Status in California and Connecticut**

<b>Mechanism</b>	<b>AMA Position</b>	<b>California</b>	<b>Connecticut</b>
Arbitration/ ADR	Believes required or permitted arbitration in lieu of litigation discourages frivolous lawsuits and saves defendants money by avoiding litigation	No requirement of arbitration prior to litigation.  However, while not the kind of arbitration the AMA refers to here, California allows health care providers and their patients to contract for the arbitration of disputes	No requirement; see voluntary screening panel above

Source: American Medical Association, Liability Reform: Common Provisions of State Law, Advocacy Resource Center, March 2002; Summary of Medical Malpractice Law, McCullough, Campbell & Lane (rev. 2/6/98)

<sup>1</sup> In CT, joint tortfeasors may seek contribution in med mal actions if they are required to pay more than their originally allocated amount. If a settlement is reached between claimant and person, that person is discharged from all liability for contribution, but the total award of damages is reduced by the amount of the released person's percentage. Further, since 1995, a defendant in a civil suit may file a complaint to add a person who is not a party to the action who is or may be liable for a proportionate share of the plaintiff's damages. This must be filed within 120 days after the return date (about a month after the original case is filed). This person is the apportionment defendant, and can be a person who has either settled with or been released by the P. This applies to any civil action filed on or after July 1, 1995.

## APPENDIX C

### Summary of Caps as of November 2003

#### **Five states currently have \$250,000 caps on non-economic damages for medical malpractice cases.**

- California, 1975; Colorado, 1986; Utah, 1986; Montana; 1995; and Texas, 2003 (per constitutional amendment).
  - Colorado also has a \$1 million dollar limit (taking into account the \$250,000 non-economic cap) on total recovery from hospital or physician. Court can award damages in excess of limit if future economic damages exceed cap and the limit would be unfair.

#### **Ten states currently have higher caps on non-economic damages for medical cases, with other variations.**

- Massachusetts (1986) \$500,000 cap, unless jury finds substantial or permanent impairment of a bodily function or substantial disfigurement or other special circumstances;
- Michigan (1986, changed in 1993) Current cap is two-tiered: \$280,000, unless there are certain circumstances, then cap is \$500,000. Circumstances include paralysis due to brain or spinal cord injury, impairment of cognitive capacity, or loss of reproductive ability. Caps adjusted annually for inflations (Original cap was \$225,000, not applicable to exceptions such as loss of a vital bodily function) (Caps do not apply to wrongful death cases (including those involving med mal))
- Missouri (1986) \$350,000 cap annually adjusted for inflation (set at \$547,000 in 2002)
- Nevada (2002) \$350,000 cap with exception for cases of gross negligence
  - Nevada also limits total damages for hospitals and physicians to \$50,000 when treating trauma patients
- North Dakota (1995) \$500,000 cap
- Oklahoma (2003) \$300,000 cap for cases involving pregnancy
- South Dakota (1985) \$500,000 cap
- West Virginia (1986, changed in 2003) Current cap is \$250,000 for wrongful death, permanent and substantial deformity, loss of limb or bodily function; will be

increased by inflation up to \$1 million maximum (original cap was \$1 million)

- Wisconsin (1995) A \$350,000 cap adjusted for inflation; as of 1998, \$500,000 for a child and \$350,000 for an adult (earlier cap ruled unconstitutional due to retroactivity)
- Florida (2003) \$500,000 cap for individual physicians (judge can increase if found to be unjust) (New cap replaced 1986 provision that tied a \$350,000 non-economic cap to agreement to arbitrate for both sides)

**Four states limit liability of health care practitioners who participate in state fund, which covers any excess liability.**

- Louisiana (1975, amended in 1984) Limits liability of health care practitioners to \$100,000; total damages paid out of the fund are limited to \$500,000 except for future medical care and related benefits, which the state Patient Compensation Fund pays as needed. (Physicians must carry \$100,000 of insurance and pay surcharge into the fund.)
- Nebraska (1976, 1986) \$1 million limit on recoveries against health care providers who participate in state-sponsored excess insurance (carry some insurance and pay surcharge to fund). (Patient can elect to be under the act or not to be, in advance of treatment, by notice to the state insurance dept.)
- New Mexico (1978, and amended ) \$600,000 cap on all med mal damages excluding punitive and medical care and related costs; \$200,000 limit on liability of health care providers (Any future medical expenses are paid on an as-needed basis and are not part of damages) Physicians carry insurance for \$200,000 and pay a surcharge)
- Indiana (1975; 1998) \$1.25 million cap on all damages for med mal cases; \$250,000 liability limit for each provider in fund (provider must have \$250,000 insurance and pay surcharge to fund)

