Medical Malpractice Liability Insurance In Vermont

A Report to the General Assembly

By

The Vermont Medical Malpractice Study Committee

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Vermont Medical Malpractice Study Committee Members

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EXECUTIVE SUMMARY

I. Introduction

In response to recent increases in the cost of medical malpractice insurance in Vermont and nationally, the Vermont Legislature, pursuant to Act 122, Sec. 292, of the 2004 session, created a committee to study medical malpractice insurance issues. Further, in Section 128(b) of the same Act, the General Assembly recognized that increasing malpractice insurance premium costs are jeopardizing access to physician services for Medicaid beneficiaries and provided a modest one-time increase in physician payments to help offset the high cost of medical malpractice insurance.

As directed by the Legislature, the seven member committee was chaired by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISCHA), and included a representative of the Vermont Association of Hospitals and Health Systems, a representative of the Vermont Medical Society, a representative of the Vermont Bar Association, a representative of the Vermont Trial Lawyers Association, the Vermont Health Care Ombudsman, and a representative of the American Insurance Association.

In 2004, American Medical Association data indicated Vermont had 1,590 direct-patient-care physicians. In 2004, Vermont medical malpractice liability insurance written premium, including self-insured and captive entities participating in the Committee's study, totaled $25.6 million ($15.6 million for the traditional companies and $10 million for the self-insured and captive entities participating in the study). The cost of medical malpractice insurance in Vermont and for health care providers around the country has escalated significantly in the past few years. In Vermont, from 2002 to date, rate increases have been approved that have exceeded 50 and 80 percent, respectively, for the two largest medical malpractice carriers doing business in the state. During this same period, physicians in some medical specialties have experienced premium increases exceeding 100 percent. However, it is important to point out that, in at least the six years preceding 2002, these same two companies and most other medical malpractice carriers did not increase rates in Vermont. As a matter of fact, during the late 1990s many companies were discounting off of approved rates and some companies were actually reducing their filed rates.

The phenomenon of long periods without rate increases followed by periods of steep increases is characteristic of the property and casualty market and is known as the "soft and hard market cycle." For the last three to four years, the medical malpractice line of insurance has experienced a hard market. The current hard market, the third the industry has experienced in the last 30 years, follows a soft market that lasted for more than ten years.

Despite the recent rate increases, Vermont's medical malpractice insurance rates remain among the lowest in New England on both an absolute

basis and as a percentage of physicians' wages. On an absolute basis Vermont's rates are also among the lowest in the country. Several factors impact rates, one of the most important of which is accident severity (i.e., average cost-per-claim). Based on the closed claims study conducted by the Committee and on available national data, Vermont's medical malpractice severity has not exhibited the upward trend seen in the rest of the country. This fact accounts for why Vermont's rates are among the lowest in New England and the country as a whole.

During the current hard market, the primary focus of concern has been on rising premium rates rather than the availability of insurance coverage. However, Vermont's medical malpractice insurance market is basically concentrated, with a small number of sellers comprising the market. Two physician-owned-and-operated mutual insurers, Medical Mutual Insurance Company of Maine and Pro-Select, held 63 percent of the market in 2003. This market concentration, while improved from historical levels in Vermont and less pronounced than in other states, does represent a potential weakness.

Another market issue is the overall level of profitability of the medical malpractice carriers in Vermont and on a national level. Following strong earnings for Vermont medical malpractice carriers during the 1990s, profitability declined significantly in 2001 and 2002. According to A.M. Best, the industry had adjusted loss ratios of 134 percent and 108 percent for 2001 and 2002, respectively, meaning that the companies doing business in Vermont had $1.34 and $1.08 in paid and incurred losses and related expenses for each dollar of premium generated for the subject periods. Additionally, the largest medical malpractice carrier in the state has recently been downgraded by a major rating agency as a result of substandard operating results through 2004.

The losses experienced for the Vermont market on the whole in 2001 and 2002 led to rate increases in the period 2002 through 2005. As a result of the recent rate increases, the loss ratios of the medical malpractice carriers doing business in Vermont have improved. To avoid repeating the disruptive effect that the insolvency of PHICO had on the Vermont medical community in 2002, it is important that companies operate with adequate rates.

Anecdotal information provided by the Vermont Medical Society (VMS) indicates that physicians have left Vermont, stopped performing high risk procedures, order more tests, make additional referrals or have retired from practice because of high medical malpractice premiums and the fear of being sued. VMS members also cited the difficulty of retaining and recruiting physicians due to the state's decreased reimbursement rates and increasing medical malpractice premiums. However, certain portions of the state have historically had a hard time recruiting physicians regardless of income or medical malpractice premiums. The data gathered by Milliman Consulting from the American Medical Association indicates that the number of practitioners has

remained stable in both rural and urban areas of the state. Notwithstanding the anecdotal information provided by the Vermont Medical Society, the empirical evidence reviewed by the Committee does not show any reduction in the number of practicing physicians in any particular county or physician specialty.

A study of ten years of closed claims data for the insurance companies and large self-insured hospitals doing business in Vermont does not demonstrate any discernible trend in either claim frequency (the number of claims) or claim severity. Vermont's data in respect to severity differs from national statistics, which show that severity has been increasing nationwide over the past ten years. On the other hand, Vermont's claim frequency statistics mirror the national data, which show that the number of claims has been flat countrywide in recent years.

Effective July 1, 2005, BISHCA approved an average 19.7 percent medical liability insurance premium increase requested by Medical Mutual Insurance Company of Maine, the largest medical malpractice carrier in Vermont. As approved by BISHCA, the premiums for some specialties will increase by 69.3 percent. In justifying the need for the premium increase, Medical Mutual indicated, "we continue to see increased severity on malpractice claims." In 2005, BISHCA also approved average rate increases of 7.2 percent for Pro-Select, the second largest medical malpractice carrier in Vermont, and 15 percent for Continental-CNA, the third largest carrier in the state.

If Vermont's medical malpractice claims severity and frequency do not demonstrate any discernible upward trends; one then needs to ask what has driven the rate increases that the state's health providers have experienced in the recent past.

There are a number of factors that impact the cost of medical malpractice insurance, the primary variable being the cost of claims and related expenses. Other influencing factors are investment income, company overhead and the cost of items such as reinsurance. It is the cost of claims, however, that primarily drives medical malpractice insurance rates. This conclusion is supported by the loss ratios shown in the A.M. Best data for Vermont carriers, the operating experience of the state's largest medical malpractice carrier, and generally, the June 2003 United States General Accounting Office medical malpractice study.

The most likely explanation for the recent rate increases in Vermont is the need on the part of the carriers doing business in the state to adjust for under-pricing that occurred during the protracted soft market that lasted throughout the 1990s, a soft market dominated by market share leader PHICO. Based on Insurance Division records going back to 1994, the only rate filing made by PHICO was a 2.2 percent decrease in 1997. The activities of PHICO that ultimately led to its insolvency had a strong influence on the rate setting practices of other carriers and market competition generally.

Another factor affecting rates is the impact of declining investment income. Following many years of high interest rates, rates began to decline in the mid-to-late 1990s. Insurance companies generally invest about 80 percent of their assets in bonds. Thus this long period of declining interest rates has also resulted in the need for companies to adjust premiums to compensate for lower investment income. According to the General Accounting Office, the typical medical malpractice insurer maintains investment assets of 4.5 times the amount of premium earned. Thus, a 1 percent decline in investment income equates to about a 4.5 percent decrease in premium income.

In an attempt to hold down rising premium rates, many states have considered various insurance and tort reform mechanisms. The technique most frequently cited is the imposition of limitations, or caps, on the amount of money that can be awarded in a medical malpractice lawsuit. While the majority of studies have concluded that caps are effective at reducing the size of jury awards and settlements, there is some disagreement about whether these savings have always been translated into premium reductions.

Because malpractice awards are lower in Vermont than in other parts of the country, the Committee's actuarial consultant concluded that a cap of $250,000 on non-economic damages would result in a premium reduction of 5.7 percent, an amount more modest than the 25 to 30 percent countrywide reduction estimated by the Congressional Budget Office as resulting from proposed federal tort reform. This more modest impact was supported by the presidents of Vermont's major malpractice writers, who testified that caps would not have an impact on rates in the short-term, but would represent a positive element of a long-term comprehensive tort reform strategy.

Although the Committee conducted a comprehensive review of other tort reforms that have been enacted around the country, there is little quantitative data available concerning the impact of most reforms on malpractice rates. An exception is limiting the legal fees that plaintiffs' attorneys can charge in malpractice cases, a measure that has produced significant cost savings for insurers in California. However, the study finding the California cost savings did not analyze premium reduction; it is unclear whether such cost savings would translate into a reduction in malpractice premiums. Generally speaking, states that have statutory changes to address malpractice costs have enacted a comprehensive package of tort reform measures rather than a single provision such as caps alone.

The "Sorry Works!" program initially instituted at the Veterans Affairs Medical Center in Lexington, Kentucky has gained interest around the country on the part of all stakeholders dealing with medical malpractice litigation matters. The program has three primary components—timely expression of apology, full disclosure, and fair compensation. Other states have implemented apology immunity laws, precluding the admission of a health care provider's apology into

evidence to prove negligence or as an admission of liability. Currently 19 states have enacted some form of the "I'm Sorry" concept, most of this occurring in the past couple of years. While some individual programs have reported savings, broader studies have indicated that it is too early to ascertain the full savings potential of the concept.

II. Areas of Agreement

A. Positions Endorsed by More Than a One-Vote Margin

The following are positions endorsed by the Committee by majority votes of more than a one-vote margin:

Factors other than medical malpractice actions have had an effect on insurance costs for health care providers nationally and in Vermont.

Efforts should be undertaken to reduce the incidents of medical malpractice through the underwriting process.

The Legislature should require public involvement in rate proceedings.

The Legislature should take steps to improve self-insurance opportunities.

The Legislature should implement an enterprise liability system for medical malpractice awards.

The Legislature should not create a fixed compensation system for medical malpractice cases based on pre-set payment amounts.

The Legislature should not require insurers to base their rates on claims experience in Vermont.

A Vermont health care facility which obtains medical malpractice insurance from a captive insurance company should not be required to do so with a Vermont-based captive insurer.

The Legislature should not require improved Experience Rating.

The Legislature should not require compressed rate classifications.

The Legislature should not implement a State Reinsurance Pool for medical malpractice insurers.

The Legislature should not Require Periodic Payments of awards.

The Legislature should not place additional mediation requirements on malpractice claims.

B. Positions Endorsed by a One-Vote Margin

The following are positions endorsed by the Committee by a one-vote margin:

Jury verdicts and settlements in Vermont have had an effect on insurance costs for Vermont health care providers.

Jury verdicts and settlements in other states have had an effect on insurance costs in those states, nationally, and in Vermont.

Caps on damages in medical malpractice actions would affect insurance costs for Vermont health care providers.

Caps on damages in other states have affected insurance costs for health care providers in those states.

The Legislature should require disclosure of investment and dividend income to policyholders.

The Legislature should take action in the area of medical malpractice actions.

The Legislature should eliminate joint and several liability.

The Legislature should place limits on contingency fees.

The Legislature should implement statute of limitations changes.

The Legislature should establish pre-trial screening panels.

The Legislature should require arbitration of medical malpractice actions.

It is not the case that insurance costs for Vermont health care providers are rising while the payments insurers make for medical malpractice claims are decreasing.

The state should not provide assistance to health care providers who have particularly high insurance costs.

III. Questions and Committee Votes

- Have jury verdicts and settlements in Vermont had an effect on insurance costs for Vermont health care providers?

  Committee Vote: YES 4, NO 3

- Have jury verdicts and settlements in other states had an effect on insurance costs in those states, nationally or in Vermont?

  Committee Vote: YES 4, NO 3

- If medical malpractice lawsuits have affected insurance costs for Vermont health care providers, can statutory changes reduce those costs?

  Committee Vote: YES 4, NO 3

- Are insurance costs for Vermont health care providers rising while the payments insurers make for medical malpractice claims are decreasing?

  Committee Vote: YES 3, NO 4

- Have factors other than medical malpractice actions had an effect on insurance costs for heath care providers nationally and in Vermont?

  Committee Vote: YES 7, NO 0

- Would caps on damages in medical malpractice actions affect insurance costs for Vermont health care providers?

  Committee Vote: YES 4, NO 3

- Have caps in other states affected insurance costs for health care providers in those states?

  Committee Vote: YES 4, NO 3

- Should the state provide some assistance to health care providers who have particularly high insurance costs?

  Committee Vote: YES 2, NO 3, ABSTAIN 2

- Should the Legislature create a fixed compensation system for medical malpractice cases based on pre-set payment amounts?

  Committee Vote: YES 1, NO 6

- Should the Legislature require insurers to base their rates on claims experience in Vermont?

  Committee Vote: YES 2 (if actuarially sound), NO 5

- Should a Vermont health care facility which obtains medical malpractice insurance from a captive insurance company be required to do so with a Vermont-based captive insurer?

  Committee Vote: YES 0, NO 7

- Should efforts be undertaken to reduce the incidents of medical malpractice through the underwriting process?

  Committee Vote: YES 5, NO 2

- Should the Legislature require improved experience rating?

  Committee Vote: YES 2, NO 5

- Should the Legislature require public involvement in rate proceedings?

  Committee Vote: YES 6, NO 1

- Should the Legislature require compressed rate classifications?

  Committee Vote: YES 0, NO 7

- Should the Legislature implement a state reinsurance pool for medical malpractice insurers?

  Committee Vote: YES 2, NO 5

- Should the Legislature take steps to improve self-insurance opportunities?

  Committee Vote: YES 6, NO 0, ABSTAIN 1

- Should the Legislature require disclosure of investment and dividend income to policyholders?

  Committee Vote: YES 4, NO 3

- Should the Legislature take action in the area of medical malpractice actions?

  Committee Vote: YES 4, NO 3

- Should the Legislature abolish the collateral source rule?

  Committee Vote: YES 3, NO 3, ABSTAIN 1

- Should the Legislature establish more specific expert witness rules?

  Committee Vote: YES 3, NO 3, ABSTAIN 1

- Should the Legislature eliminate joint and several liability?

  Committee Vote: YES 4, NO 3

- Should the Legislature place limits on contingency fees?

  Committee Vote: YES 4, NO 3

- Should the Legislature require periodic payments of awards?

  Committee Vote: YES 1, NO 6

- Should the Legislature implement statute of limitations changes?

  Committee Vote: YES 4, NO 3

- Should the Legislature establish pre-trial screening panels?

  Committee Vote: YES 4, NO 3

- Should the Legislature require arbitration of medical malpractice actions?

  Committee Vote: YES 4, NO 3

- Should the Legislature place additional mediation requirements on medical malpractice claims?

  Committee Vote: YES 2, NO 5

- Should the Legislature implement an enterprise liability system for medical malpractice awards?

  Committee Vote: YES 4, NO 2, ABSTAIN 1

- Should the Legislature mandate that accepted medical guidelines be available as an affirmative defense in medical malpractice cases?

  Committee Vote: YES 3, NO 3, ABSTAIN 1

BACKGROUND

I. Enabling Legislation/History of Report

In response to recent increases in the cost of medical malpractice insurance in Vermont and nationally, the Vermont Legislature, pursuant to Omnibus Act 122, Sec. 292 of H. 768, FY 2005 Appropriations Act (the Act), created a committee (the Committee) to study medical malpractice insurance issues. The Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) was charged by the Legislature with chairing the Committee and providing professional and administrative support to the Committee as it considered the issues identified for study under the Act.

The Act directed the Committee to report its findings and recommendations (including proposals for legislative actions) on a wide-ranging selection of issues relating to medical malpractice insurance in Vermont. A copy of the enabling statute is attached as *Exhibit 1*. The various topics of consideration are discussed later in the order in which they were presented in the Act.

II. The Medical Malpractice Insurance Study Committee

As directed by the Legislature, the Committee was chaired by BISCHA, and included a representative of the Vermont Association of Hospitals and Health Systems, a representative of the Vermont Medical Society, a representative of the Vermont Bar Association, a representative of the Vermont Trial Lawyers Association, the Vermont Health Care Ombudsman, and a representative of the American Insurance Association. The Committee was given a year and a half to study the numerous issues in the Act. The Committee met 15 times from August 24, 2004 to October 26, 2005. These meetings included presentations and testimony on each issue. In addition, other documents such as relevant articles and reports were provided to the Committee for their review. The slide presentations and other meeting materials are attached hereto as exhibits.

The Committee consisted of the following members:

- **Deputy Commissioner of BISHCA (Committee Chair)**—J. Peter Yankowski
- **Vermont Medical Society**—Paul Harrington, Executive Vice President
- **Vermont Association of Hospitals and Health Systems**—Marie Beatrice Grause, President & CEO
- **Vermont Trial Lawyers Association**—Thomas J. Sherrer, Esq.
- **Vermont Bar Association**—John Evers, Esq.

- **Vermont Health Care Ombudsman**—Donna Sutton Fay, Esq.
- **American Insurance Association**—Laura L. Kersey, Assistant Vice President, State Affairs

In conjunction with this study and as directed by the Act, the Committee engaged an independent third-party consultant, Milliman, Inc., to assist in the collection and analysis of relevant data and the drafting of this report. With Committee direction, Milliman devised and sent a data call to the major medical malpractice insurance companies in Vermont and to the Vermont Association of Hospitals and Health Systems, which coordinated the collection of data from Vermont hospitals (Milliman Vermont Data Call).

