

DIGEST

MEDICAL MALPRACTICE INSURANCE RATES

The Legislative Program Review and Investigations Committee undertook this study in February 2003 to assess the circumstances underlying the costs of medical malpractice insurance and analyze 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.

I. Overview of Market

- 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 practice; and 2) to provide compensation for individuals who suffer harm from negligent doctors.
- An estimated 7,000 active patient care physicians in Connecticut are required to be insured for malpractice, along with six other types of health care practitioners. Hospitals and other health care institutions are also exposed to malpractice risks.
- Most malpractice insurance policies cover claims made during the policy year, and a typical individual coverage limit is \$1 million per incident with an annual aggregate limit of \$4 million.
- The medical malpractice market is cyclical in terms of premiums charged, profits, and insurance availability, where a “soft” market is characterized by stable or declining prices, and a “hard” market has significant price increases and availability problems.
- The medical malpractice market consists of the traditional market, which comprises commercial and mutual insurers, and the alternative market, which is made up of a number of different financing arrangements that allow related organizations to come together to insure themselves.
- The top five medical malpractice insurers in Connecticut over the last decade have written between 71 and 93 percent of the total premium, and the top two have consistently written over 50 percent of total premium.
- As of September 2003, there were five companies actively writing individual medical malpractice policies in Connecticut according to the Insurance Department.
- Four significant new medical malpractice carriers have entered the Connecticut market over the last decade, and of the four, two remain.
- Two established medical malpractice carriers have either left the market or no longer write individual policies on a nationwide basis, including Connecticut.
- The alternative market for managing medical malpractice exposure has reportedly grown. Only six of the 31 acute care hospitals in Connecticut maintain commercial insurance as their primary means of handling malpractice risk.

II. Medical Malpractice Claims

- Medical malpractice is a tort (a civil wrong) and occurs when a doctor fails to exercise the same degree of skill and care--the standard of care --that doctors in the same specialty ordinarily exercise in like cases, with resulting harm.
- 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.
- Connecticut has in place many tort reform provisions intended to reduce the financial impact of personal injury suits but their utilization is varied.
- Common law and statutes allow for economic and noneconomic damages to compensate for losses.
- Most medical malpractice claims are resolved through the civil lawsuit process, which includes a formal filing of a complaint and answer by the parties, a discovery phase for information gathering, and opportunities for settlement between parties throughout the process.

Findings and Recommendations (recommendations bolded)

- Damage caps with varying characteristics are in place in 25 states. When caps were adopted also varies. The earliest was in 1975, several were enacted in the mid-1980s, and a few states just enacted the provisions.
- Logically, placing a limit on the amount of recovery should lower rates, all other factors staying the same. Prospectively determining cap impact on rates and the amount of that impact, though, is a complicated exercise.
- Forty-three Connecticut plaintiff awards in medical malpractice cases totaled \$54.5 million dollars in the aggregate, made up of \$9.5 million in economic damages (21 percent) and \$45 million in non-economic (79 percent).
- The average total award amount was \$1,266,348, with the average economic damage amount \$220,927 and the average non-economic damage amount, \$1,045,420. 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 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.
- Thirteen of the 43 verdicts also had interest added to them under the offer of judgment (OOJ) statute.

- 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.
- However, that potential benefit disrupts integral components of our current civil litigation system, that is, 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. 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.
- 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.

Premium Assistance Fund

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**
- **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 Interest

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 2 percent on January 1 of each year.

Certificate of Good Faith

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

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 Fees

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

Alternative Mechanism

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. 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.

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.

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.

III. Insurance Pricing

- There are four major determinants of insurance pricing: expected losses, expenses, profit and contingencies, and investment income.
- In general, losses, expenses, and profits and contingencies are added together, while investment income is subtracted to get a projected price.
- Individual premium rates for medical malpractice insurance will vary according to the claims costs by medical specialty.
- The cost to pay for losses is the largest component of the premium.

IV. Insurance Department Oversight

- Insurance companies selling medical malpractice insurance are regulated by the Insurance Department as a property/casualty type 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.

- Connecticut uses the “file and use” method of rate review, which does not require prior approval of rates.
- State statutes prohibit excessive, inadequate, or unfairly discriminatory rates. The Connecticut Insurance Department reports no medical malpractice insurance rates have in memory been found excessive, inadequate, or discriminatory.

Findings and Recommendations (recommendations bolded)

- The insurance commissioner and other members of the department who review rate filings have stated the medical malpractice insurance market in Connecticut is not competitive.
- A non-competitive market does not serve the interests of consumers, especially those like physicians who are required to purchase medical malpractice insurance.
- Other states have stronger regulatory frameworks for setting medical malpractice rates than Connecticut.
- No medical malpractice rate filing in Connecticut, in recent memory, has been found to be excessive or inadequate.
- 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.
- The insurance department does not maintain adequate information to gauge market competition.
- The insurance department does not have a clear and complete picture of the premiums charged in the medical malpractice area.
- The medical malpractice insurance market is changing and the insurance department has limited or no regulatory oversight over some of these newer risk mechanisms.

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; 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 on 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.

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.

V. Physician Oversight

Findings and Recommendations (recommendations bolded)

- 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.
- There are no formal disciplinary guidelines to assist the department in its negotiations with a licensee or the Board of Medical Examiners 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. That time period is on average at least five years from the date of the incident, and in many cases even longer.
- Committee staff were 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 National Practitioner Data Bank (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.
- Department disciplinary and medical malpractice payment data are not crosschecked with the NPDB for consistency or completeness.
- 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.
- 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.

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 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, 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.

VI. Data Analysis

- 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 have increased more than the national experience. Nationally, over the last 12 years, incurred losses increased on an inflation-adjusted basis 97 percent, but the increase was over 340 percent in Connecticut.
- 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.