**Six states have caps on non-economic damages for personal injury cases, including med mal claims**

- Alaska (1997) Two-tiered: Personal injury non-economic injuries capped at greater of \$400,000 or plaintiff's life expectancy in years multiplied by \$8000; for severe injury the cap is the greater of \$1 million or life expectancy in years time \$25,000 Had a \$500,000 cap earlier

- Hawaii (1986) \$375,000 cap for personal injury or death pain and suffering, excluding disfigurement, mental anguish, loss of enjoyment of life and loss of consortium
- Idaho (1987, 2003) \$400,000 cap on non-economic damages in any personal injury action including death unless caused by “willful or reckless misconduct”; adjusted according to the state’s average annual wage. (earlier damage cap limited to med mal held unconstitutional in 1977)
- Kansas (1988) \$250,000 cap on personal injury non-economic damages
- Maryland (1986) Initial \$500,000 cap with annual \$15,000 increases; as of 2002, cap is \$620,000
- Mississippi (2003) \$500,000 cap on non-economic damages; increases to \$750,000 on July 1, 2011 and to \$1 million on July 1, 2017 (caps are exclude in disfigurement cases or at judge’s discretion)

**25 states have no caps on damages**

- Connecticut (considered in 1994 amendment to health bill; defeated)
- Ohio State legislature has tried twice to enact a cap on non-economic damages, both found unconstitutional by Ohio Supreme Court (in 1975, cap was at \$200,000 and in 1997, at \$250,000 or 3 times economic damages up to \$500,000, which ever was greater; for more serious losses, \$1 million or 35,000 times remaining life expectancy)
- Illinois
- Arizona
- Arkansas
- Delaware
- Georgia
- Illinois (struck down)
- Iowa
- Kentucky
- Maine
- Minnesota
- New Hampshire
- New Jersey
- New York
- North Carolina

- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Vermont
- Virginia
- Wyoming

## APPENDIX D

### Summary of Commonly Cited Studies on Cap Impact

There is much debate on the impact caps on non-economic damages have on medical insurance premiums. The analysis is complicated by the variations in caps among the states as well as the fact that other factors, such as other tort reform measures, other liability cost-shifting measure, and types of insurance regulation are in the mix. Below is a summary of six evaluations of the impact of caps on med mal premiums. For each study PRI staff summarizes the method of analysis and conclusions. Where warranted, PRI staff offers comments.

Some find that caps do or could lower rates, one suggests California's mix of reforms is responsible for the low California rates, one finds caps do not lower rates, and one finds the available data inconclusive

#### **U.S. Dept. of Health and Human Services, March 3, 2003**

##### **■ Caps impact rates**

HHS Methods: Grouped states without "reasonable limits on non-economic damages" (18 including CT) and showed the highest rate increase reported for any of the three specialties in the MLM.

Calculated the average highest premium increases for all three specialties in states experiencing a litigation crisis (9 states) (8 included in above 18, one new one) (CT not in this list)

Compares 2002 premiums in "non-reform" states to those charged in California (using highest and lowest premiums reported for three specialties (MLM))

Compares average highest premium increase between states with caps to states without meaningful non-economic caps.