The Milliman Vermont Data Call was designed to obtain detailed information on market and claims trends, claim history, underwriting practices, and market intent. The surveyed insurance companies represented between 80percent and 90percent of the current Vermont medical malpractice voluntary insurance market (as measured by written premium). In addition, two major Vermont hospitals responded to the survey. A copy of the survey is attached as *Addendum 2*. As required by the Act, information gathered from this survey was confidential and results were presented to the Committee only in summary statistical form that did not identify individual providers, health care facilities, or patients.

III. Overview of Medical Malpractice Insurance Market

A. Medical Malpractice Liability Tort System

In Vermont and nationally, medical malpractice lawsuits are generally based on principles of tort law, as defined by statute and case law. A tort is a wrongful act or omission by an individual that causes harm to another individual. Typically, a malpractice tort is premised on the claim that the health care provider has been negligent by failing to meet the acceptable standard of care owed to the patient, and as a result of that negligence, the patient has been harmed.[1]

When a doctor has negligently harmed a patient, the patient may not discover the negligence or the injury for some time. Although the statute of limitations limits the period in which a claimant can sue, medical malpractice claims may take a period of time to manifest. Further, once claims have been brought, they typically take a long time to resolve due to the complex nature of medical issues. Based on the Milliman data call, the average amount time from the date a claim is reported to the date the claim is settled in Vermont is about two years.

Damages available in typical medical malpractice cases may be classified as economic and non-economic. Economic damages compensate a plaintiff for economic losses such as lost wages and medical expenses. Non-economic

damages are intended to compensate a claimant for pain, suffering, loss of consortium and other non-pecuniary losses. In certain situations, punitive damages may also be available.

In Vermont, by statute, a medical malpractice plaintiff must establish three things to be entitled to damages: 1) the degree of skill ordinarily exercised by a reasonably skillful, careful and prudent health care provider engaged in a similar practice under the same or similar circumstances whether or not within the state of Vermont; 2) that the defendant lacked this degree of skill or failed to exercise the degree of care; and 3) that as a proximate result of this lack of skill or care the plaintiff suffered injuries that would not have otherwise occurred. 12 V.S.A. § 1908. Medical malpractice liability may also be imposed for unreasonably failing to obtain informed consent. 12 V.S.A. § 1909.

Medical malpractice actions typically rest on complex medical issues involving the appropriate standard of care, whether the standard of care was followed and whether the plaintiff's injuries were a result of the care. Because of this complexity, malpractice actions tend to involve the extensive use of doctors and other health care providers as expert witnesses. The use of such experts can be very expensive for both parties and can slow down the resolution of a case due to extensive discovery and scheduling challenges.

B. Medical Malpractice Liability Insurance Market Overview

1. Overview of Medical Malpractice Insurance

Most physicians and health care facilities purchase malpractice liability insurance to protect their financial situation by maintaining financial stability. Health care providers typically purchase insurance from the traditional market (private carriers) or choose alternative risk management mechanisms, such as self-insurance or coverage through a captive insurance company.

Medical malpractice liability coverage is provided by:

- Traditional multi-line insurance companies (insurance companies that write multiple lines of insurance, not just medical malpractice liability insurance),

- Mono-line medical malpractice insurance companies, also called specialty writers (insurers that write only medical malpractice insurance and are often owned by their physician policyholders); and

- Alternative market mechanisms, such as captive insurance companies and self-insureds.

Many captives are owned and controlled by their policyholders. A more detailed discussion of captives is contained in the discussion of Issue 9, below. In Vermont, most of the major hospitals and hospital alliances utilize alternative market mechanisms to provide liability coverage for their physicians.

Insurance sold in the traditional market (and for some captives) may be provided either on an "occurrence" or "claims-made" policy basis. An occurrence policy provides insurance coverage to the policyholder for allegedly negligent acts that occurred during the policy year, even if a claim is not made until after the policy year has ended. A claims-made policy provides insurance coverage to the policyholder for claims that are reported during the policy year and that occurred after the policy's "retroactive date." The retroactive date, set by the insurance carrier, is the date before which the carrier does not assume liability. In other words, a claim that is reported during the policy year and that occurred after the retroactive date is covered by the policy, but a claim that is reported during the policy period, but occurred prior to the retroactive date is not covered by the policy. Typically, an insured that renews coverage each year with the same carrier will keep the same "retroactive date," such that the risk assumed by the insurer grows.

An extended reporting period policy or "tail coverage" policy allows a policyholder to obtain coverage for claims reported after the expiration of a claims-made policy. This type of policy also often has an associated retroactive date. Tail coverage is often purchased when a doctor changes carriers or retires.

On a countrywide basis, 76% of the premium spent on malpractice liability insurance in 2003 was used to purchase claims-made coverage while 24% was used to purchase occurrence-based coverage.[2] The results of the Milliman Vermont Data Call indicate that, in Vermont, over 95% of 2004 physicians and surgeons premium was provided on a claims-made basis.

Medical malpractice insurance policies are offered with policy limits that identify the maximum loss amount that will be paid by the insurance provider. In general, defense costs are not limited by policy limits; defense costs are typically provided on an unlimited basis to the policyholder for all covered claims.

Overall, medical malpractice liability costs for both traditional and alternative markets represent approximately 2.5% of the total property and casualty premium written in the United States.[3] Medical malpractice costs represent approximately 1.7% of the total health care costs of the United States and less than one per cent of total health care costs in Vermont.[4]

2. Overview of the Ratemaking Process

Ratemaking is a process by which an insurance company sets the premium it will charge customers for the insurance being sold. Rates are reviewed and updated periodically, in order to maintain competitiveness and ensure solvency.

In general, the premiums an insurer collects plus its investment income must be sufficient to offset its losses and expenses. A common benchmark statistic is the "combined ratio." The combined ratio measures the amount that an insurer must pay to cover claims and expenses per dollar of earned premium. For example, a 150% combined ratio means that an insurer has $150 in paid and incurred losses and expenses for every $100 of premium collected.

Insurance companies determine their rates on a state-by-state basis. In general, insurers base their rates on a review of their own historical premiums, losses, and expenses in a particular state. However, for many insurance companies, especially those with a small market share, company experience data for an individual state is not completely statistically credible. In these instances insurers must supplement rate-making calculations with data from other states or sources of data. For example, insurance companies may consider their competitors' rates, their own rates in another state or their present rates adjusted for inflation. At the present time, all carriers in Vermont use other data besides Vermont experience because of the lack of full credibility of their own Vermont experience data. The use of complementary experience data to supplement experience that lacks full credibility is an actuarially sound practice employed by insurance companies throughout the country.

A detailed example of the ratemaking process may be found in *Exhibit 30*.

3. Market Dynamics Countrywide

Over the past 10 years national and Vermont trends may be characterized as follows:

a. Unprofitable Financial Results: The countrywide combined ratio for medical malpractice insurers (a common profitability measure) grew steadily from around 100% during the mid 1990s up to 150% in 2001. A 150% combined ratio means that insurers had $150 in paid and incurred losses and expenses for every $100 of premium collected. More recently, the countrywide combined ratio has declined from its 2001 peak down to 128% in 2004.[5]

b. Withdrawal of Major Insurers: St. Paul, previously one of the largest medical malpractice insurers in the United States, stopped writing medical malpractice insurance in 2001. Other carriers, most notably PHICO, have withdrawn from the market due to insolvency. Additionally, some carriers have

reduced their writings by becoming more stringent in assuming risks. Although the Vermont market was heavily impacted by both the St. Paul withdrawal and the PHICO insolvency, other carriers moved in to fill the gaps and availability of coverage does not appear to be a problem thus far.

c. Large Rate Increases Implemented by Remaining Carriers: In response to deteriorating financial results, the remaining insurance companies increased rates significantly over the past few years. From 2000 to 2003, countrywide medical malpractice aggregate premiums have grown by over 75%.[6] Vermont health care providers have seen their premium rates increase in the last four years by between 33% and 93.5%.[7]

d. Concerned Physicians and Patients: There are anecdotal reports that in some parts of the country increased premiums or lack of coverage are leading doctors to retire, re-locate, or stop performing certain high risk procedures. Milliman was unable to find any empirical data indicating that this is a problem in Vermont. Anecdotal information provided by the Vermont Medical Society indicates that physicians have left Vermont, stopped performing high risk procedures, order more tests, make additional referrals or have retired from practice because of high medical malpractice premiums and the fear of being sued. VMS members also cited the difficulty of retaining and recruiting physicians due to the state's decreased reimbursement rates and increasing medical malpractice premiums.

e. Reform: State legislatures have been considering and implementing legislative responses such as tort reform and/or alternative market mechanisms. The Bush Administration is supporting national tort reform legislation that would limit non-economic damage awards to $250,000, limit punitive damage awards, require advance notice of claims, and dictate legal contingency fee schedules.

4. Specific Market Dynamics in Vermont

There has been a trend toward a high level of market concentration in the Vermont medical malpractice insurance market. The top two Vermont medical malpractice insurance companies (Medical Mutual Insurance Company of Maine and ProSelect Insurance Company) are both mono-line mutual insurance companies owned by the physicians they insure. In 2003, these top two writers represented approximately 63% of the Vermont medical malpractice insurance company market, while the top five writers represented over 86% of the market.[8] Such a highly concentrated market makes the state more vulnerable to coverage availability shortages or price fluctuations if one of the top carriers withdraws from the market. Further detail on the top writers is provided later in the report at *Table 1* of the *Supporting Tables* section.

Two of the most significant recent events in the Vermont medical malpractice insurance market were the insolvency of PHICO and the withdrawal of St. Paul Insurance Company, both of which occurred in 2001–2002. St. Paul and PHICO represented as much as 70% of the Vermont market in 1995, and even though their collective market share was in decline, the combined market share of these two companies at the time of their withdrawal was 25%. *See Table 2 of Supporting Tables Section*. PHICO, in particular, dominated the Vermont market and represented over half the medical malpractice premiums written in the state's traditional medical malpractice liability insurance market from 1987 to 1996. *See Exhibit 109.* It is generally believed that a major factor in PHICO's insolvency was the company's under-pricing of the policies written in the years leading up to its insolvency.

Based on data from the Medical Liability Monitor, malpractice premium rates charged in Vermont for certain high-risk specialties, such as internal medicine, general surgery, and OB/GYNs, are generally lower than those in the rest of New England, both as in absolute dollars and as a percentage of wages. (See Table C below; data from Medical Liability Monitor, October 2004, Vol. 29, No. 10.) For example, the average premium rate for an OB/GYN in Massachusetts in 2003 was $101,462 per year, whereas, the rate for an OB/GYN in Vermont was between $31,193 and $49,064. Table C below also compares the premium rates as a percentage of the mean annual wage (wages from the U.S. Bureau of Labor Statistics).

Table A
ProSelect Insurance Company
Medical Malpractice Rate Changes for Selected Specialties
10 Year Period—1996 through 2005

Specialty	Filed Rate ($) in effect 1996	Filed Rate ($) in effect 1/1/2001	Filed Rate ($) in effect 2/1/2005	Change 96' - 01' ($)	Change 96' - 01' (%)	Change 01' - 05' ($)	Change 01' - 05' (%)	Change 96' - 05' ($)	Change 96' - 05' (%)
Anesthesia	7,759	7,759	11,150	0	0.0%	3,391	43.7%	3,391	43.7%
Cardiac Surgery	19,399	19,399	27,876	0	0.0%	8,477	43.7%	8,477	43.7%
Family/Gen. Prac. Minor Surgery	5,175	5,175	7,436	0	0.0%	2,261	43.7%	2,261	43.7%
General Surgery	14,296	14,296	20,543	0	0.0%	6,247	43.7%	6,247	43.7%
Neurosurgery	38,801	38,801	51,587	0	0.0%	12,786	33.0%	12,786	33.0%
Obstetrics/Gyn.	38,801	38,801	51,587	0	0.0%	12,786	33.0%	12,786	33.0%
Opthalmology	5,106	5,106	7,333	0	0.0%	2,227	43.6%	2,227	43.6%
Orthopedic Surgery	25,527	25,527	36,681	0	0.0%	11,154	43.7%	11,154	43.7%
Otolaryngology	11,231	11,231	16,141	0	0.0%	4,910	43.7%	4,910	43.7%
Radiology	4,793	4,793	7,436	0	0.0%	2,643	55.1%	2,643	55.1%
Thoracic Surgery	19,399	19,399	27,876	0	0.0%	8,477	43.7%	8,477	43.7%
Urology	9,190	9,190	13,203	0	0.0%	4,013	43.7%	4,013	43.7%
Vascular Surgery	21,442	21,442	30,814	0	0.0%	9,372	43.7%	9,372	43.7%

Filed rates listed are mature claims-made rates (the most expensive base rates) at $1,000,000/$3,000,000 Limits.

Table B
Medical Mutual Insurance Company of Maine
Medical Malpractice Rate Changes for Selected Specialties
10 Year Period—1996 through 2005

Specialty	Filed Rate ($) in effect 1996	Filed Rate ($) in effect 1/1/2001	Filed Rate ($) in effect 7/1/2005	Change 96' - 01' ($)	Change 96' - 01' (%)	Change 01' - 05' ($)	Change 01' - 05' (%)	Change 96' - 05' ($)	Change 96' - 05' (%)
Anesthesia	8,192	8,192	12,274	0	0.0%	4,082	49.8%	4,082	49.8%
Cardiac Surgery	20,570	20,570	38,355	0	0.0%	17,785	86.5%	17,785	86.5%
Family/Gen. Prac. Minor Surgery	6,045	6,045	10,548	0	0.0%	4,503	74.5%	4,503	74.5%
General Surgery	14,036	14,036	26,849	0	0.0%	12,813	91.3%	12,813	91.3%
Neurosurgery	33,134	33,134	53,697	0	0.0%	20,563	62.1%	20,563	62.1%
Obstetrics/Gyn.	23,585	23,585	42,192	0	0.0%	18,607	78.9%	18,607	78.9%
Opthalmology	6,045	6,045	10,548	0	0.0%	4,503	74.5%	4,503	74.5%
Orthopedic Surgery	20,570	20,570	32,602	0	0.0%	12,032	58.5%	12,032	58.5%
Otolaryngology	8,192	8,192	15,342	0	0.0%	7,150	87.3%	7,150	87.3%
Radiology	6,045	6,045	12,274	0	0.0%	6,229	103.0%	6,229	103.0%
Thoracic Surgery	20,570	20,570	38,355	0	0.0%	17,785	86.5%	17,785	86.5%
Urology	7,332	7,332	15,342	0	0.0%	8,010	109.2%	8,010	109.2%
Vascular Surgery	20,570	20,570	38,355	0	0.0%	17,785	86.5%	17,785	86.5%

Filed rates listed are mature claims-made rates (the most expensive base rates) at $1,000,000/$3,000,000 Limits.

Table C
Comparison of Medical Malpractice Rates—New England

	(1)	(2)	(3)	(4)	(5)
	Medical Liability Monitor Rate Survey		BLS		
	2003	2003	2003 Mean	Rate as % of Wages	
State	Low Rate	High Rate	Annual Wage	Low Rate	High Rate
Internal Medicine					
MA	11,226	11,226	151,760	7.4%	7.4%
CT	8,622	21,420	122,550	7.0%	17.5%
RI	7,967	8,504	151,790	5.2%	5.6%
NH	6,148	10,935	184,200	3.3%	5.9%
ME	5,877	6,672	138,240	4.3%	4.8%
VT	**4,848**	**6,293**	**105,840**	**4.6%**	**5.9%**
General Surgery					
MA	36,289	36,289	184,530	19.7%	19.7%
CT	42,385	50,566	171,860	24.7%	29.4%
RI	28,642	32,312	*184,530	15.5%	17.5%
NH	24,447	40,110	201,720	12.1%	19.9%
ME	19,727	20,446	198,590	9.9%	10.3%
VT	**18,076**	**18,562**	**178,110**	**10.1%**	**10.4%**
OB/GYN					
MA	101,462	101,462	172,710	58.7%	58.7%
CT	80,904	123,470	170,570	47.4%	72.4%
RI	66,325	71,833	187,130	35.4%	38.4%
NH	39,547	61,773	180,900	21.9%	34.1%
ME	32,546	34,314	184,180	17.7%	18.6%
VT	**31,193**	**49,064**	**161,360**	**19.3%**	**30.4%**

(1),(2): Medical Liability Monitor, October 2004

(3): 2003 Mean Annual Wage from U.S. Dept. of Labor Bureau of Labor Statistics, "November 2003 State Occupational Employment and Wage Estimates"

*Note: RI uses same wage as MA for General Surgery; no information in BLS data

ANSWERS TO QUESTIONS POSED BY LEGISLATURE

I. How have medical malpractice lawsuits affected insurance costs for Vermont health care providers, including:

(A) whether jury verdicts and settlements in Vermont have had an effect on insurance costs for Vermont health care providers; and

(B) whether jury verdicts and settlements in other states have had an effect on insurance costs in those states, nationally, or in Vermont.