##### HHS Conclusion:

States with realistic limits on non-economic damages are faring better than non-cap states

*PRI Comment: What HHS did in this comparison underscores PIAA's criticism of Weiss for using MLM data as it is not weighted by the actual amount of insurance sold (see PIAA summary below.) HHS took the highest premium percentage increases from the previous year for each reported MLM specialty (Internal Medicine, General Surgery, OBGYNs) for each state and compared them. For California, in 2001, the highest premium percentage increases were 20.6% (OBGYN); 20.6% (IM); and 20.6% (GS) for an average of 20 percent. HHS compared this result to states without caps, including Connecticut. HHS reported Connecticut's highest premium percentage increase to be 50 percent in 2001, based on an across-the-board rate submitted by American Health Care (i.e., not broken down by specialty.) In 2001, American Health Care insured 471 CT physicians, compared to CMIC, who insured 3,164. CMIC's average premium percentage increase was 12 percent. ProSelect, who insured 858 physicians that year had an average percentage increase of 7 percent.*

**Joint Economic Committee (JEC), U.S. Congress (May 2003)**

■ **Mix of reforms impact California rates**

JEC Method: Did not present any statistical analysis relative to cap issue, but cited California as the “most successful example of reform at the state level.”

JEC Conclusion: “MICRA contained several provisions including a \$250,000 cap on noneconomic damages, binding arbitration on disputes, collateral sources offsets, limits on contingency fees, advance notice of malpractice claims, statutes of limitations, and periodic payment of damages. Although California still has problems with its malpractice system (including a high claiming rate), it has not experienced the same rate of growth in malpractice premiums. Over the period 1976 –2000, med mal premiums in California increased by 167 percent, while premiums for the rest of the nation rose by 505 percent.”

*PRI Comment: While this study is cited as evidence that caps impact rates, the study does not actually say that. Rather it suggests a combination of reforms in California have impacted rates.*

**General Accounting Office (GAO) June 2003**

■ **Available date inconclusive to assess impact**

GAO Method: Analyzed premium rates in seven states (California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, Texas) (reviewed base rates and percentage changes in three medical specialties (from Medical Liability Monitor (MLM)) and aggregated paid and incurred losses adjusted for inflation)

GAO Conclusions: Lack of comprehensive data on losses at the insurance company level makes measuring precise impact of the measures [to reduce premium costs, including caps] impossible. However, a cap on non-economic damages may decrease insurers’ losses on claims by limiting the overall amount paid out by insurance companies, especially since non-economic damages can be a substantial part of losses on some claims. Notes that in addition to attempting to decrease losses on medical malpractice claims, two GAO sample states have passed laws directly affecting premium rates and insurance regulations. (California and Texas). Among other items, California’s 1988 Proposition 103 required a 20 percent rollback of prices for all property casualty insurers (including med mal insurers) (California Supreme Court permitted companies to decrease prices less than 20 percent upon a showing the rollback would prohibit the company from making reasonable profit.

**Weiss Ratings Inc. (June 3, 2003)**

■ **Caps do not impact rates** (The report criticized widely by the Physician Insurers Association of America-see below)

Weiss Method: Identified 19 states that had implemented caps at various levels from \$250,000 to \$1,000,000. Compared the median payouts for the period between 1991 and 2002 in those 19 states with the same data in the 32 states (includes D.C.) without caps in the same timeframe. (using NPDB data.)

Also compared median med mal premiums paid by doctors in three specialties: internal medicine, general surgery, and ob-gyn for the same period between the two groups of states.

Weiss Conclusions:

*1. Caps do reduce burden on insurers*

*Payouts are reduced:* States without caps, median payout was \$116, 297 (range \$75,00 to \$220,00)

States with caps, median payout was \$98,079 (15.7% lower than cap states (range \$50,000 to \$190,000))

*Growth in payouts slowed substantially.* Median payout in no cap states increased by 127.9% (\$65,831 in 1991 to \$150,000 in 2002). Median payouts in cap states increase by 83.3% (\$60,000 in 1991 to \$110,000 in 2002)

*2. But insurers continue to increase premiums at a rapid pace, regardless of caps.*

States with caps had sharper increases in median annual premiums. Median annual premium increased by 48.2% in the cap states (from \$20,414 to \$30,246)

In no cap states, the median annual premium increased by 35.9% (\$22, 118 to \$30,056)

A smaller proportion of states with caps were able to contain premium increases

Only two cap states experienced flat or declining med mal rates following cap implementation. In comparison, six of the no cap states experienced flat or declining premiums.

*Premiums in states with caps are more likely to exceed national median*

Looking at 2002 premium data, in 47.4% of the cap states, 2002 median premiums were below the national median premium (\$30,093), compared to in 50% of no cap states, where 2002 median premiums were below the national median.

**Physician Insurers Association of America (PIAA) Press Release July 9, 2003**

■ **Caps impact rates** (Purpose of release to dispute Weiss Ratings methods and conclusions (see above description))

PIAA Criticism of Weiss: Weiss's grouping of cap states "lumps" together states with all sorts of variations of caps. Also, as Weiss uses 1991 as its baseline data, it should only use cap states that had caps in place prior to 1991 to compare to the other states.

The way Weiss calculates median premiums is flawed. The method will concentrate on general surgery rates due to search for middle values. Plus rates are not adjusted for discounts and surcharges, they are not weighted by the amount of actual insurance sold, and any policy holder dividends are not reflected in the data.

MLM statement: “We believe it is misleading to use median annual premiums compiled with data from MLM to demonstrate the effect of non-economic damage limits on liability rates.”

Use of NPDB median claim payment value compromised greatly the accuracy of Weiss analysis. It cannot be used to measure the claim payment burden on insurers (what it shows is what a plaintiff may receive). What should be used is the total claims payment reported by a state. NPDB also disputed the Weiss approach.

Runs counter to CBO, JEC, DHHS, etc.

PIAA Methods: Compare the four states with \$250,000 caps prior to 1991 with all the other states, using total premiums earned and total payments reported to NPDB.

PIAA Conclusions: Comparing the four states with \$250,000 caps prior to 1991 with all the other states, using total premiums earned (TPE), (not MLM premium data, as Weiss did), the average percentage change from the total premiums earned in 1991 to 2002 was 28%, compared to 47.7% for the states without \$250,000 caps in place prior to 1991. This indicates that the caps did have lowering impact on premium paid.

Comparing the four states above with all the other states in terms of total payments reported to NPDB, the average percentage change for the four states was 52.8%, compared to 100.1 % for the other states. This indicates the impact of caps shown in the lower rate of increase in payouts over the years.

*PRI Comment: Connecticut is included in the group of states without caps, which had an aggregate total premiums earned percent change of 47.7 percent. However, as Figure D-1 shows, Connecticut’s individual total premiums earned percent increase from 1991 to 2002 was 16.8 percent, lower than the four “model” states’ aggregated TBE percent increase as well as each of those state’s individual TPE percent increase. (Figure D-1 is an excerpt from the PIAA report.)*

*Also the PIAA criticism of the shortcomings of MLM data (i.e., aren’t weighted by actual amount of insurance sold and not reflective of any discounts or dividends given that lower the actual cost to physician) can apply to all users of MLM data, including HHS.*

### **Milliman USA Consultants and Actuaries July 17, 2003**

#### **■ A cap could impact rates, based on assumptions and limitations**

(For Pennsylvania, to estimate effect of \$250,000 cap on noneconomic losses for PA MDs.

Milliman Method: Actuarial model, based on data from NPDB supplemented by publicly available data from Florida and Texas insurance departments, plus results from a 1997 Milliman study on non-economic caps in New York.

Assumptions: Used an inferred verdict value of 1.297 (based on Rand and other Milliman work.) This means Milliman expects for every verdict dollar, a settlement

would \$.30 less. They assume, using the Texas economic/non-economic distribution, that awards are made up a two-thirds non-economic allocation. (In Florida, 75 percent of the paid loss is for non-economic damages, in New York, 70 percent. Milliman also adjusted for post-verdict action, but assumed the capped non-economic damages wouldn't be reduced.

Limitations noted: "...although we base our results on generally accepted actuarial and statistical procedures and our professional judgment, our results also reflect numerous assumptions. Dues to the uncertainty associated with these assumptions and with the prediction of future events, actual results will vary from our projections. ...Further no simple theoretical model can reflect all of the forces underlying a complex insurance process.

Milliman Conclusion: A \$250,000 cap on non-economic damages would reduce loss (indemnity) by about 22 percent, which corresponds to an 18 percent reduction in the combined losses and defense costs for physician policies written in 2004. Milliman thinks this should mean that adequate rates should be 18 percent lower (however, if the rates were inadequate prior to cap application, the "margin of inadequacy should be reduced by 18%, but there wouldn't necessarily be a rate reduction.") This leads to a projected reduction of 11 % for the primary layer in Pennsylvania (which covers the first \$500,000 of liability plus expense costs.)