A. General Discussion

Section 292(c)(1) of the Act asked the Committee to consider "whether and how medical malpractice lawsuits have affected insurance costs for Vermont health care providers, including: (a) whether jury verdicts and settlements in Vermont have had an effect on insurance costs for Vermont health care providers; and (b) whether jury verdicts and settlements in other states have had an effect on insurance costs in those states, nationally, or in Vermont. This issue was considered by the Committee on March 2, 2005. Meeting materials can be found at *Exhibits 1 – 19.*

Simply put, in all cases, an insurer's losses will have an impact on insurance rates. This is because the goal of ratemaking is to ensure that the premiums an insurer collects are sufficient to cover its anticipated losses ("loss costs") and overhead. Prior loss experience in a market is the basis that a carrier uses for estimating future losses or loss costs. Medical malpractice liability insurance ratemaking is no different.

In general, when establishing Vermont medical malpractice rates, insurance carriers first examine their own historical premium, loss, and expense experience in Vermont. Because of the relatively small size of the Vermont data, even the largest traditional insurance companies doing business in the state find that their Vermont loss experience is not sufficiently credible to rely upon exclusively for actuarially sound rates. (Credibility is a measure of the predictive value in a given application that is attached to a particular body of data.) [9] As such, carriers must consider other information, such as their historical loss experience in complementary demographic regions, or the historical loss experience or rates of their competitors in Vermont and similar markets. It is impossible to quantify precisely the impact that out-of-state losses have on Vermont rates because insurance companies employ a variety of different formulas to blend Vermont and non-Vermont loss experience. However, it is clear that, because of the nature of the ratemaking process, the cost of jury verdicts and settlements in Vermont and in other states do affect insurance costs in Vermont.

This fact raises the question of whether loss experience in Vermont, as reflected in jury verdicts and settlements, is comparable to loss experience in other parts of the country. On a countrywide basis, some studies suggest that jury verdicts and settlements have increased significantly since the mid-to-late-1990s. For example, a study by the Congressional Budget Office notes that "the average payment for a malpractice claim has risen fairly steadily since 1986, from $95,000 in that year to $320,000 in 2002. That increase represents an annual growth rate of nearly 8 percent—more than twice the general rate of inflation "[10] This trend is also reflected by the increase in the median value of jury verdicts countrywide (Table 1.1 below), which, according to Jury Verdict Research rose from $473,055 in 1996 to $1,200,000 in 2003. (The median award is the award that is in the middle of the group—half of the awards are less than or equal to the median value and half of the awards are greater than or equal to the median value). It must be noted that **data compiled by Jury Verdict Research is primarily self-reported and does not represent a comprehensive picture of all jury verdicts.** However, nationally no representative database including all jury verdicts presently exists.

Table 1.1

Medical Malpractice Jury Award Trends
Countrywide Data

Year	Award Median
1996	473,055
1997	500,000
1998	700,000
1999	712,500
2000	1,000,000
2001	945,338
2002	1,000,000
2003	1,200,000

"Current Award Trends in Personal Injury," 43rd ed. (2004)
Jury Verdict Research

In Vermont, the trend in the size and frequency of jury verdicts and settlements is not so clear. The Committee looked at three different measures of malpractice activity in Vermont. Tables 1.2 and 1.3 below show the median value and mean value (average) of settlements and jury verdicts as compiled by the National Practitioner Databank (NPDB) on a countrywide basis as well as for Vermont and the other New England states. These tables indicate that malpractice losses in Vermont are lower on average than malpractice losses in other parts of the country and that they have not exhibited the dramatic inflation

seen elsewhere in recent years. As with Jury Verdicts Research, the NPDB data has its shortcomings; studies have uncovered problems with underreporting, gaps in data, and inaccurate problem reports.[11] In addition, the mean values included in the tables below are the mean of all verdicts in favor of the plaintiff and do not include defense verdicts.[12] **Data compiled by the NPDB is reported pursuant to a federal statutory mandate but, according to a recent GAO study, does not represent a comprehensive picture of all claims.**

Table 1.2
Medical Malpractice Payment Trends for Physicians
Countrywide and Vermont Data

	Countrywide			Vermont		
Year	Payment Median	Payment Mean	Number of Claims Paid	Payment Median	Payment Mean	Number of Claims Paid
1996	75,000	183,126	14,005	50,000	80,520	28
1997	75,000	185,702	13,815	90,000	123,342	35
1998	83,463	216,617	13,322	123,750	185,491	49
1999	85,000	195,093	14,215	39,250	136,588	33
2000	125,000	248,947	14,619	75,000	144,273	23
2001	135,000	270,854	15,724	112,500	181,976	24
2002	150,000	275,094	14,468	40,865	109,353	19
2003	160,000	294,814	14,275	80,000	137,444	26

Notes: National Practitioner Data Bank; Annual Reports 1996-2003

Table 1.3
Comparison of Average Loss Payments - 2003 Only
New England States and Countrywide Data

State	Mean Payment	Median Payment	Rank of Median Payment
Vermont	137,444	80,000	48
Rhode Island	333,387	150,000	28
Maine	254,131	180,000	19
New Hampshire	248,806	250,000	2
Massachusetts	409,321	250,000	2
Connecticut	483,502	250,000	2
Countrywide	294,814	160,000	

Notes: National Practitioner Data Bank; Annual Reports 2003
Payments not adjusted for inflation

The Milliman Data Call to Vermont carriers and hospitals also requested settlement and jury verdict-related information. Altogether, ten of the top 13 insurance providers in Vermont (two hospitals and eight traditional insurers representing 89.8% of the traditional market in the state), provided information on closed and open malpractice claims from 1994 through late 2004. As noted

above, a former large Vermont writer, PHICO, was not included in the respondents, as the company is in run-off and is not required to respond to data requests.[13] In addition, some of the respondents were unable to provide the requested information due to data limitations.

Nevertheless, the results of the Data Call support the conclusion that Vermont has not experienced a dramatic increase in malpractice losses during the past decade. Of the 1,083 closed claims reported by the responding carriers for the ten plus year period surveyed, only 20, or 1.8%, resulted in jury verdicts, and of these, only five (or one-half of one percent) resulted in verdicts for the claimant. During this period, the average cost-per-claim reported by the responding carriers (including indemnity payments, defense costs and investigation expenses) was approximately 78% of the countrywide average (columns 3 and 4 in Table 1.4 below), a figure that is consistent with the lower-than-average Vermont loss payments reported in the National Practitioner Databank. Finally, based on the ten-year ultimate severity history shown in column 2 of Table 1.4 and the nine-year claim frequency history shown column 3 of Table 1.5, there does not appear to be any discernable upward trend in either the number of claims or the average cost-per-claim in Vermont. Although the Milliman Data Call does not have full statistical credibility because of the small number of Vermont claims, it does represent the best available information on Vermont medical malpractice losses at this time.

Table 1.4
Vermont Medical Malpractice
VT Data Call - 10 Entities Reporting (8 Insurers & 2 Hospitals)
Claims with Indemnity Loss

(1) Year	(2) Vermont Ultimate Severity	(3) Countrywide Ultimate Severity	(4) Vermont Severity Relative to Countrywide Severity
1994	249,299	196,939	126.6%
1995	145,627	215,276	67.6%
1996	230,543	218,201	105.7%
1997	217,806	247,821	87.9%
1998	249,041	266,658	93.4%
1999	153,427	266,070	57.7%
2000	168,785	271,895	62.1%
2001	301,511	314,202	96.0%
2002	227,794	300,334	75.8%
2003	155,591	342,369	45.4%
2004	0	N/A	
Total	206,141	264,209	78.0%

(2): VT data call; excludes claims closed with no indemnity loss
(3): August 31, 2004, Insurance Services Office, Inc., Circular - AS-PR-2004-015. (Countrywide Data)

Table 1.5
Vermont Data Call - 10 Entities Reporting
Claim Frequency

Year	(1) On-Level Written Premium	(2) Reported Claims Counts	(3) Frequency (2)/(1) x 1M
1996	11,171,790	69	6.176
1997	11,689,178	56	4.791
1998	11,862,638	45	3.793
1999	12,170,659	71	5.834
2000	12,763,552	68	5.328
2001	16,431,028	96	5.843
2002	17,857,937	105	5.880
2003	17,621,142	85	4.812
2004*	13,839,865	68	4.899
Total	125,407,788	663	5.284

(1): From Milliman Data Call; adjusted for rate level changes
(2): Reported claims are claims closed with payment, and open claims with a reserve
(3): Frequency equals the Reported Claim Counts divided by On-Level Written Premium, multiplied by 1 million
* 2004 is approximately 3/4 of a year

The Committee also heard evidence indicating that there has not been a dramatic increase in medical malpractice litigation in Vermont. At the April 25, 2005 meeting, the Committee heard testimony from the administrators of the Vermont state and federal courts indicating that medical malpractice cases were a small portion of the total caseload for both courts. In federal court, from 1991 to 2004, an average of 1.95% of the cases filed were medical malpractice cases and none of those cases resulted in a verdict in favor of a plaintiff. *Exhibits 87 and 89.* In state court, for fiscal years 2002 through 2004, medical malpractice cases were less than one percent of all civil cases filed in Vermont. Of the 19 state court judgments entered in medical malpractice cases from January 1, 2002 through April 26, 2005, three were entered in favor of the plaintiff. *Exhibits 91 and 93.*

Since insurance companies writing business in Vermont do not have fully credible Vermont experience upon which to base their Vermont rates, an increase in insurance costs for risks outside of Vermont can impact the rates they derive for Vermont policyholders, even if Vermont malpractice losses are lower than those in the rest of the country. However, as discussed below in Section VIII, limiting carriers to Vermont loss experience will not resolve this issue.

B. Committee Vote

Have jury verdicts and settlements in Vermont had an effect on insurance costs for Vermont health care providers?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Have jury verdicts and settlements in other states had an effect on insurance costs in those states, nationally or in Vermont?				
VOTE SUMMARY: Other States—4; Nationally—4; Vermont—4; No Effect—3				
Committee Member	**Other States**	**Nationally**	**In Vermont**	**No effect**
BISHCA	X	X	X	
Vermont Medical Society	X	X	X	
Vermont Association of Hospitals and Health Systems	X	X	X	
Vermont Trial Lawyers Association				X
Vermont Bar Association				X
Vermont Health Care Ombudsman				X
American Insurance Association	X	X	X	

II. If medical malpractice lawsuits have affected insurance costs for Vermont health care providers, could statutory changes reduce those costs?

A. General Discussion

Section 292(c)(2) of the Act asked the Committee to consider "if medical malpractice lawsuits have affected insurance costs for Vermont health care providers, whether and how statutory changes could reduce those costs." This issue was considered by the Committee on March 2, 2005. Meeting materials can be found at *Exhibits 65 - 72***.**

As discussed in connection with Issue 1 above, there is little doubt that medical malpractice lawsuits and settlements have affected insurance costs for Vermont health care providers. There was disagreement among the Committee members, however, about the extent to which malpractice losses have contributed to rising premium rates in Vermont. Committee members who believed that malpractice losses are the driving force behind rate increases were more apt to support statutory changes designed to contain or reduce those losses. Committee members who believed that malpractice losses are not the primary contributor to rising rates tended to oppose such changes.

Specific statutory changes are discussed in other sections of this report.

B. Committee Vote

If medical malpractice lawsuits have affected insurance costs for Vermont health care providers, can statutory changes reduce those costs?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

III. Are insurance costs for Vermont health care providers rising while the payments insurers make for medical malpractice claims are decreasing and, if so, why does this apparent discrepancy exist?

A. General Discussion

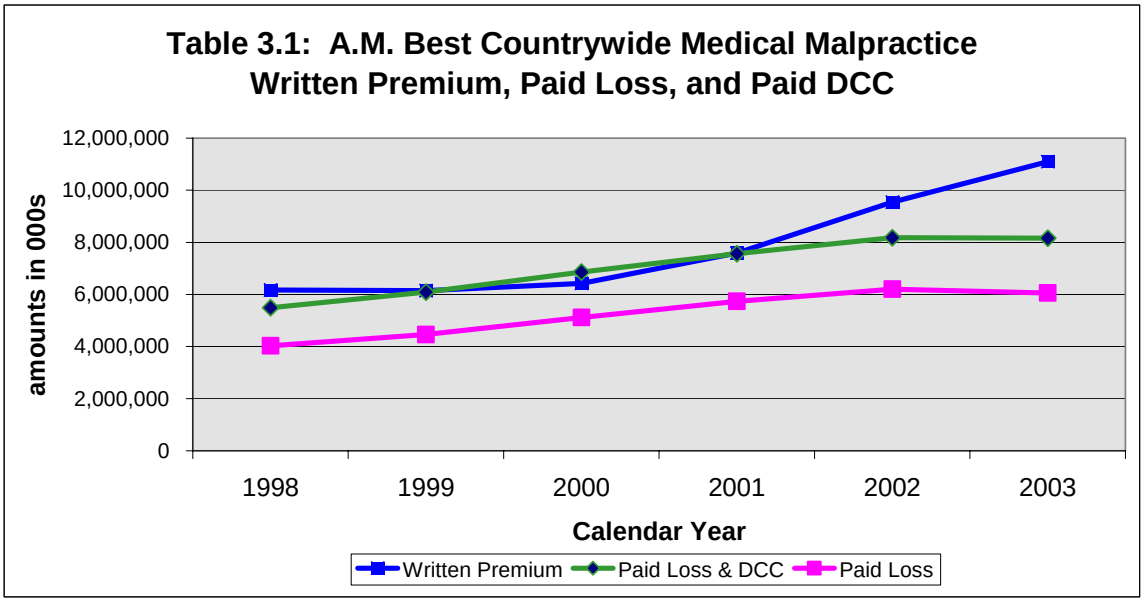
Section 292(c)(3) of the Act asked the Committee to consider "whether insurance costs for Vermont health care providers are rising while the payments insurers make for medical malpractice claims are decreasing, and, if so, why does this apparent discrepancy exist." This issue was considered by the Committee on January 26, 2005. Meeting materials can be found at *Exhibits 56 - 64*.

The genesis for this question was data presented to the Legislature by Tom Sherrer in 2005 showing, based on NPDB data, that medical malpractice payouts appeared to be decreasing while medical malpractice premiums were increasing. A study by the Americans for Insurance Reform (AIR) entitled "*Medical Malpractice Insurance: Stable Losses/Unstable Rates* looked at this issue.[14] According to the 2004 version of this study, "the amount medical malpractice insurers have paid out, including all jury awards and settlements, directly track the rate of medical inflation. On the other hand, medical insurance premiums charged by insurance companies have not corresponded to the increases or decreases in payouts. Rather, they have risen and fallen in sync with the state of the economy, reflecting gains or loses experienced by the insurance industry's market investments."[15]

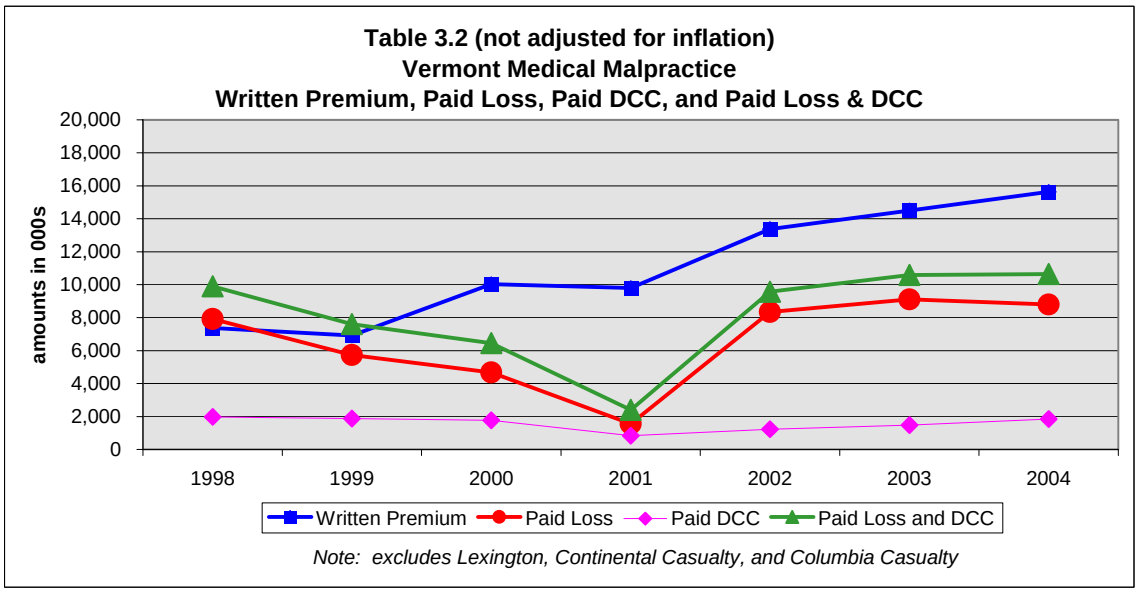
The AIR study compared paid losses to premiums, adjusted for medical inflation and to reflect increases in physician population. Comparing these numbers, the study concluded that paid losses were not increasing and that premium increases reflect the industry market cycle and the economy in general.