**Figure D-1. Excerpt from Physician Insurers Association of America (PIAA)  
Report July 9, 2003**

States with Caps of \$250,000 in place prior to 1991

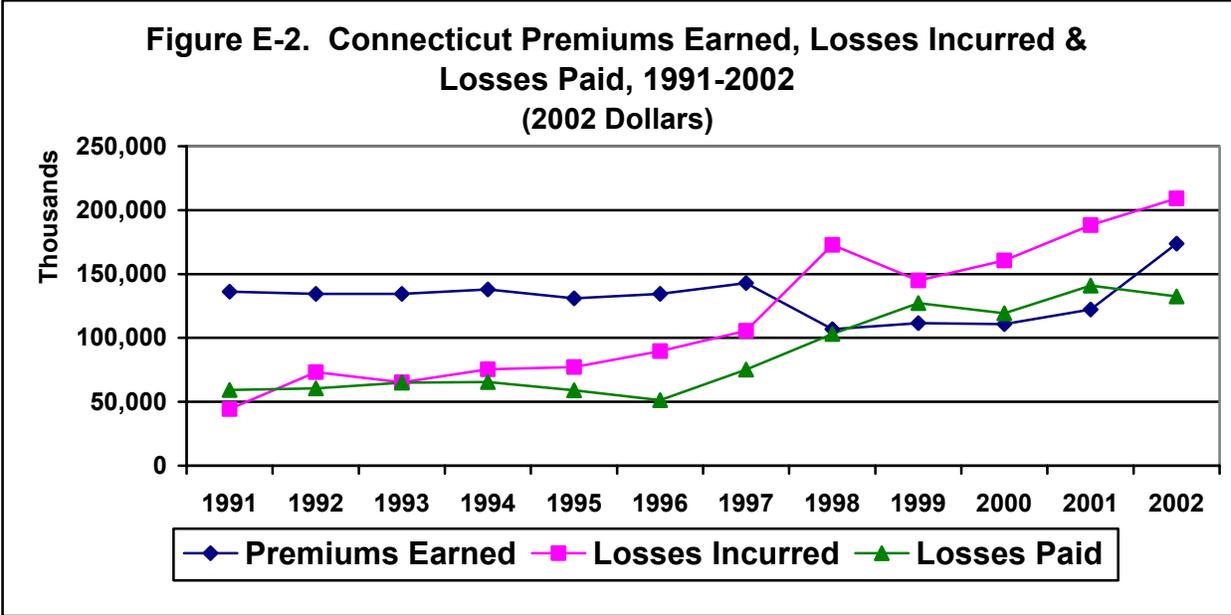
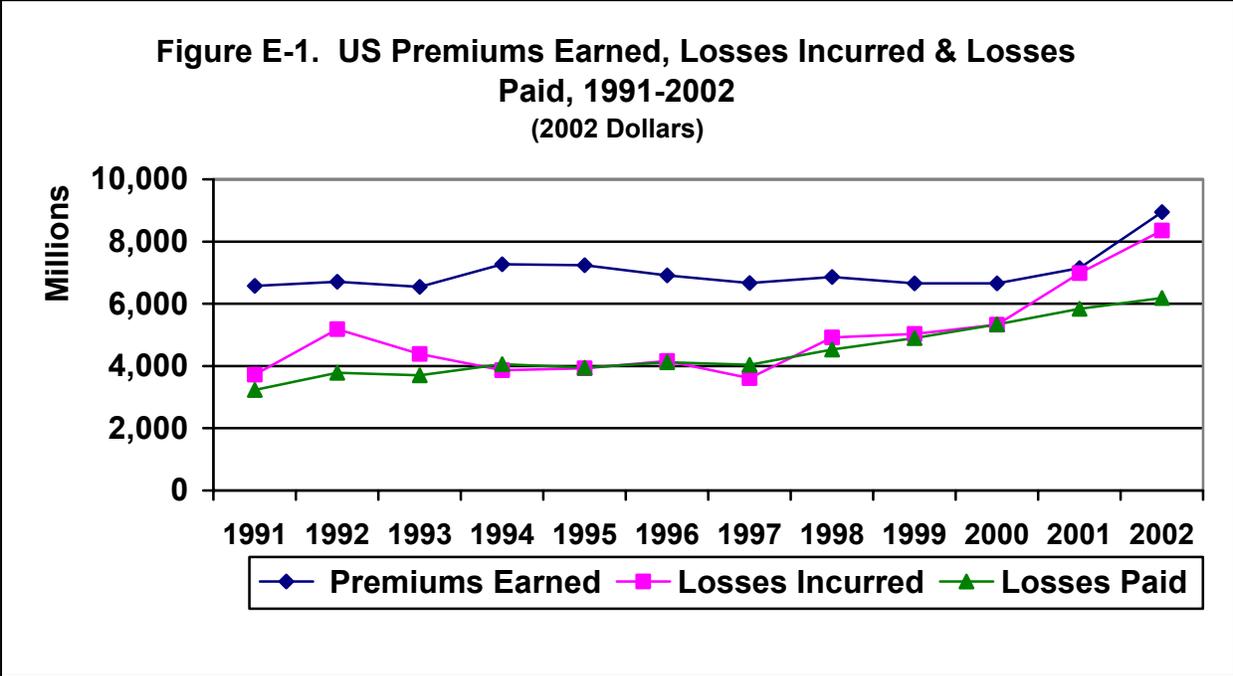
State	91 Total Prem	01 Total Prem	% Change
CA	\$529,056	\$644,598	21.8%
CO	\$65,543	\$97,668	49.0%
IN	\$34,174	\$58,693	71.7%
KS	\$32,544	\$45,804	40.7%
<b>TOTAL</b>	<b>\$661,317</b>	<b>\$846,763</b>	<b>28.0%</b>