The AIR study indicates that it compares paid losses, including defense costs, to premiums based on A.M. Best data (on which the AIR claims its data is based). However, when Milliman examined the A.M. Best data, it did not appear that the AIR paid loss amounts include defense costs.[16] This could significantly compromise the AIR argument because defense costs are a significant factor in insurance loss costs.

Milliman presented a comparison of countrywide paid losses plus DCC expenses versus premium to the Committee. When examining countrywide paid losses with DCC costs included, paid losses more closely resemble premiums collected. *See* Table 3.1 below. Table 3.1 does not include other expenses incurred by insurance companies, such as underwriting expenses (which typically constitute about 15% of premiums).[17]



With Vermont data only, Milliman performed a similar comparison of written premium to paid losses. See Table 3.2 below. When reviewing this data, however, it is important to note that as a result of its insolvency, PHICO stopped reporting data beginning in 2001. Thus Table 3.2 excludes PHICO premium in 2001 and PHICO paid loss and paid DCC experience for 2001 to 2003.[18] As such, the PHICO data limitations may make it impossible to analyze the AIR arguments as they may apply to Vermont. However, from 1998 to 2003 it does not appear that paid losses have been decreasing, but rather when examined over six years, they have been flat and may be on the increase. Values in Table 3.2 have not been adjusted for medical inflation or for any changes in physician population.



B. Committee Vote

Are insurance costs for Vermont health care providers rising while the payment insurers make for medical malpractice claims are decreasing?		
VOTE SUMMARY: Yes—3; No—4		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society		X
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association		X

IV. Have factors other than medical malpractice actions had an effect on insurance costs for health care providers nationally and in Vermont?

A. General Discussion

Section 292(c)(4) of the Act directed the Committee to consider "whether factors other than medical malpractice actions have had an effect on insurance costs for health care providers nationally and in Vermont." This issue was considered by the Committee at its meetings on October 27, 2004 and November 16, 2004. Meeting materials can be found at *Exhibits 35 - 55*.

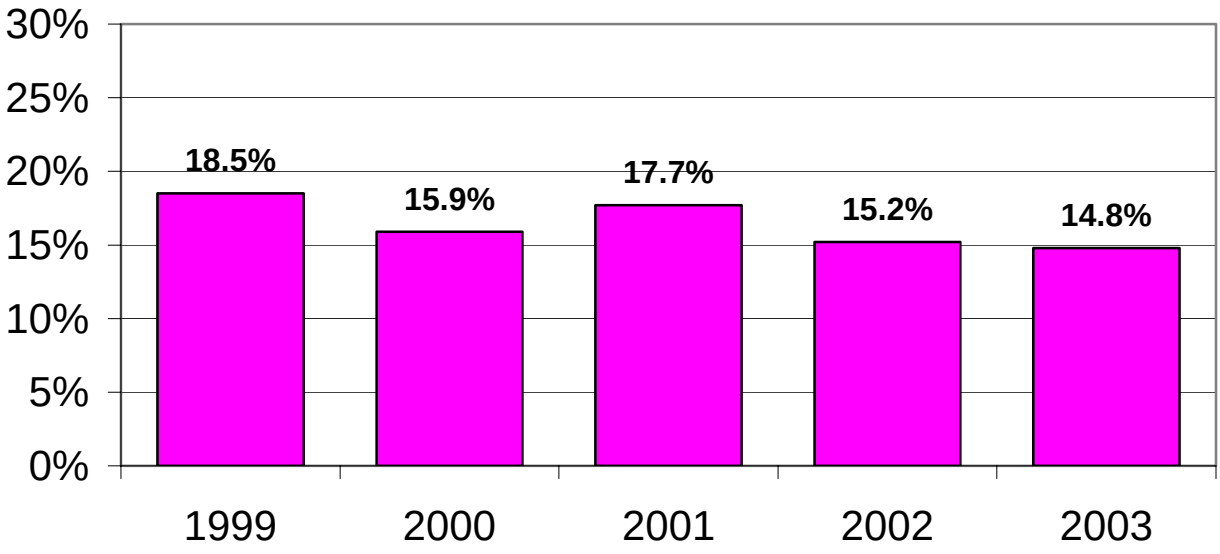
Although payments of medical malpractice claims are the most significant expense that insurers face,[19] commentators generally agree that other factors can also have an impact on premium rates. A June 2003 study by the United States General Accounting Office found that declining investment income, climbing reinsurance rates, the cyclical hard insurance market, and a less competitive market environment had all contributed to rising premium rates on a countrywide basis, in addition to increasing malpractice losses.[20] Others have noted the cyclical nature of the insurance market in general.[21] The Committee examined the impact of each of these factors on rates in Vermont and also looked at the question of whether underwriting expenses have contributed to the increase in premium rates.

1. Underwriting Expenses

Underwriting expenses are the expenses that an insurer incurs to produce written premiums. Underwriting expenses include such items as commissions, salaries, advertising costs and a portion of overhead. As illustrated in Table 4.1

below, the underwriting expense ratios of medical malpractice specialty carriers (i.e., the ratio of a malpractice carrier's underwriting expenses to its written premium) have been stable or decreasing over the last several years. The fact that underwriting expense ratios have been stable or declining indicates that underwriting expenses are not contributing to an increase in medical malpractice insurance costs.

Table 4.1: Medical Malpractice Specialty Writers · Underwriting Expense Ratios (% of Premium)



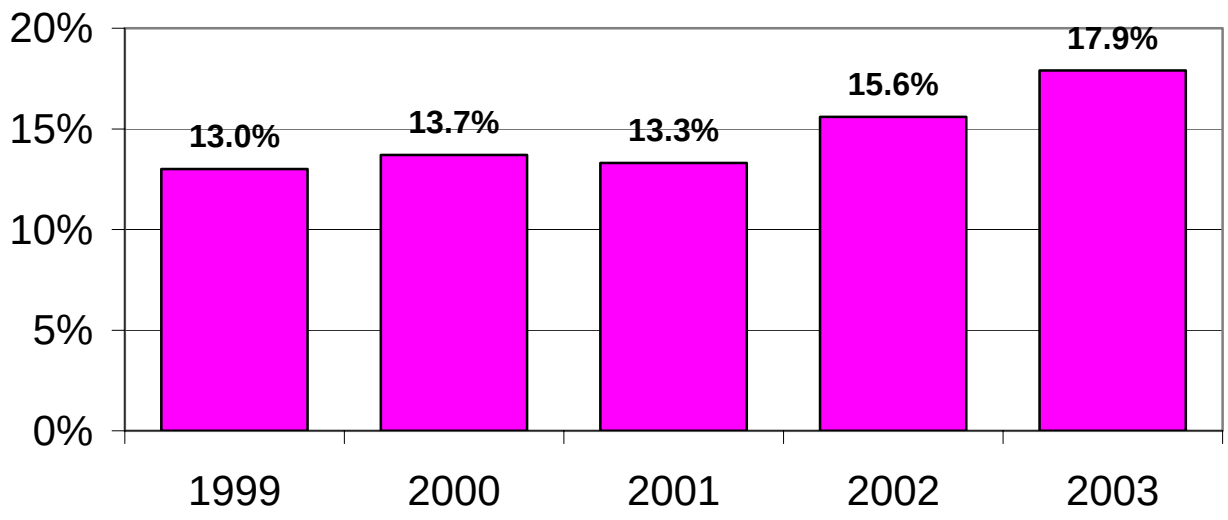
Source: Annual Statement Data from National Underwriter Insurance Services

2. Reinsurance Costs

Medical malpractice insurers, especially smaller carriers, purchase reinsurance to protect themselves against the potentially devastating consequences of an extremely large loss. Over the past 3 to 4 years, reinsurance costs have increased for all types of carriers. Table 4.2 below, which displays reinsurance costs as a percentage of written premium, shows that reinsurance costs increased steadily for medical malpractice specialty companies from 1999 to 2003 (the most current year for which data is available). Increasing reinsurance costs have likely had some impact on medical malpractice rates, although it is difficult to quantify this impact since some carriers attempt to offset rising reinsurance costs by increasing the dollar threshold of any loss at which reinsurance coverage begins. The 2003 GAO study referred to above cites anecdotal evidence from one insurance carrier that the increase in its

reinsurance costs from 2000 to 2002 resulted in a 2% to 3% increase in medical malpractice premium rates.[22]

Table 4.2: Medical Malpractice Specialty Writers - Reinsurance Costs (% of Premium)



Source: Annual Statement Data from National Underwriter Insurance Services

3. Investment Income

Generally speaking, insurers invest the premiums that they collect and use the income from these investments to help pay their expenses, including their losses on claims. When interest rates are relatively high, as they were during most of the 1990s, investment returns cover a larger share of an insurer's expenses, resulting in an ability to decrease premiums to reflect the additional investment income. Conversely, when interest rates decline, the amount of investment income insurance companies can earn from the premium they collect decreases and carriers may be required to increase rates in order to compensate for the shortfall in income. According to the General Accounting Office, every 1% decrease in return on a carrier's investments represents a 4.5% increase in medical malpractice premiums.[23]

As noted by the General Accounting Office, most state laws restrict medical malpractice carriers to conservative investments, primarily bonds.[24] In 2003, the 54 largest writers of medical malpractice insurance in the country invested, on average, 80% of their assets in bonds.[25] Similarly, Richard Brewer,

the president of ProSelect Insurance Company, Vermont's second largest medical malpractice writer, testified to the Committee that most of his company's assets are invested in long-term bonds. As displayed in Table 4.3 below, annual yields on bonds have decreased steadily since 2000.[26] The General Accounting Office estimates that the decline in the investment income of medical malpractice insurers from 2000 to 2002 "would have resulted in an increase in premium rates [countrywide] of around 7.2 percent over the same 2-year period."[27] In Vermont, as shown in Table 4.4, the average investment income of the top four medical malpractice carriers declined approximately 1.5% from 1998 through 2003, based on publicly available Annual Statement data. Applying the General Accounting Office formula described in the preceding paragraph and holding other factors constant, this decrease in investment income would have resulted in an overall increase in premium rates in Vermont during this period of around 6.75%.

Table 4.3: U.S. Treasury (10 year) Yields

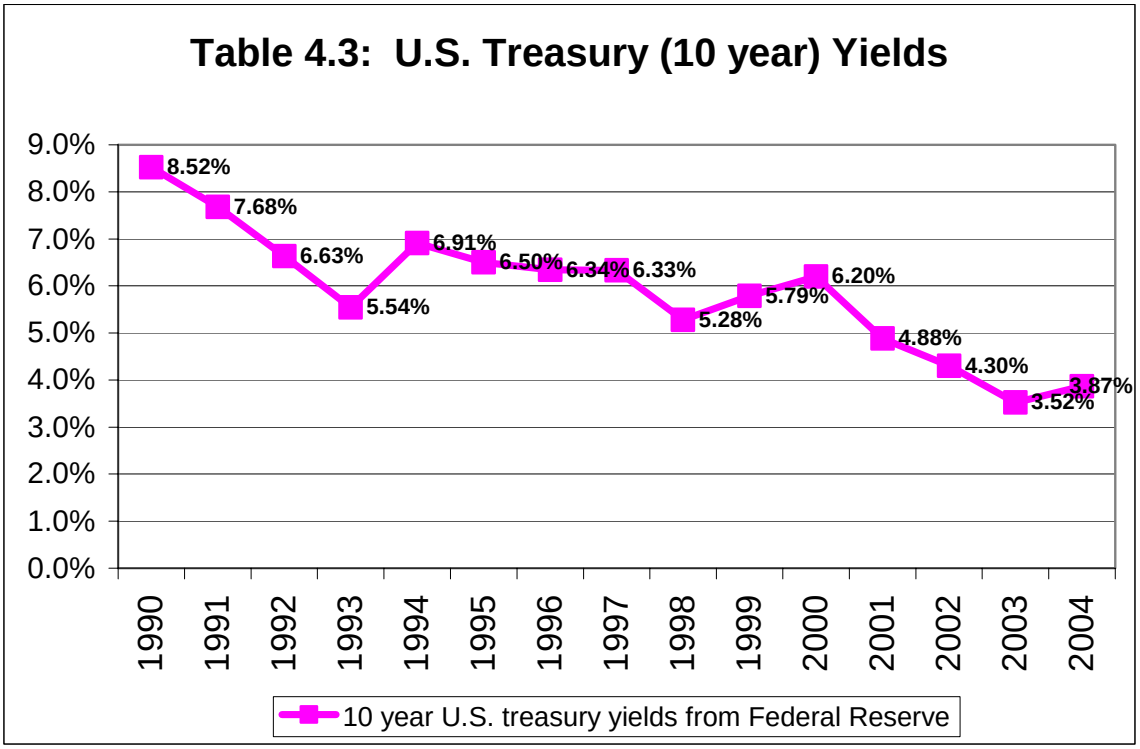
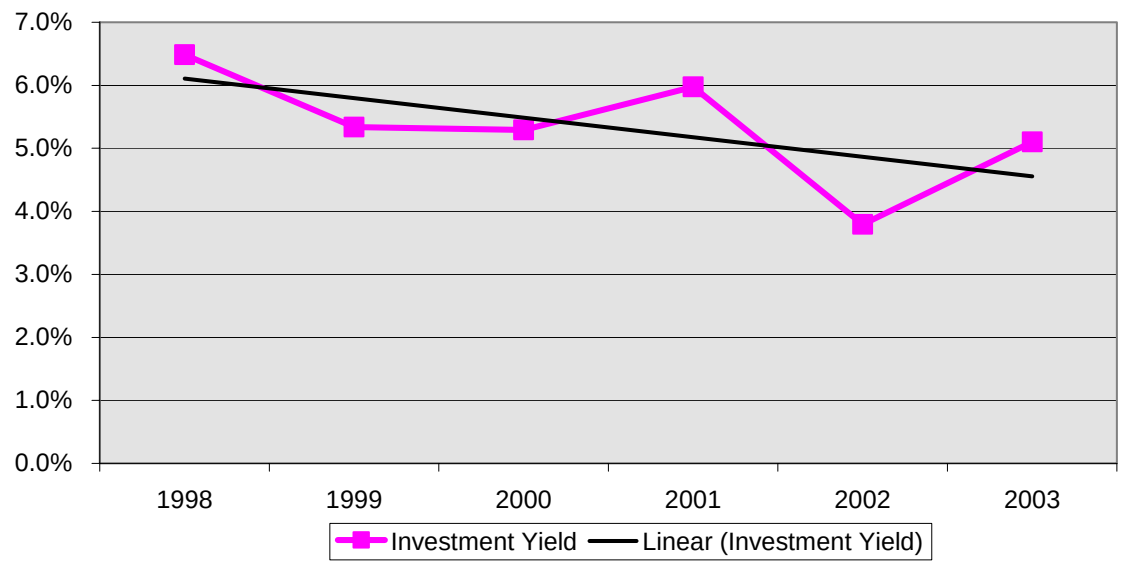


Table 4.4: Top 4 Vermont MedMal Writers - Investment Yields



Based on Annual Statement data for companies

4. Competitive Climate

As noted in the Background section of this report, the competitive climate of the medical malpractice insurance market in Vermont underwent a major change in early 2002 when PHICO, a Pennsylvania-based malpractice insurer, was declared insolvent. For most of the 1990s, PHICO was the largest writer of medical malpractice insurance in Vermont, with a high market share of 76.9% in 1991. Prior to its insolvency, PHICO was widely believed to be charging artificially low premium rates, a practice that likely lead to its financial collapse and which, in light of PHICO's dominant market share, would have had an inhibiting effect on the rates of its smaller competitors. With the removal in 2001 of the pricing distortions caused by PHICO's artificially low rates, it would be expected that rates would show a return to more rational levels as part of a natural market correction. In fact, as shown in Tables 4.5 through 4.12 below, this is the pattern that rates actually followed from 1995 to 2004, with a period of stability and rate reductions in the late 1990s being followed by significant rate increases in 2001 in the wake of PHICO's departure from the Vermont market.

Table 4.5

Vermont
Medical Malpractice Carriers
Market Share Percentage*
1994 – 2003

Company	2003	2002	2001	2000	1999	1998	1997	1996	1995	1994
PHICO	0.0	0.0	0.0	21.8	29.2	31.0	40.3	54.2	54.9	67.1
Pro-Select	26.6	19.9	28.6	9.5	3.4	3.4	3.0	0.1	0.0	0.0
MMICM	36.4	24.4	30.2	18.4	25.0	16.6	6.0	0.2	0.0	0.0
Continental	12.3	18.2	4.8	4.2	7.9	7.1	7.8	6.5	9.7	7.6
GE Global	5.9	4.6	8.3	5.5	6.8	0.0	0.0	0.0	0.0	0.0
St. Paul	0.1	0.3	3.6	3.3	5.1	12.2	14.8	12.4	15.1	13.4
Doctor's Co.	4.6	3.5	4.9	4.4	7.4	12.9	12.6	11.2	8.8	2.7
Total	85.9	70.9	80.4	67.1	84.8	83.2	84.5	84.6	88.5	90.8

* Source: A.M. Best—Five Year Trend A7 Reports (includes entire medical malpractice market)

Data for the 2003 column is from the A7 2003 data report
Data for the 2002 column is from the A7 2002 data report
Data for the 2001 column is from the A7 2001 data report
Etc.

Table 4.6

PHICO
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
67.10%	1994		0.00%			
54.90%	1995		0.00%			
54.20%	1996		0.00%			
40.30%	1997	11/01/1997	-2.20%	-64,900	100.00%	410
31.00%	1998		0.00%			
29.20%	1999		0.00%			
21.80%	2000		0.00%			
---	2001		---			
---	2002		---			
---	2003		---			
---	2004		---			
	% Change 1994-2001		-2.20%			
	% Change 2001-2004		---			
	% Change 1994-2004		---			

Data from BISHCA rate filings
* Includes entire medical malpractice market

Table 4.7

Pro-Select
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
0.00%	1994		---			
0.00%	1995		---			
0.10%	1996		0.00%			
3.00%	1997		0.00%			
3.40%	1998		0.00%			
3.40%	1999		0.00%			
9.50%	2000		0.00%			
29.40%	2001		0.00%			
20.30%	2002	02/01/2002	12.00%	137,280	100.00%	263
26.60%	2003	02/01/2003	18.60%	475,860	100.00%	434
n/a	2004	02/01/2004	8.00%	260,000	100.00%	465
n/a	2005	02/01/2005	7.20%	240,000	98.60%	481
	% Change 1994-2001		0.00%			
	% Change 2001-2005		53.79%			
	% Change 1994-2005		53.79%			

Data from BISHCA rate filings
* Includes entire medical malpractice market

Table 4.8

Medical Mutual Insurance Company of Maine
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
0.00%	1994		---			
0.00%	1995		---			
0.20%	1996		0.00%			
6.00%	1997		0.00%			
16.60%	1998		0.00%			
25.00%	1999		0.00%			
18.40%	2000		0.00%			
31.10%	2001		0.00%			
24.80%	2002	01/01/2002	15.30%	227,494	100.00%	219
36.40%	2003	01/01/2003	15.00%	489,945	100.00%	316
38.44%	2004	01/01/2004	15.00%	615,921	100.00%	314
n/a	2005	07/01/2005	19.70%	588,877	100.00%	200
	% Change 1994-2001		0.00%			
	% Change 2001-2005		82.52%			
	% Change 1994-2005		82.52%			

Data from BISHCA rate filings
* Includes entire medical malpractice market

Table 4.9

Continental-CNA
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
7.60%	1994		0.00%			
9.70%	1995		0.00%			
6.50%	1996	10/10/1996	2.90%	5,723	100.00%	55
7.80%	1997		0.00%			
7.10%	1998		0.00%			
7.90%	1999		0.00%			
4.20%	2000		0.00%			
5.00%	2001		0.00%			
18.50%	2002		0.00%			
12.30%	2003	01/01/2003	45.70%	65,463	100.00%	24
n/a	2004		0.00%			
n/a	2005	08/01/2005	15.00%	25,488	100.00%	13
	% Change 1994-2001		2.90%			
	% Change 2001-2005		67.55%			
	% Change 1994-2005		72.41%			

Data from BISHCA rate filings
* Includes entire medical malpractice market

Table 4.10

GE Global
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
0.00%	1994		0.00%			
0.00%	1995		0.00%			
0.00%	1996		0.00%			
0.00%	1997		0.00%			
0.00%	1998		0.00%			
6.80%	1999		0.00%			
5.50%	2000		0.00%			
8.50%	2001		0.00%			
4.60%	2002		0.00%			
5.90%	**2003	03/01/2003	0.00%	0	0.00%	0
n/a	2004		0.00%			
	% Change 1994-2001		0.00%			
	% Change 2001-2004		0.00%			
	% Change 1994-2004		0.00%			

* Initial filing for physicians & surgeons

Data from BISHCA rate filings
** Includes entire medical malpractice market

Table 4.11

St. Paul Insurance Company
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
13.40%	1994	01/01/1994	-5.00%	n/a	n/a	43
15.10%	1995		0.00%			
12.40%	1996	05/15/1996	-15.00%	-73,100	n/a	35
14.90%	1997		0.00%			
14.80%	1998	07/15/1998	2.20%	4,847	n/a	25
5.40%	1999	09/01/1999	5.00%	12,908	n/a	22
3.30%	2000		0.00%			
1.70%	2001	01/15/2001	15.00%	17,706	100.00%	14
2.40%	2002		0.00%			
2.10%	2003		0.00%			
n/a	2004		0.00%			
	% Change 1994-2001		-0.35%			
	% Change 2001-2004		15.00%			
	% Change 1994-2004		-0.35%			

Data from BISHCA rate filings
* Includes entire medical malpractice market

Table 4.12

Doctor's Company Insurance Group
Approved Average Overall Rate Increases
Physicians & Surgeons Only

% Market Share*	Year	Effective Date	% Change	Estimated $ Change	% of Policyholders Affected	# of Policyholders Affected
2.70%	1994	3/15/1994	12.80%	n/a	70.00%	21
8.80%	1995	12/21/1995	12.70%	40,795	75.00%	63
11.20%	1996		0.00%			
12.60%	1997		0.00%			
12.90%	1998		0.00%			
7.40%	1999		0.00%			
4.40%	2000		0.00%			
4.90%	2001	01/01/2001	-1.00%	-5,139	31.40%	22
4.90%	2001	09/01/2001	14.50%	64,116	100.00%	61
3.50%	2002	08/01/2002	14.80%	73,314	96.00%	53
3.50%	2002	12/01/2002	21.30%	106,008	98.4%	61
4.60%	2003	03/01/2003	2.60%	15,360	100.00%	85
n/a	2004		0.00%			
	% Change 1994-2001		25.85%			
	% Change 2001-2004		61.95%			
	% Change 1994-2004		105.88%			

Data from BISHCA rate filings
* Includes entire medical malpractice market

B. Committee Vote

Have factors other than medical malpractice actions had an effect on insurance costs for health care providers nationally and in Vermont?		
VOTE SUMMARY: Yes—7; No—0		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association	X	

V. Would caps on damages in medical malpractice actions affect insurance costs for Vermont health care providers?

A. General Discussion

Section 292(c)(5) of the Act asked the Committee to consider "whether and how caps on damages in medical malpractice actions would affect insurance costs for Vermont health care providers, including whether such caps enacted in other states have affected insurance costs for health care providers in those states, nationally, or in Vermont." This issue was considered by the Committee on March 2, 2005. Meeting materials can be found at *Exhibit 65 – 72.*

As discussed in the Background section of this report, damage awards may be classified as economic and non-economic. Caps on economic damages limit the amount of money that can be awarded for lost wages (past and future) and medical expenses. Caps on non-economic damages limit the amount of money that can be awarded for subjective losses such as pain and suffering or marital companionship. Most states that have implemented caps on damages have capped the non-economic portion of awards.

Overall, 34 states have imposed some limit on awards in medical malpractice cases, although these limits have been declared unconstitutional in at least seven states. Table 37 of the 2004 NAIC Medical Malpractice Insurance Report provides a summary of caps by state. *See Exhibit 123, pp. 110-113.*

The subject of caps has been studied extensively, with the majority of reports concluding that caps on non-economic damages are effective at reducing

malpractice losses and defense costs. A March 30, 2005 report by the Maine Bureau of Insurance concluded that a $250,000 cap on non-economic damages could reduce indemnity payments and defense costs by 15%-22% in that state.[28] Similarly, an October 13, 2004 study by the Wyoming Healthcare Commission found that a $250,000 non-economic damage cap could reduce malpractice losses and defense costs in Wyoming by 15%.[29] The Maine report surveyed the available literature on non-economic damage caps and found "[o]f 22 actuarial studies that specifically address the impact of non-economic damage caps, the majority reach the same conclusion: caps on non-economic damages will reduce the amount of dollars spent to settle insurance losses."[30]

Whether the savings realized by imposing caps on non-economic damages translate directly into savings on malpractice premiums is an issue that has been the subject of debate. As part of a March 2003 study of the economic impact of proposed federal tort reform legislation, the Congressional Budget Office performed a statistical comparison of historical premium and claims data in states with and without limitations on medical malpractice awards. Based on this analysis, the CBO concluded that "certain tort limitations, primarily caps on awards and rules governing offsets from collateral source benefits, effectively reduce average premiums for medical malpractice insurance."[31] In that study, the CBO estimated that a nationwide cap on non-economic damages of $250,000, coupled with limitations on legal fees and abolition of the collateral source rule (which prohibits defendants from showing that the plaintiff has received compensation for his injuries from another source), would result in medical malpractice insurance premiums that "would be an average of 25 to 30 percent lower than what they would be under current law."[32] Subsequently, in a January 2004 report entitled "Limiting Tort Liability for Medical Malpractice," the CBO surveyed the published literature on caps and found that it too "indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise."[33]

Not all studies that have addressed this issue agree with the CBO, however. For example, a June 2, 2003 report by Weiss Ratings, Inc., a consumer advocacy organization, found that premiums continued to increase in states with limitations on damage awards even though the limitations resulted in lower loss payouts for insurers.[34] Based on this, the *Weiss* study concluded that there were more important factors driving the increase in malpractice premiums than loss payments.[35] These factors, according to *Weiss,* included the rapid rise in general medical costs from 1991 to 2002, the decline in insurers' investment income resulting from lower interest rates, and a need on the part of some insurers to shore up reserves that had been under-funded during the "soft" insurance market of the 1990s.[36] Similar conclusions were reached in a March 2005 report issued by researchers at the University of Texas Law School and a May 2005 report issued by researchers at Dartmouth College. Both studies concluded that recent rapid increases in medical malpractice premiums were the result of market dynamics largely unrelated to malpractice losses.[37]

According to the 2004 Wyoming Healthcare Commission study, one factor that could dilute the effectiveness of caps in a market would be the existence of inadequate rates. “If rates are inadequate prior to the application of the cap,” the study noted, “the cap should reduce the margin of inadequacy by 15%, but will not necessarily support a rate reduction.”[38]

One of the first states to limit damage awards in malpractice actions was California, which imposed a $250,000 cap on non-economic damages in 1975 as part of a comprehensive tort reform package known as the Medical Injury Compensation Reform Act (MICRA). Other significant provisions of MICRA include a limitation on the legal fees that lawyers can charge in malpractice actions, abolition of the collateral source rule, and a shortening of the time period (“statute of limitations”) within which malpractice actions can be brought.

According to a 2004 study by the RAND Institute for Civil Justice, MICRA’s caps on damage awards and legal fees have reduced net recoveries (i.e., final judgments minus legal fees) in medical malpractice actions by approximately 15%, with very large awards being affected the most.[39] Proponents of the effectiveness of caps point to the fact that, in the 25 years following the enactment of MICRA, medical malpractice insurance premiums increased by 167% in California, while premiums for the rest of the country rose by 505%.[40] Critics of MICRA argue that the low rate of premium growth in California is largely a result of the passage in 1988 of Proposition 103, which requires the prior approval of property and casualty rates by the state Insurance Department.[41] Critics also contend that MICRA’s cap on non-economic damages results in inadequate compensation for the most severely injured claimants and that its limitation on legal fees prevents injured individuals from obtaining skilled legal representation.

Because non-economic damage awards exceeding $250,000 are not as common in Vermont as in other parts of the country (i.e., 14 inflation-adjusted payments exceeding $250,000 in the last ten years),[42] caps on non-economic damages would result in modest rather than dramatic short-term premium reductions in this state. Based upon the information collected in the Milliman Data Call, a $250,000 cap on non-economic damages in Vermont may be expected to result in approximately a 5.7% decrease in medical malpractice premiums, assuming that all savings are passed along to Vermont health care providers.[43] Caps on non-economic damages of $100,000 and $500,000 may be expected to result in decreases in medical malpractice premiums of approximately 9.9% and 2.2%, respectively.

It should be noted that because the Vermont capping analysis used 364 claims rather than the 1,084 claims required for full credibility under industry standards, the credibility of the projected rate reductions is approximately 60%.

Not all respondents were able to provide a distinction between the economic and non-economic portions of awards and settlements.

On November 16, 2004, the Committee asked the Presidents of the two largest Vermont malpractice writers for their opinions on damage caps. *See Exhibits 53 – 55.* Dr. Patrick Dowling, President and CEO of Medical Mutual Insurance Company of Maine, testified that a $250,000 cap on non-economic damages would not have any immediate impact on premiums. Mr. Richard Brewer, President and CEO of ProMutual Insurance Group, indicated that "MICRA-like reforms" would have very little impact in Vermont. Mr. Brewer also indicated that due to the long tail nature of malpractice claims, reforms tend not to result in premium decreases, but rather to lead to smaller increases going forward.

B. Committee Vote

Would caps on damages in medical malpractice actions affect insurance costs for Vermont health care providers?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Have caps in other states affected insurance costs for health care providers in those states?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

VI. Is it feasible for the state to provide some assistance to health care providers who have particularly high insurance costs?

A. General Discussion

Section 292(c)(6) of the Act directed the Committee to consider "whether it would be feasible for the state to provide some assistance to health care providers who have particularly high insurance costs, and how such a system would operate." This issue was considered by the Committee on March 30, 2005. Meeting materials can be found at *Exhibit 73 – 84.*

Some observers have expressed concern that if medical malpractice liability insurance costs in Vermont become too expensive, physicians may choose not to practice in the state, resulting in health care access challenges, especially in rural areas. In order to ascertain whether this phenomenon was occurring, the Committee reviewed physician populations in Vermont, by specialty and county.

Tables 6.1 through 6.6 below show the number of Vermont direct patient care physicians for select specialties by county by year from 2000 to 2005. *Exhibit 85* shows the number of Vermont direct patient care physicians on a per capita basis for the same select specialties by county by year for the years 2000 to 2005. This data indicates that the Vermont physician population remains relatively stable both by specialty and by county and that, despite anecdotal evidence to the contrary, physicians are not leaving the state in either rural or urban areas.

Table 6.1						
	Number of Physicians—Pediatrics					
County	2000	2001	2002	2003	2004	2005
Addison	14	15	13	12	11	11
Bennington	4	4	5	4	4	4
Caledonia	5	5	5	4	3	3
Chittenden	49	49	47	47	48	48
Essex	0	0	0	0	0	0
Franklin	6	6	7	9	10	10
Grand Isle	1	1	1	0	0	0
Lamoille	3	2	2	2	2	2
Orange	5	7	7	7	8	8
Orleans	2	2	3	3	3	3
Rutland	7	9	8	8	7	7
Washington	7	7	7	8	7	7
Windham	10	9	11	11	12	12
Windsor	12	12	12	11	11	11
Total	**125**	**128**	**128**	**126**	**126**	**126**

Table 6.2						
	Number of Physicians—Emergency Medicine					
County	2000	2001	2002	2003	2004	2005
Addison	3	4	4	5	6	6
Bennington	8	8	7	6	6	6
Caledonia	1	1	2	2	2	2
Chittenden	15	18	19	21	20	19
Essex	0	0	0	0	0	0
Franklin	0	1	1	0	0	0
Grand Isle	0	0	0	0	0	0
Lamoille	5	5	5	7	5	5
Orange	0	0	2	2	1	1
Orleans	3	2	3	3	3	3
Rutland	10	8	11	13	15	16
Washington	5	6	8	7	6	6
Windham	1	1	1	2	0	0
Windsor	0	2	1	2	2	2
Total	**51**	**56**	**64**	**70**	**66**	**66**

Table 6.3						
	Number of Physicians—Family Practice					
County	2000	2001	2002	2003	2004	2005
Addison	27	29	32	33	32	32
Bennington	22	24	24	30	37	36
Caledonia	20	20	21	18	18	20
Chittenden	154	157	166	188	183	183
Essex	1	2	2	2	1	1
Franklin	12	15	15	16	14	14
Grand Isle	4	3	2	2	2	2
Lamoille	18	18	25	26	25	24
Orange	16	19	16	16	11	11
Orleans	13	19	18	19	20	20
Rutland	41	47	47	50	52	52
Washington	42	51	50	50	50	50
Windham	27	30	31	33	38	39
Windsor	49	53	54	55	54	54
Total	**446**	**487**	**503**	**538**	**537**	**538**

Table 6.4						
	Number of Physicians—OB/GYN					
County	2000	2001	2002	2003	2004	2005
Addison	4	3	3	3	3	3
Bennington	4	4	5	6	6	6
Caledonia	3	3	3	2	2	2
Chittenden	28	27	28	30	31	31
Essex	0	0	0	0	0	0
Franklin	4	4	4	5	5	5
Grand Isle	0	0	0	0	0	0
Lamoille	1	1	1	2	2	2
Orange	5	6	3	3	3	3
Orleans	2	2	2	2	2	2
Rutland	6	6	6	6	6	6
Washington	5	6	7	7	6	6
Windham	4	5	5	5	5	5
Windsor	6	6	6	4	5	6
Total	**72**	**73**	**73**	**75**	**76**	**77**