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States without Caps of \$250,000 in place prior to 1991

State	91 Total Prem	01 Total Prem	% change
AK	\$13,731	\$13,226	-3.7%
AL	\$84,979	\$123,351	45.2%
AZ	\$107,812	\$135,597	25.8%
AR	\$23,135	\$39,727	71.7%
CT	\$103,224	\$120,543	16.8%
DE	\$20,068	\$17,215	-14.2%
DC	\$37,612	\$30,893	-17.9%
FL	\$241,421	\$604,014	150.2%
GA	\$134,604	\$200,600	49.0%
HI	\$16,066	\$30,092	87.3%
ID	\$14,837	\$21,840	47.2%
IL	\$289,811	\$399,142	37.7%
IA	\$44,120	\$58,831	33.3%
KY	\$58,212	\$81,826	40.6%
LA	\$50,850	\$82,000	61.3%
MD	\$107,893	\$155,433	44.1%
MA	\$31,127	\$182,898	487.6%
MI	\$169,347	\$177,045	4.5%
MO	\$112,915	\$119,300	5.7%
MT	\$16,613	\$17,348	4.4%
ME	\$28,883	\$27,055	-6.3%
MN	\$62,903	\$56,147	-10.7%
MS	\$22,132	\$44,522	101.2%
NE	\$17,972	\$22,359	24.4%
NV	\$25,250	\$57,293	126.9%
NH	\$10,253	\$19,296	88.2%
NJ	\$241,892	\$290,103	19.9%
NM	\$15,161	\$29,940	97.5%
NY	\$699,493	\$888,290	27.0%
NC	\$91,687	\$158,764	73.2%
ND	\$12,764	\$12,887	1.0%
OH	\$246,063	\$300,057	21.9%
OK	\$59,666	\$63,526	6.5%
OR	\$48,144	\$56,534	17.4%
PA	\$228,266	\$335,491	47.0%
RI	\$7,927	\$21,681	173.5%
SC	\$8,542	\$23,587	176.1%
SD	\$9,862	\$10,543	6.9%
TN	\$118,135	\$250,361	111.9%
TX	\$214,757	\$422,003	96.5%
UT	\$24,858	\$37,152	49.5%
VA	\$76,537	\$141,345	84.7%
VT	\$12,593	\$6,891	-45.3%
WA	\$104,323	\$134,009	28.5%
WI	\$74,812	\$64,060	-14.4%
WV	\$34,595	\$76,937	122.4%
WY	\$8,118	\$10,594	30.5%
<b>Total</b>	<b>\$4,170,234</b>	<b>\$6,159,122</b>	<b>47.7%</b>
<b>Total</b>	<b>\$8,340,468</b>	<b>\$12,318,244</b>	<b>47.7%</b>