Table 6.5						
	Number of Physicians—General Surgery					
County	2000	2001	2002	2003	2004	2005
Addison	4	5	4	5	4	4
Bennington	6	6	6	5	6	6
Caledonia	2	3	2	3	3	3
Chittenden	17	21	21	21	21	21
Essex	0	0	0	0	0	0
Franklin	6	7	7	7	7	7
Grand Isle	0	0	1	0	1	1
Lamoille	2	2	2	3	3	3
Orange	1	2	2	2	2	1
Orleans	1	2	2	2	2	2
Rutland	7	6	6	5	6	6
Washington	6	7	7	9	9	9
Windham	5	5	4	3	5	5
Windsor	9	10	9	10	10	10
Total	**66**	**76**	**73**	**75**	**79**	**78**

Table 6.6						
	Number of Physicians—Orthopedic Surgery					
County	2000	2001	2002	2003	2004	2005
Addison	2	2	3	4	3	3
Bennington	3	4	4	4	4	4
Caledonia	2	2	2	2	2	2
Chittenden	15	15	15	17	19	19
Essex	1	1	0	0	0	0
Franklin	1	2	2	2	2	2
Grand Isle	0	0	0	0	0	0
Lamoille	1	1	2	2	2	2
Orange	1	1	1	1	1	1
Orleans	1	1	2	2	1	1
Rutland	5	6	6	6	6	6
Washington	4	5	5	5	5	5
Windham	3	5	5	5	5	5
Windsor	4	3	5	5	5	5
Total	**43**	**48**	**52**	**55**	**55**	**55**

Table 6.7						
	Number of Physicians - Total for Selected Specialties					
County	2000	2001	2002	2003	2004	2005
Addison	54	58	59	62	59	59
Bennington	47	50	51	55	63	62
Caledonia	33	34	35	31	30	32
Chittenden	278	287	296	324	322	321
Essex	2	3	2	2	1	1
Franklin	29	35	36	39	38	38
Grand Isle	5	4	4	2	3	3
Lamoille	30	29	37	42	39	38
Orange	28	35	31	31	26	25
Orleans	22	28	30	31	31	31
Rutland	76	82	84	88	92	93
Washington	69	82	84	86	83	83
Windham	50	55	57	59	65	66
Windsor	80	86	87	87	87	88
Total	**803**	**868**	**893**	**939**	**939**	**940**
*Pediatrics, Emergency Medicine, OB/GYN, Family Practice, General Surgery, Orthopedic Surgery						

Table 6.8						
	Number of Physicians - Total for All Specialties					
County	2000	2001	2002	2003	2004	2005
Addison	69	73	73	78	76	75
Bennington	88	95	98	108	110	109
Caledonia	46	48	49	45	39	41
Chittenden	570	591	617	664	653	651
Essex	3	4	3	2	1	1
Franklin	42	48	53	54	53	53
Grand Isle	8	11	9	7	8	8
Lamoille	49	45	49	57	52	50
Orange	41	47	46	45	41	40
Orleans	28	38	44	43	45	46
Rutland	127	141	142	145	155	156
Washington	116	131	132	133	128	129
Windham	97	105	102	103	104	105
Windsor	126	145	145	131	125	127
Total	**1,410**	**1,522**	**1,562**	**1,615**	**1,590**	**1,591**

Vermont's physician population on a per capita basis appears to be higher than the national average. On a statewide basis, as of 2002, Vermont had 2.53 physicians per 1,000 population and 1.99 full time equivalent (FTE) physicians per 1,000 population, as compared to the corresponding countrywide averages of 1.98 and 1.60. Although Vermont's per capita averages are below those of Connecticut, Massachusetts and New York, they are above comparable figures for Rhode Island, Maine and New Hampshire.[44] According to the Health Resource Allocation Plan for the State of Vermont, adopted on August 2, 2005, 4 out of 13 Vermont Hospital Service Areas are categorized as having serious shortages of primary care physicians. Those include the Morrisville, Newport, St. Albans and White River Junction Health Service Areas.

Several potential mechanisms have been used by other states to address rising premiums and diminishing physician populations. These include the use of excess funds, tax credits, incentives to reduce insurance rates, and low interest loans. Such mechanisms have been funded by these other states in a variety of ways, including assessments (on hospitals, doctors, or different types of insurers) or taxes.

1. Excess Funds

"Excess funds" provide insurance coverage for losses above a specific dollar amount (e.g., $1 million). The most common type of excess fund is known as a Patient Compensation Fund (PCF). Some PCFs require premiums to be paid by the physician policyholders, whereas others are funded by assessments or taxes on outside sources. Even in states where excess funds are supported by premiums paid by the medical profession itself, they require a substantial capital infusion in the start-up phase or in the event that annual losses exceed fund reserves. Moreover, in order to be successful, an excess fund requires an annual premium base large enough to pay the losses that are passed on to the fund. This may be problematic in a small state like Vermont.

Two Northeast states have implemented excess funds with mixed results. In 2003, Pennsylvania established the Medical Care Availability and Reduction of Error Fund (MCARE Fund), an excess fund providing coverage for certain types of doctors for losses ranging from $500,000 to $1 million. The MCARE Fund is funded in part by cigarette taxes, but presently is running a deficit. Similarly, in 1986, New York created an excess fund, funded initially by health insurers and now by tax revenue, which provides coverage in excess of $1.3 million at no charge to doctors. The New York fund is also in deficit. Pennsylvania and New York's medical malpractice liability premiums are still higher than Vermont's. *See Exhibit 48.*

2. Tax Credits

Some states provide tax credits to reduce the net cost of malpractice insurance for certain health care providers. In West Virginia, the state granted a tax credit of up to 10% of the actual annual premium, subject to a cap based on the average premium for the specific specialty.[45] It should be noted, however, that the West Virginia tax credits were a temporary measure that was implemented for a two-year period from 2002 to 2004.

3. Reinsurance

In response to coverage availability limitations and concerns about resulting health care access, Oregon recently adopted a reinsurance program that seeks to reduce malpractice premiums for doctors who spend more than 60% of their practice in qualifying rural areas.[46] The Oregon program is intended as a temporary measure and is scheduled to expire on December 31, 2007. Insurers are not required to participate in the program, but those that do[47] must reduce the rates they charge to qualifying doctors and are reimbursed for the reduction by the state's workers compensation fund ("SAIF"). This approach may not be effective in Vermont because of the absence of a funding source comparable to the Oregon Workers' Compensation fund and because the high market concentration in this state would leave the program vulnerable to a decision by a large insurer not to participate.[48] Further, the Committee did not review any empirical data indicating that in Vermont medical malpractice liability coverage in rural areas has been less available than in urban areas.

4. Low interest loans

In an attempt to address insurer insolvencies and the withdrawal of carriers from the market, Wyoming has passed legislation that provides low interest loans to help doctors pay for their medical malpractice premiums. In order to qualify, the physician must agree to practice in Wyoming for at least three years and provide services to residents who qualify for Medicaid or Kidcare (Wyoming's child health insurance program).

In general, when states have chosen to provide assistance to health care providers, it has been in response to a specific issue or issues, such as high medical malpractice premiums relative to other states, insurance carriers leaving the market, a decline in physician population, or other health care access issues. As noted above, premium rates are relatively low in Vermont and the physician population appears to be stable. In addition, although the medical malpractice insurance market in Vermont is highly concentrated, with the top five carriers writing 86% of the premium, there is no evidence at this time that any insurance companies plan to discontinue writing business in the state.[49] Thus, despite the withdrawal of two large carriers from the Vermont market during the past five

years (PHICO and St. Paul), it appears that medical malpractice coverage is currently available in Vermont and will continue to be for the foreseeable future.

B. Committee Vote

Should the state provide some assistance to health care providers who have particularly high insurance costs?		
VOTE SUMMARY: Yes—2; No—3; Abstain—2		
Committee Member	**Yes**	**No**
BISHCA	ABSTAIN*	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	ABSTAIN	

*BISHCA abstains and supports recommendations recently made by the Health Care Workforce Development Partnership and HRAP on this issue.

VII. Is it feasible to create a fixed compensation system for medical malpractice cases based on pre-set payment amounts for particular types of injuries?

A. General Discussion

Section 292(c)(7) of the Act directed the Committee to consider "whether it would be feasible to create a fixed compensation system for medical malpractice cases based on pre-set payment amounts for particular types of injuries, including how such a system would operate and whether it would have an impact on medical malpractice insurance costs". This issue was considered by the Committee on September 29, 2004 and October 27, 2004. Relevant materials are attached as *Exhibits 31 – 33, 42 and 43.* Additionally, Harvey Yorke, President and CEO of Southwestern Vermont Health Care presented his proposal on a fixed compensation system at the October 27, 2004 meeting. An outline of Mr. Yorke's proposal is attached as *Exhibit 36.*

A fixed compensation system is a term typically used to describe a system which provides compensation to injured parties without regard to fault or negligence and in lieu of access to the court system. No fault fixed compensation systems are used for workers compensation claims in the U.S. and are used to resolve medical malpractice claims in Australia, New Zealand and Sweden.

Opponents of fixed compensation systems argue that they deprive injured parties of their right to a jury trial and fail to deter medical errors. Proponents of fixed compensation systems argue such systems actually help to prevent medical errors because they can be devised to promote the critical examination of adverse events and, further, that the traditional tort system is highly inefficient in providing compensation for those harmed by medical error.[50]

In the United States, there are some examples of this type of system being used for specific types of catastrophic medical injuries on a limited basis. By removing these large claims from the system, it is hoped that insurance costs can be stabilized. However, evidence that such systems have stabilized insurance rates is lacking.

In the 1980's, Virginia established the Birth-Related Neurological Injury Compensation Fund (the "Birth Injury Fund") to increase malpractice liability insurance availability for obstetricians, and in turn, to encourage obstetricians to continue practicing, particularly in rural areas.[51] Families of qualifying infants receive lifetime compensation for medically reasonable and necessary expenses relating to the injury, but do not have the right to sue the obstetrician involved in the birth.

The Birth Injury Fund provides compensation only for medical injuries of infants who suffer severe neurological damage due to oxygen deprivation or mechanical injury to the brain or spinal cord during birth, provided the doctor is a participant in the program. [52] Compensation from the fund is determined on a no-fault basis, meaning that a finding of fault is not necessary to qualify for compensation. If the doctor or hospital do not participate in the program, or the child's injuries do not qualify for the program, a traditional medical malpractice lawsuit is still an option.

The Birth Injury Fund pays for only "medically necessary and reasonable expenses" and is provided on a reimbursement basis, after collateral sources are used. Funding is provided by assessments on hospitals, doctors and the insurance industry. It also provides payments (in regular installments) for loss of earnings from age 18 to 65 and reimbursement of reasonable expenses incurred in connection with filing a claim.[53] Physician participation in the program is voluntary. Claims for compensation are made to, and awarded by, the Virginia Workers' Compensation Fund.

Although premiums for Virginia obstetricians fell after the implementation of the fund, it is difficult to quantify the impact the creation of the Birth Injury Fund had on premium rates because Virginia also employs other tort reform measures, such as caps on damages.[54] The Virginia Joint Legislative Audit and Review Committee concluded that the Fund had a positive impact on insurance availability, but has had mixed success in meeting some of its objectives. For example, although the limited data available suggests that premiums have been

stabilized, it is not clear that the Birth Injury Fund's existence has had a significant impact on the availability of obstetric services in the state or that, when coupled with the assessments necessary for funding, much money has been saved by health care providers.[55]

Similar to Virginia, in 1988 Florida established the Birth-Related Neurological Injury Compensation Association. Unlike the voluntary nature of the Virginia program, hospital participation in the Florida program is mandatory. The Florida program is funded through assessments on hospitals.[56]

Another example of a no fault system in use in the United states, is the National Vaccine Injury Compensation Program (VICP), established by the federal government and designed to compensate individuals and their families for injuries resulting from childhood vaccines. The legislative intent was to "ensure an adequate supply of vaccines, stabilize vaccine costs, and to establish and maintain an accessible and efficient forum for individuals thought to be injured by childhood vaccines."[57] The program is mandatory, but injured patients can file suit if their claim is rejected or they disagree with the outcome. Under VICP, initially the number of lawsuits dropped, but over time more claims were rejected and lawsuits rose again.

In addition to no fault, fixed compensation systems, some parties are advocating for "health courts" which would require a finding of fault in order for compensation to be granted, but would use a set schedule of payments for injury compensation rather than allow a jury to award damages. Common Good, a legal reform coalition, and the Harvard School of Public Health are developing a prototype for a medical injury compensation system that would include specialized administrative courts and will include study of the New Zealand and Swedish systems.[58] In 2005, U.S. Representative Mac Thornberry of Texas introduced legislation to create such courts on a pilot project basis.[59]

As presently envisioned, the "health court" concept would include dedicated judges to hear medical malpractice cases, independent medical experts, no jury trials, a set schedule of benefits and limited appeal rights for both claimants and defendants.[60] Proponents claim that such a system would provide for much swifter resolution of cases, allow people with smaller claims access to compensation, reduce administrative costs associated with a claim and allow health care providers to improve patient safety by creating a coherent body of decisions regarding the appropriate standard of care and facilitating critical analysis of medical errors. Opponents claim that such a system would favor defendants and deprive claimants of the constitutional right to a jury trial.[61]

While adoption of a fixed compensation system for medical malpractice is possible, it is mostly untested in the U.S. When contemplating such a system, the following related issues should be considered: 1) whether there are constitutional or moral limitations on depriving a claimant a right to a jury trial; 2) the

parameters of coverage offered by such a system; 3) how compensation schedules would be established and maintained; 4) how to avoid complicated and potentially biased relationships among those involved with the system (a particularly tricky problem in a state as small as Vermont); and 5) ways to integrate the system into an effective patient safety system. Some of these issues are intended to be addressed by the Harvard project.

B. Committee Vote

Should the Legislature create a fixed compensation system for medical malpractice cases based on pre-set payment amounts?		
VOTE SUMMARY: Yes—1; No—6		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association		X

VIII. Can and should the state require insurers to base their rates on claims experience in Vermont?

A. General Discussion

Section 292(c)(8) of the Act directed the Committee to consider "whether the state can and should require insurers to base their rates on claims experience in Vermont." The Committee reviewed information about ratemaking at the August 24, 2004, September 29, 2004 and November 16, 2004 meetings. Relevant meeting materials can be found at *Exhibits 16, 30 and 48.*

In general, when an insurance company establishes its medical malpractice premium rates in a particular state, it reviews its historical premium and loss experience in that state for the most recent five years. If a carrier finds this loss experience fully credible, the carrier will utilize that loss experience exclusively in developing its rates. "Credibility," as used in the actuarial sense, "reflects the degree of belief that the entity's experience is a valid predictor of future costs."[62] Thus, if the loss experience is based on sample sizes which are too small to be considered fully credible, carriers must look at loss experience in other similar markets in order to more accurately predict future costs.

The total 2003 medical malpractice insurance premium written by traditional insurance companies in Vermont is $16.6 million, with the largest insurer writing premium of $5.9 million.[63] In Vermont, at the present time, every

insurance company's historical Vermont experience is not sufficient enough to be fully credible when establishing rates. Because of the high concentration of market share in two dominant carriers, most Vermont medical malpractice insurers annually write less than $500,000 in premium and offer policy limits of $1 million on a per occurrence basis.[64] The inclusion of just one large loss in the most recent five years of loss history could significantly impact rates.

Because the Vermont medical malpractice insurance market is presently comprised entirely of insurers whose Vermont experience is not fully credible, requiring insurance companies in Vermont to base rates solely on Vermont experience is problematic for two reasons. First, if carriers were forced to rely exclusively on Vermont experience, rates would fluctuate dramatically, both up and down as Vermont losses fluctuated. Thus, this requirement would not positively control insurance costs for health care providers. Further, regulating rate making at this level and forcing companies to disregard actuarial principles could lead to insurance companies leaving the Vermont market because carriers would likely perceive such state intervention in pricing structure as potentially preventing them from charging appropriate rates.

Medical malpractice rates are subject to state oversight. In Vermont, claims-made medical malpractice insurance rates must be filed and approved before use. BISHCA must approve rates prior to use and is required by statute not to approve rates which are excessive, inadequate or unfairly discriminatory (8 V.S.A. § 4688a). Typically, in reviewing such rates, BISHCA engages an actuary to analyze the rates prior to approval; rate filings are highly technical and require technical expertise to interpret. It does not appear that any other state requires carriers to rely exclusively on state-specific loss experience.

B. Committee Vote

Should the Legislature require insurers to base their rates on claims experience in Vermont?		
VOTE SUMMARY: Yes if actuarially sound—2; No—5		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X*	
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association	X*	
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association		X

* VMS and VTLA only support rates exclusively based on claims experience in Vermont if it is actuarially sound.

IX. Should a Vermont health care facility which obtains medical malpractice insurance from a captive insurance company be required to do so with a Vermont-based captive insurer?

A. General Discussion

Section 292(c)(9) of the Act directed the Committee to consider "whether a Vermont health care facility which obtains medical malpractice insurance from a captive insurance company should be required to do so with a Vermont-based captive insurer." This issue was considered by the Committee on October 27, 2004 when BISHCA's Director of Captives, Derick White, testified before the Committee.

Captive insurance refers to a subsidiary corporation established to provide insurance to the parent company and its affiliates. The forming of a captive allows an entity to take financial control and manage risks. Advantages of forming a captive include: coverage can be tailored to meet the specific entity's needs, operating costs can be reduced, captives can allow funding and underwriting flexibility which may not be available in the traditional market and can allow for more ability to introduce incentives and flexibility in loss control. For these reasons and others, forming a captive insurance company has been an attractive option for many health care entities. It should be noted that although captives do offer increased flexibility in managing risk, forming a captive insurance company does not guarantee lower insurance costs.

Derick White, Vermont's Director of Captives, addressed the Committee regarding this issue. Mr. White explained that a captive is an entity or group of entities that form its own insurance company. Mr. White testified that, while Vermont should encourage the consideration of captives and risk retention groups as an alternative to traditional carriers, Vermont should not mandate that Vermont health care facilities can only obtain a Vermont captive license.

Mr. White explained that different jurisdictions have different regulatory requirements for forming a captive. Vermont has certain capital requirements that some Vermont health care facilities may be unable to meet. By forcing facilities to utilize only the Vermont framework, certain entities would be unable to take advantage of captives or risk retention groups.

Mr. White also testified that Vermont has a robust captive regulatory program which licenses many entities from other states. Requiring Vermont medical facilities to license only in Vermont could trigger other states to pass similar retaliatory legislation which could hurt Vermont's captive program. Mr. White testified that Vermont's captive program stands to lose far more than it would potentially gain by forcing Vermont medical facilities to use the Vermont program.

B. Committee Vote

Should a Vermont health care facility which obtains medical malpractice insurance from a captive insurance company be required to do so with a Vermont-based captive insurer?		
VOTE SUMMARY: Yes—0; No—7		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society		X
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association		X

X. Should efforts be undertaken to reduce the incidents of medical malpractice through the underwriting process?

A. General Discussion

Section 292(c)(10) of the Act asked the Committee to consider "whether any efforts have been or should be undertaken to reduce the incidents of medical malpractice through the underwriting process." This issue was considered by the Committee on January 26, 2005. January meeting materials can be found at *Exhibits 56 – 64.* On behalf of the Committee, Milliman solicited data from nine of the top ten carriers writing business in Vermont regarding the underwriting guidelines presently in place.

Of these nine carriers, eight have written underwriting guidelines. These guidelines allow carriers to modify the rates charged to a policyholder based upon the policyholder's own experience.

Some insurance companies use a Schedule Rating Plan to modify rates through the application of a system of debits and credits to the base rate. In theory, these credits and debits are based upon the risk characteristics and actual loss experience of the policyholder and could motivate policyholders to modify behavior in order to lower the applicable rates. Seven of the Vermont carriers responding to the Milliman data call indicated having such a debit/credit system in place. Credits are given for such things as the existence of effective risk management programs, loss history or meeting continuing education requirements. For example, a company might offer an individual physician a certain percentage discount for each consecutive year the physician is loss free and insured by the insurance company. Debits are applied for such things as

frequent movement from state to state or practice to practice, loss history, lacking board certification or having an excessive patient load.

However, the Committee heard anecdotal evidence from the Vermont Medical Society and an insurance producer familiar with the market that, in practice, the utilization of these underwriting policies is often driven more by market competition than by the actual experience of the policyholder. That is, when there is less competition in the marketplace and rates are rising, the use of credits is less and the use of debits is more. Conversely, when the trend is toward reducing rates in the marketplace, the use of credits is more and the use of debits is less.

Insurance pricing is cyclical, with the last five years characterized by significant annual rate increases. Based on anecdotal evidence, due to the present insurance cycle of continuing increasing rates, the current marketplace appears to provide very limited credits to physicians anywhere, including Vermont. The phasing out of these debits and credits, along with base rate increases, has caused some individual doctors' premiums to increase more dramatically than others.

B. Committee Vote

Should efforts be undertaken to reduce the incidents of medical malpractice through the underwriting process?		
VOTE SUMMARY: Yes—5; No—2		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association		X

XI. Whether insurance reforms will have a positive impact on medical malpractice insurance costs?

A. General Discussion

Section 292(c)(11) of the Act directed the Committee to consider "whether insurance reforms would have an impact on medical malpractice insurance costs, including such reforms as improved experience rating, public involvement in rate proceedings, compressing rate classifications, state reinsurance pools, improved self-insurance opportunities, and disclosure of insurers' investment and dividend

income to policyholders." This issue was considered by the Committee on March 30, 2005. Meeting materials can be found at *Exhibits 73 – 84.*

The following is a brief discussion of the reforms identified by the Legislature in this section.

1. Improved Experience Rating

"Experience rating" refers generally to the statistical procedure used to calculate a premium rate based on the loss experience of an insured group.[65] Major carriers writing business in Vermont currently utilize experience rating when writing coverage for larger risks.[66] Experience rating is typically applied to larger risks (such as physician groups and hospitals), but claims-free discounts may be applied to individual doctors.[67] Based on the evidence available, the methodology used by carriers in calculating experience rating, in Vermont and other states, does not appear to be in need of improvement, legislatively or otherwise.

2. Public Involvement in Rate Proceedings

The setting of medical malpractice premiums is a highly technical and actuarial process that does not lend itself to opinion-based analysis. Most states do not have public involvement in rate proceedings. Washington, California and some states that run patient compensation funds allow public involvement in rate proceedings. Based on anecdotal evidence from individuals involved in those systems, it is not clear if public involvement in rate proceedings would alter the ratemaking process or have an impact on carriers' rates. Anecdotally, it has been suggested that in states allowing public involvement in rate proceedings requested rate increases tend to be below threshold levels set to trigger public involvement.[68]

For example, as part of Proposition 103, California implemented procedures allowing for public participation in the rate review process.[69] For rate increases of less than 7% (7% for personal lines and 15% for commercial lines), the Commissioner of Insurance has the discretion of allowing or rejecting public intervention. For rate increases above the 7% and 15% thresholds, the Commissioner of Insurance has no discretion and the public can intervene as a matter of right. Based on a February 17, 2005 conversation with personnel from the California Insurance Department (San Francisco Rate Filing Bureau Chief), there have been only a handful of public interventions over the past five years, all brought by the same party—the Foundation for Tax and Consumer Rights.[70]

Under 8 V.S.A. § 4688(e), medical malpractice insurance premium increases for claims-made policies are open to public inspection *only after* the Department has approved the rate increase. Thus, under current Vermont law, the public has no opportunity to formally know of a proposed rate increase and provide

comment. Legislation supported by the VMS (H.329/S.149) has been introduced that would allow the public to view any proposed medical malpractice rate increase prior to approval by BISHCA.[71]

3. Compressing Rate Classifications

Compressing rate classifications refers to the process of combining classifications of physicians for cross-subsidization of experience. Under such a system, for example, high-risk specialties (such as OB/GYNs) would have rates, in essence, subsidized by lower risk specialties (such as family practitioners).

Wisconsin's Patient Compensation Fund utilizes compressed rate classifications for its excess coverage, resulting in the cross subsidization of rates among classifications of physicians.[72] That is, physicians in lower rated classes pay more than their indicated base rate in order to help reduce the rates charged for the higher rated classes of doctors. If not funded by an outside source, adoption of this measure would result in lower rate payers subsidizing the premiums of higher rate payers (e.g., a rural general practitioner's rates would go up in order to subsidize an OB/GYN in an urban area).

4. State Reinsurance Pools

A state reinsurance pool refers to a state-run or mandated pool that reinsures the risk of a state's medical malpractice insurance companies. Commentators have typically discussed state reinsurance pools within the context of small group health insurance where the state reinsurance pool is intended to stabilize the market for small group health insurers.[73]

Currently, there is only one state reinsurance pool for medical malpractice—Oregon—which is discussed in conjunction with Issue 6 above. The mechanism most closely resembling a reinsurance pool utilized in medical malpractice liability is the patient compensation fund (PCF). PCFs are also discussed in Issue 6 above. Conceptually, a state reinsurance pool for medical malpractice insurance might be used to provide reinsurance to carriers for the very largest judgments or the highest risk specialties. The availability of such reinsurance may stabilize rates by mitigating the impact of the largest risks. Difficult questions remain, however, concerning funding and eligibility.

5. Improved Self-Insurance Opportunities

Self-insurance opportunities include self-insurance or the use of captives. Currently, large hospitals are using these options in Vermont. The Committee also heard testimony from the BISHCA Captives Division indicating that Vermont has licensed captives which might be available to write smaller rural hospitals. Although in the past there have been limitations on insuring doctors who had privileges at a specific hospital, but who were not directly employed by the

hospital, the Committee heard testimony indicating that such limitations have eased in recent years. As such, hospitals are able to extend coverage to doctors who are not only employed by the hospital, but also those doctors who have admitting privileges.

However, without access to a large group such as a hospital, most individual doctors in Vermont do not have meaningful self-insurance opportunities. The Vermont Medical Society has indicated that the formation of a captive is not a viable option for individual doctors at this time, in large part due to the initial start up capital requirements.

6. Disclosure of Insurers' Investment and Dividend Income to Policyholders

Disclosure of investment and dividend income is already required by the National Association of Insurance Commissioners (NAIC) and is reported in detail in the Annual Statements of all insurance companies.[74]

The Committee is unaware of any states that require specific proactive disclosure of this type of information to policyholders. However, this information is available to any policyholder that requests it.

B. Committee Vote

Should the Legislature require improved experience rating?		
VOTE SUMMARY: Yes—2; No—5		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society		X
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman		X
American Insurance Association		X

Should the Legislature require public involvement in medical malpractice liability insurance rate proceedings?		
VOTE SUMMARY: Yes—6; No—1		
Committee Member	**Yes**	**No**
BISHCA	X*	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association		X

*****BISHCA supports transparency by letting the public know when rate filings are made and the amount of a requested change.

Should the Legislature require compressed rate classifications?		
VOTE SUMMARY: Yes—0; No—7		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society		X
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association		X

Should the Legislature implement a state reinsurance pool for medical malpractice liability insurers?		
VOTE SUMMARY: Yes—2; No—5		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association		X

Should the Legislature take steps to improve self-insurance opportunities?		
VOTE SUMMARY: Yes—6; No—0; ABSTAIN—1		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association	ABSTAIN	

Should the Legislature require disclosure of insurers' investment and dividend income to policyholders?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association		X

XII. Is Legislative action advisable in the area of medical malpractice actions?

A. General Discussion

Section 292(c)(12) of the Act directed the Committee to consider "whether legislative action is necessary or advisable in the area of medical malpractice actions, and, if so, particular recommendations for legislation." Much of the Committee's work touched on this issue. Additionally, this issue was specifically considered by the Committee on April 27, 2005. Relevant exhibits include *Exhibits 10 – 12,14, 56, 60, 67, 86 – 96.*

Caps on damages is a legislative action in the area of medical malpractice actions; that issue is discussed in Section V. above. The impact of legislative actions in the area of medical malpractice actions can be difficult to quantify because so often these statutes are passed as part of an overall reform package, thus making it challenging to isolate the impact of any one statutory action.

The following discusses potential legislative actions on which the Committee voted. Attached as *Exhibit 122* is a list of other potential malpractice actions reforms that the Committee did not consider in depth, but which have been the subject of some discussion nationally.

1. Revision of the Collateral Source Rule

The collateral source rule is a judicial procedural rule which provides that evidence of sources of compensation other than from the defendant (such as health insurance or Medicaid) cannot be presented to a jury, and that such compensation shall not be deducted from the damages awarded by the jury to the plaintiff for his or her injuries. Vermont presently employs the collateral source rule, although the Committee heard evidence from the attorneys on the Committee that most typical collateral sources obtain reimbursement from awards made to the plaintiff.

Some states have abolished or modified this rule in order to allow for the recognition of these other sources of compensation when deciding the amount to be awarded to a plaintiff. The collateral source rule is typically a priority measure sought by tort reform advocates.

Research on the effectiveness of abolishing the collateral source rule is scant and study results conflict.[75]

2. Establish More Specific Expert Witness Rules

By statute, expert witnesses in Vermont must be qualified by "knowledge, skill, experience, training or education" and their testimony must be based upon sufficient facts, be the product of reliable principles and methods, and the expert must have applied the principles and methods reliably to the case.[76] Further, Vermont courts have adopted the criteria set out by the United States Supreme Court for allowing expert testimony in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). Under *Daubert*, before admitting expert testimony, the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but also reliable (509 U.S. at 589).

Some states require that experts must be board certified or actively practicing in the area in which they are going to testify. Some have advocated for court appointed independent expert witnesses to mitigate bias in expert witness testimony.[77] Plaintiffs' attorneys, however, worry that doctors have an inherent tendency to protect their colleagues and that a court appointed independent expert may not be as independent as he or she should be.

The Committee did not review data indicating there is a problem with unqualified experts testifying in Vermont medical malpractice cases.

3. Elimination of Joint and Several Liability

The common law rule of joint and several liability holds each defendant responsible for the full amount of the plaintiff's damages, regardless of that defendant's proportion of fault. In order for joint and several liability to apply, the defendants must be jointly liable for the plaintiff's injury. Some states have eliminated this rule or implemented a statutory threshold (such as 50%) that must be exceeded before a defendant can be liable for all of the plaintiff's damages.

Proponents believe elimination of this rule will stop plaintiffs from going after "deep pockets", while opponents are concerned that injured parties may not be adequately compensated if this rule is abolished.

Vermont has joint and several liability, although in situations with multiple defendants the plaintiff's comparative negligence can work to reduce each defendant's liability. However, according to attorneys on the Committee, comparative fault principles do not often come into play in medical malpractice actions.

4. Limits on Plaintiffs' Attorney Fees

Limits on lawyer contingency fees have been enacted in some states, such as California, in an attempt to reduce the number of medical malpractice cases filed. Proponents argue that such limits prevent frivolous lawsuits and ensure that plaintiffs receive adequate compensation. Opponents believe such limits interfere with a person's freedom to contract and limit plaintiffs' access to qualified counsel. The Committee heard no testimony indicating that lawyers in Vermont are collecting unreasonably large contingency fees.

The RAND Corporation's study of the California MICRA reforms found that while attorney fees were reduced in total by 60% from the impact of both caps on non-economic damages and limits on attorney fees, 46% of this 60% was due to the limits on attorney fees.[78] The RAND study also found that had caps been implemented with no fee limits, plaintiffs' net recoveries would have been reduced by 30%, whereas with caps and corresponding fee limits, net recovery was reduced by 15%.[79] The study further noted that fee limits appeared to impact the net recoveries of those plaintiffs with larger non-economic damages awards.[80]

5. Periodic Payments of Damages

Traditionally, damages awarded to a plaintiff are paid in one lump sum, although a lump sum payment is often reduced to the present value of the award (to the extent the award compensates the plaintiff for future economic or other damages). "Periodic payments" typically refers to allowing defendants to pay damage awards over a period of time, often through the purchase of an annuity,

thus reducing overall cost to the defendant. Periodic payments allow malpractice insurers to reduce costs by spreading the payments over time or potentially returning unused portions of the award (for example, if an award were for future medical expenses that did not come to fruition).[81]

In Vermont, periodic payments are not mandatory, although there is no obstacle to voluntary periodic payment structures. According to the Physician Insurance Association of America (PIAA), an insurance trade association, thirty-one states have some rule addressing periodic payment issues.[82]

Proponents of this reform argue that it ensures that a plaintiff will receive a continuing stream of payments and be provided for throughout the duration of the injury and that, by defraying damage costs, it stabilizes the insurance market. Opponents argue that this reform interferes with a person's right to make financial decisions to best protect his or her interests and limits flexibility.

6. Shortening the Statute of Limitations

The statute of limitations is the statutorily prescribed time limit a plaintiff has to bring a claim against a health care provider before the claim is barred. In Vermont, medical malpractice claimants must bring a suit within three years of the treatment or two years of the date the injury is or should have been discovered, but in no event not more than seven years after the date of treatment (12 V.S.A. § 521). However, the statute of limitations does not begin to run for minors until after they have reached the age of majority (12 V.S.A. § 551). Because of this, certain specialties (such as obstetricians) have extremely long risk exposure periods (up to 25 years for delivered patients), thus increasing their overall insurance costs.

Some states have adopted a shorter statute of limitations in an attempt to lessen the burden on health care providers associated with having to maintain insurance on such long-term risks.

7. Establish Pre-Trial Screening Panels

Pre-trial screening panels assess the merits of a case prior to its being filed in court. Several states have enacted pre-trial screening panels. According to the National Conference of State Legislatures (NCSL), 14 states have some form of pre-trial screening available for medical malpractice actions.[83]

Such panels can provide a variety of functions, but most are intended to eliminate frivolous lawsuits before they get to the court system. Panels can be mandatory or voluntary. Some pre-trial screening panels, such as the one in Maine, are more akin to arbitration.[84] For the purposes of this section, "pre-trial screening panels" will refer to more limited panels intended to provide initial case

screening to eliminate frivolous or non-meritorious lawsuits through a limited scope review, such as the panel in Massachusetts.

In Massachusetts, after a malpractice claim is filed, the plaintiff must submit an offer of proof to the panel. Although the panel reviews evidence (such as medical records and expert witness statements), the panel only decides whether or not a legitimate question of liability appropriate for judicial inquiry exists or whether the plaintiff's case is merely an unfortunate medical result.[85] The panel's findings, and expert testimony given before the panel, are admissible in any subsequent court proceeding.