Total Premiums Earned 1991-2001 PIAA



### Hospital Malpractice Claims Data

No public or private agency collects comprehensive data about medical malpractice claims for Connecticut's 31 acute care hospitals. To access such data for this study, which data are considered confidential and proprietary, the program review committee entered into an agreement with the Connecticut Hospital Association (CHA) in the fall of 2003 to obtain certain hospital malpractice information for the limited use of the committee and on the condition of non-disclosure under applicable state law. Per the agreement, the committee sought medical malpractice data for the period of 1995 through 2002 from each of the hospitals through a survey instrument.

In addition to a cover letter, the survey consisted of five forms requesting different information: 1) a questionnaire seeking a description of each hospital's medical malpractice liability program; 2) a worksheet related to hospital claims and losses; 3) a worksheet related to court/jury awards for each hospital; 4) a worksheet related to case settlements for each hospital; and 5) a worksheet related to earned premium and loss data by specialty. Because of confidentiality concerns, all completed worksheets were returned by the hospitals directly to CHA, which redacted hospital names and then forwarded these redacted worksheets to program review staff (CHA provided nonidentifying "identifier" numbers for each hospital.) The questionnaire containing a descriptive overview of each hospital's malpractice liability program was not redacted.

**Response.** A total of 18 of the 31 hospitals (58 percent) responded to the survey.<sup>52</sup> However, most surveys were incomplete. Consequently, caution must be exercised in interpreting the data. Aggregated data are discussed below; however, because such limited data were submitted, it is questionable if the data are representative of the medical malpractice experience of all of Connecticut's acute care hospitals.

**Data results.** Staff aggregated the survey information to examine trends in hospital medical malpractice payouts. Thirteen different hospitals reported a total of 336 settlements with a total pay out of \$80 million from 1995 through 2002. In recent years, after a decline in 2000, the average settlement has increased from approximately \$247,000 to \$296,000. Only four verdicts were reported in that timeframe ranging from \$4.2 million to over \$20 million.

The minimum and maximum settlement amounts were tabulated by hospital. Two of the 13 hospitals did not provide information on specific settlements but reported total amounts paid out by year and could not be included in this analysis. The minimum and maximum amounts for the remaining 11 hospitals ranged from \$1 to \$8 million. The 11 hospitals reported 298 settlements between 1995 and 2002 – 14 of which were over \$1 million.

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<sup>52</sup> A total of 23 hospitals eventually responded; however, five hospitals submitted data after the committee deadline and after the analysis had begun. Four of these five hospitals provided no or incomplete settlement information.

## AGENCY RESPONSES



# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

June 10, 2004

Carrie Vibert, Director  
Legislative Program Review and Investigations  
State Capitol  
Room 506  
Hartford, CT 06106

Dear Ms. Vibert:

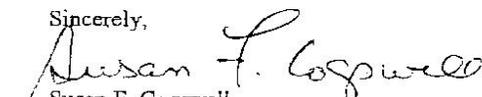
The Connecticut Insurance Department reviewed the draft copy of the Legislative Program Review Investigation Committee's report on *Medical Malpractice Rates* that we received on Monday, June 7, 2004.

As you mentioned in your cover letter, The Department had already reviewed the two staff briefing reports that were combined into this final document. In general, our responses to those documents were incorporated into this report.

The one exception is the Insurance Premium Assistance Fund that is recommended to be established by the Treasurer, but administered by the Insurance Department. The Department would have difficulty in administering this type of fund. It would be problematic in that it would require expertise we do not currently have to certify classes that would be eligible and to determine the amount of the subsidy, among other tasks.

I would like to compliment you and Scott Simoneau for the amount of quality work that went into this detailed report. We enjoyed working with you and look forward to working in conjunction with you on future reports.

Sincerely,

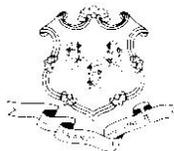
  
Susan F. Cogswell  
Commissioner

Cc: John Purple, Chief Actuary, Department of Insurance

# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

J. Robert Galvin, M.D., M.P.H.  
Commissioner



John G. Rowland  
Governor

June 14, 2004

The Honorable Senator Joseph J. Crisco, Jr., Co-Chair  
The Honorable Representative Mary G. Fritz, Co-Chair  
Legislative Program Review and Investigations Committee  
State Capitol, Room 506  
Hartford, CT 06106

Dear Senator Crisco and Representative Fritz:

Thank you for providing the Department of Public Health (DPH) with the opportunity to comment on the Legislative Program Review and Investigations Committee (LPRIC) findings and recommendations on Medical Malpractice and Insurance Rates. DPH appreciates the effort of Carrie Vibert, Scott Simoneau and other members of your staff in addressing this issue, and the opportunity provided to my staff to comment on the draft report.

The DPH fully embraces the idea of a strong physician disciplinary process, and is working proactively with internal and with external partners on many of the issues identified in these findings. We offer the following for your consideration:

Data collection: Currently, DPH data collection does not substantiate the assertion that many physicians, particularly in high-risk specialties, are curtailing or leaving their practices as a result of the rising cost of medical malpractice insurance premiums. A priority of the agency is the implementation of an on-line license renewal system providing the DPH with the capability of collecting additional data (e.g., identification of physicians actively involved in patient care), as well as monitoring and publishing trends.

Use of consultants: The DPH recognizes the disadvantages of relying on volunteer consultants to review cases and make recommendations concerning breaches in standards of care, and obligates current agency funds to support four part-time physician consultants. To supplement these resources, it is recommended that the license renewal fee be waived for physicians who provide consultative services to the DPH.

Disciplinary screening and investigation process: The DPH utilizes its expertise as it considers many factors in determining which complaints to investigate, including standards of practice and federal and state laws. While the Department agrees that its policies and practices for processing complaints should be reduced to writing, it does not believe that it is necessary or even advisable to write such policies and procedures into regulations. It is recommended that a percentage of dismissed cases be reviewed by a quality assurance panel comprised of DPH staff and Connecticut Medical Examining Board members.

Disciplinary guidelines: The Department agrees that the creation of such guidelines would be helpful to the Board as well as to the Department in its efforts to settle cases, since such guidelines would provide consistency and predictability. Written guidelines, not regulations, would be advisable and the responsibility for creating such guidelines should rest equally on the Connecticut Medical Examining Board and the Department.



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*Affirmative Action/Equal Employment Opportunity Employer*

June 14, 2004  
LPRIC  
Page 2 of 2

Communication with petitioners and licensees: The DPH is committed to communicating with petitioners throughout the investigation process to ensure consistency and clarity, as allowed by statutory provisions. For cases that are dismissed, current statutory provisions prohibit the agency from releasing information about the investigation (e.g., a consultant's report and findings) to the petitioner. Statutory changes would be necessary to provide petitioners with access to additional information during the investigative process.

Medical malpractice payment notifications: Statutory changes are necessary to require the Judicial Branch to provide notification to the DPH of all medical malpractice lawsuits filed with the courts.

Physicians with multiple licensure actions and/or multiple medical malpractice payments: The Department recommends that the physician profile statutes be revised to require physicians to report any changes or updates for all of the mandated reporting information, and that adverse licensure actions taken in other states be added to the list of mandated reporting items. Because legislation is required to implement changes in the physician profile reporting system, the DPH is not able to meet the recommended completion date of December 31, 2004.

Continued competence: The Department has been supportive of establishing mandatory continuing education requirements for physicians focusing on areas such as AIDS/HIV, domestic violence and sexual assault, and is prepared to implement upon passage of enabling legislation. The DPH is opposed to establishing a requirement for a re-licensing examination for all physicians. For physicians warranting further evaluation, the Federation of State Medical Boards administers the Special Purpose Examination (SPEX).

Thank you for providing the Department with the opportunity to comment on the LPRIC's final report. As noted above, the agency continues to move forward in the revision and revitalization of the physician disciplinary process. Please do not hesitate to contact me if you have any questions concerning our comments.

Sincerely,



J. Robert Galvin, M.D., M.P.H.  
Commissioner

JRG/wjj