The Committee heard testimony from Vermont state and federal court representatives indicating that medical malpractice cases are not a burden on the court system. The Committee did not receive any data indicating that frivolous lawsuits were a problem in Vermont.

8. Mandatory Arbitration

Arbitration is sometimes called a mini-trial and is intended to allow the merits of a claim to be heard without the expense of trying the case in court or in front of a jury. In this report, the term arbitration differs from a pre-trial screening panel in that an arbitration determines the merits of a case (i.e. was the health care provider negligent and is the plaintiff entitled to an award of damages), whereas a pre-trial screening refers to a panel assessing a more limited issue (such as whether the case has sufficient merit to be allowed to go forward in court).

In some states, arbitration of medical malpractice claims is mandatory, although states differ on the level and type of judicial review available for arbitrated claims. Although not technically arbitration, in West Virginia, upon agreement parties can move filed cases to a quicker and less expensive summary trial.[86] Other states expressly allow parties to sign contracts requiring arbitration of medical malpractice claims prior to treatment. In state court in Vermont, parties can voluntarily agree to arbitrate their case. *See* 12 V.S.A. § 7002 *et seq.*

Proponents claim that arbitration can allow claims to be resolved more quickly and at less cost. Opponents claim that arbitration increases costs, delay resolution of the claim and unfairly and unconstitutionally denies the plaintiff's right to a jury trial.

9. Mediation

Mediation is a formal process whereby the parties attempt to resolve the case working with an independent third party to reach a settlement. Some states have implemented mandatory mediation procedures, specifically aimed at

medical malpractice cases.[87] Some hospitals and other health care entities have mediation programs intended to decrease overall defense costs. The Committee heard testimony that Vermont state and federal courts have successful mediation programs in place for most cases, including medical malpractice cases.

In federal courts in Vermont, parties must participate in an early neutral evaluation procedure, wherein after some initial discovery, the litigants must meet with a neutral evaluator who is knowledgeable in the subject matter of litigation to discuss all aspects of the case.[88] The purpose of the procedure is to provide litigants with an opportunity for realistic settlement negotiations, relatively early on in the process. Even if the case is not settled, the ENE process allows for narrowing the issues, which may help additional discovery and make any trial less costly and more efficient.[89]

In state courts in Vermont, under Vermont Court Rule 16.3, parties in a medical malpractice case must stipulate to some form of alternative dispute resolution, which can include mediation. If the parties cannot agree on a form of alternative dispute resolution, then the court will schedule a preliminary evaluation to assist in the process.[90]

10. Enterprise Liability

Enterprise liability shifts legal liability away from individual doctors to health care institutions. In most models, the health care institution would be exclusively liable for any medical errors committed by the physician while practicing at the institution.

Proponents claim that such a system can increase efficiency in resolving cases and can also insulate doctors from the fear of liability, thus encouraging physicians to disclose errors and examine treatment decisions more objectively and enhance the patient-physician relationship. The Joint Commission on Accreditation of Healthcare Organizations argues that an enterprise liability system promotes institutional safety and has the potential to stabilize liability insurance rates.[91]

The Committee heard testimony from two hospital administrators indicating that the majority of medical errors occur because of systems failures, not necessarily by individual doctor error, and that hospitals often emphasize a team model for treatment and that such focus facilitates patient safety. An enterprise liability system may facilitate such a treatment model. However, enterprise liability does not provide premium relief to doctors who are not affiliated with a hospital.

11. Medical Guidelines

Medical guidelines set practice parameters for certain medical procedures. Although there have been numerous studies of the impact of medical guidelines on the quality of health care,[92] in the medical malpractice liability context medical guidelines are generally understood as providing a statutorily defined affirmative defense from liability for doctors who can show the guidelines were followed.

In the typical traditional malpractice lawsuit, the standard of care applicable to the plaintiff's treatment is an issue litigated through the use of expert testimony, a timely and costly process. Thus, often both parties introduce expert testimony to assist the jury in determining the appropriate standard of care. In the current system, a health care provider may introduce guidelines as evidence of the appropriate standard of care; however, parties may differ regarding the applicability of those standards.

If a specific standard of care (such as one adopted by a specified institution) is defined by statute as an affirmative defense to negligence, the health care provider (and perhaps also the plaintiff) can conclusively establish the applicable standard of care without expert testimony. The litigation then focuses on whether or not the standard of care was followed.

Proponents of medical guidelines as a statutorily defined affirmative defense, claim such guidelines should reduce litigation, decrease the cost of defensive medicine on the health care system, and improve medical outcomes.[93] However, not all treatments are amenable to medical guidelines. Some refer to the use of medical guidelines as "cookbook medicine".

In 1992, Maine implemented a pilot program (the Maine Liability Demonstration Project) to test the use of malpractice guidelines as an affirmative defense, hoping to lower treatment costs and reduce malpractice claims.[94] Under the Maine program, 20 guidelines were adopted in four practice areas (anesthesiology, emergency medicine, obstetrics and gynecology, and radiology). If doctors chose to participate in the program, they could use the guidelines as an affirmative defense in any subsequent litigation, presumably with no or minimal expert testimony. Conversely, the plaintiff could not use the guidelines to show negligence through noncompliance, unless the physician introduced the guidelines first. Doctors participating in the program also had to pledge to limit their use of defensive medicine (thus, presumably, reducing overall health care costs). The Maine program began a five-year test period in 1992 and was expanded in 1996. At the end of 1999, the program was not renewed since no cases were ever filed against participating doctors and the constitutionality of the program was never tested.[95] In 2000, the Maine Superintendent of Insurance, issued an order finding that the medical malpractice professional liability cost savings attributed to the Medical Liability Demonstration Project was zero percent.[96]

B. Committee Vote

Should the Legislature take action in the area of medical malpractice actions?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature abolish the collateral source rule?		
VOTE SUMMARY: No—3; Yes—3; Abstain—1		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	ABSTAIN	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature establish more specific expert witness rules?		
VOTE SUMMARY: No—3; Yes—3; Abstain—1		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	ABSTAIN	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature eliminate joint and several liability?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature place limits on lawyer contingency fees?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature require periodic payments of awards?		
VOTE SUMMARY: No—6; Yes—1		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association		X

Should the Legislature implement statute of limitations changes?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature establish pre-trial screening panels?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature require arbitration of medical malpractice actions?		
VOTE SUMMARY: Yes—4; No—3		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	X	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature place additional mediation requirements on medical malpractice claims?		
VOTE SUMMARY: No—5; Yes—2		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems		X
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

Should the Legislature implement an enterprise liability system for medical malpractice awards?		
VOTE SUMMARY: No—2; Yes—4 (one conditional); Abstain—1		
Committee Member	**Yes**	**No**
BISHCA		X
Vermont Medical Society	X*	
Vermont Association of Hospitals and Health Systems	ABSTAIN	
Vermont Trial Lawyers Association	X	
Vermont Bar Association	X	
Vermont Health Care Ombudsman	X	
American Insurance Association		X

*VMS only supports enterprise liability with the agreement of VHA.

Should the Legislature mandate that accepted medical guidelines be available as an affirmative defense in medical malpractice actions?		
VOTE SUMMARY: Yes—3; No—3; Abstain—1		
Committee Member	**Yes**	**No**
BISHCA	X	
Vermont Medical Society	X	
Vermont Association of Hospitals and Health Systems	ABSTAIN	
Vermont Trial Lawyers Association		X
Vermont Bar Association		X
Vermont Health Care Ombudsman		X
American Insurance Association	X	

XIII. What other issues should the Legislature consider to address the availability or the affordability of medical malpractice insurance in Vermont?

A. General Discussion

Section 292(c)(13) of the Act asked the Committee to consider "any other issues which the committee believes would have an impact on the availability or affordability of medical malpractice in Vermont." Several additional issues that the Committee members felt important to address with respect to the availability and affordability of medical malpractice insurance in Vermont are discussed below.

B. Defensive Medicine/Safety Standards

Some of the debate surrounding medical malpractice liability and tort reform has discussed the theory that health care provider fears related to tort liability motivate such parties to engage in defensive medicine, or the over-utilization of certain diagnostic tests or procedures to reduce liability exposure. Some argue that the use of defensive medicine has contributed to rising health care costs. However, studies conflict regarding the use and impact of defensive medicine.

In January 2004, the CBO issued a report indicating that based on its analysis of existing research, the costs associated with defensive medicine remain unclear and the "CBO believes that savings from reducing defensive medicine would be very small."[97] Similarly, the United States General Accounting Office issued a report concluding that "[a]lthough available research suggests that defensive medicine may be practiced in specific clinical situations, the findings are limited and cannot be generalized to estimate the prevalence and costs of defensive medicine nationwide."[98] The GAO report noted that previous studies had used too small of sample sizes, failed to measure the extent of defensive medicine and account for variations in different clinical areas.[99] The GAO noted that some studies had failed to account for other reasons that excessive procedures might be undertaken (such as profit motive).

Likewise, according to an August 2004 study by the National Bureau of Economic Research: "For the most part, there is little evidence of change in treatment patterns in response to increases in premiums." [100] In addition, "the results...show small and insignificant effects" for most of the treatments studied. However, the study found that "the use of mammography seems somewhat more sensitive to malpractice costs than the other procedures tested."

A February 2000 study by the Stanford Law School concluded: "Malpractice reforms reduced hospital expenditures about 7% in areas with both low and high levels of managed care enrollment, without impacting patient

health." In addition, the study found that "Managed care and liability reforms are substitutes for each other: the reduction in defensive practices through reforms is smaller in areas with high managed care usage."[101]

C. Safe Apologies by Health Care Professionals

There has recently been an increased interest in safe apology laws, one of the legislative initiatives supported by the American Medical Association. Simultaneously, some stakeholders have been studying new approaches to addressing unanticipated medical events that incorporate elements of apology and/or disclosure. Physician safe apology laws permit a medical provider to communicate with patients without those statements being used against him or her in future litigation. Studies show that such statements can lessen the chances a patient will file a lawsuit.[102] Similarly, apology and disclosure based programs, such as Sorry Works!, seek to minimize litigation, reduce costs and, some proponents argue, reduce medical error.[103]

By letter dated May 19, 2005, the Senate Judiciary Committee requested that the Committee consider and make recommendations on the issue of safe apologies by health care providers. Specifically, the Committee was asked to examine laws prohibiting the courtroom use of apologies by medical providers and programs established in other states to comprehensively address health care providers' ability to apologize, explain or offer compensation for medical errors, including the Sorry Works! program.

In response to this request, the Committee discussed the issue at its regularly scheduled meetings on June 29, 2005 and October 3, 2005. The Committee retained Milliman, Inc. to research the issue and prepare materials for presentation to the Committee. Committee members were hopeful that this area could provide an opportunity for a unanimous recommendation to the Legislature.

1. Exclusions of Apologies from Evidence

Nineteen states have enacted laws that protect health care provider apologies from being admitted into evidence. Although most of these laws are broadly similar, there are some notable differences. Some states provide sweeping protection for any admission of culpability. For example, in Arizona statements of responsibility are excluded from evidence. Likewise, Colorado allows the exclusion of statements of fault from evidence. On the other hand, several states provide for the exclusion of apologies, but specifically do not exclude statements of fault. Some states specifically prohibit any discovery into apologies, while some state protections are not so broad or explicit. Several states provide general immunity for apologies in medical malpractice actions as well as other torts, but most states have passed apology immunity laws specifically applying to medical malpractice actions. The only apology immunity law found by the Committee that imposes a time limit on how long the physician

has to apologize is the recently passed legislation in Illinois.[104] For a chart summarizing apology immunity laws, see Exhibit 124.

Most apology immunity state laws specific to health care providers were enacted between 1999 and 2005. Because these laws are relatively new, quality studies that seek to measure objectively the impact of these laws on medical malpractice claim payments or liability insurance premiums are unavailable.

2. Sorry Works! and the Lexington, Kentucky VA

The Sorry Works! program embodies what is sometimes called a humanistic risk management approach to medical malpractice cases. The approach is based on a program implemented at the Lexington, Kentucky Veterans Administration (VA) hospital in 1987.[105] Sorry Works! is based on the premise that when medical mistakes or unanticipated outcomes occur, doctors and hospitals should thoroughly examine the facts of the incident and quickly notify the patient and/or family of their findings. If it is determined that an error has occurred, the health care provider should apologize, answer questions and fully disclose findings and offer a fair settlement amount up front.

Proponents of programs like Sorry Works! claim that they can reduce medical error, the number of lawsuits, total and average settlement costs, and defense costs related to medical malpractice claims. Further, proponents note that such programs have the potential to enhance the doctor-patient relationship. Opponents contend that such programs could actually invite litigation, thereby potentially raising total costs. Further, the VMS has noted that the longest running program has been implemented at a facility protected by the Federal Tort Claims Act, which provides certain protections for medical error liability.

As noted, Sorry Works! is based on a program implemented at the Lexington, Kentucky VA Hospital in 1987. The program began as a result of the facility losing two large medical malpractice cases and incurring judgments of approximately $1.5 million. The facility management decided to implement a proactive policy of investigation into potential malpractice cases. The intent was to better prepare a defense to such cases, as well as identify and investigate incidents of medical negligence. This included notifying the patient of the investigation findings, even in situations where the patient was unaware of medical negligence. It was felt that the facility's prime role was as caregiver to the patient and that communication with the patient on such matters was ethically required. The administration and staff at the Lexington facility now believe that this policy of extreme honesty has resulted in unanticipated financial benefits.

For the Lexington facility's program, a risk management committee identifies and investigates all instances of accident, negligence or malpractice. The committee also investigates whether there has been a loss of the patient's function, life or earning capacity as a result of the error. The committee then

contacts the patient or the patient's family. The initial telephone conversation provides only enough detail to indicate that a medical mistake was made. A face-to-face meeting is scheduled and the patient is advised that an attorney may accompany the patient if desired.

The meeting with the patient is held with key hospital personnel and the facility's counsel. All details of the investigation are provided to the patient. Emphasis is placed on regret of the facility and the personnel involved, on preventing similar incidents in the future, and on pursuing any corrective action. The patient's questions are answered. All information and medical records are provided to the patient's attorney. In addition to corrective treatment, other restitution may be offered to the patient at this time, including monetary compensation and assistance filing for disability benefits. If the investigation indicates a medical error has occurred, the facility's attorney works with the patient's attorney to reach an equitable settlement. Settlement amounts are calculated based on the loss, but do not include punitive damages.

In 1999, Steve S. Kraman, M.D. and Ginny Hamm, J.D. studied the Lexington program using data from the years 1990-1996.[106] The study concluded the Lexington program "has had encouragingly moderate liability payments."[107] The study reported that from 1990 to 1996, the facility paid out on 88 claims, including five cases involving permanent disability or death which probably would not have resulted in a claim without disclosure.[108] Average payment per claim was $15,622. Eight lawsuits were filed in that time; seven of them were dismissed before trial and the remaining case resulted in a defense verdict.[109] Because the committee's investigations were thorough and prompt, the facility was able to successfully defend against nuisance claims.

The Lexington facility did not have data regarding settlement and verdicts prior to the implementation of the program, but the study's authors compared the Lexington's experience to that of 35 similar Veterans Affairs medical centers. Thirty of the facilities had fewer claims, but only seven of the facilities had lower total payments.[110] More recently, it has been reported that the average payment at the Lexington facility was $15,000, whereas the average payment in Veterans Affairs facilities nationwide is about $98,000.[111] Additionally, cases in the Lexington facility are closed in two to four months instead of the usual two to four year average, thereby presumably saving on defense costs.[112]

Kraman and Hamm concluded that "despite a policy that seems to be designed to maximize malpractice claims, the Lexington facility's liability payments have been moderate and comparable to those of similar facilities. We believe this is due in part to the fact that the facility honestly notifies patients of substandard care and offers timely, comprehensive help in filing claims; this diminishes the anger and desire for revenge that often motivates patients' litigation."[113] The authors further noted that plaintiffs' attorneys, after confirming the accuracy of the clinical information provided by the facility, are willing to

negotiate a settlement on the basis of calculable monetary damages rather than seeking over-sized judgments.[114]

Kraman and Hamm acknowledge various limitations to their study, including that it is difficult to compare the VA experience to that of the private sector[115] and that malpractice payments are determined by many factors unrelated to medical care.

3. Other Programs Premised on Apology and Disclosure

Some feel that the success associated with the Sorry Works! type programs is partly a result of the proactive disclosure to patients about what has occurred. A recent article reviewing published studies of communications with patients about medical errors[116] found that 91% of study subjects who pursued medical negligence actions did so at least in part out of a desire for an explanation about what had happened.[117] Similarly, the article cited a study in which 41% of respondents pursuing medical negligence claims reported that they felt something could have been done once the incident occurred that would have prevented the need for legal action, including an explanation and apology.[118]

Based in part on the experience of the Lexington VA hospital, the Department of Veterans Affairs now requires such a policy for all of its facilities. In addition, some private hospitals are exploring the possibility of adopting similar policies. For example, Johns Hopkins Hospital instituted a policy in 2001 that encourages physicians to openly disclose errors and apologize. A managing attorney for claims and litigation at Johns Hopkins indicated that this policy reduced expense payment related to legal claims by 30%.[119] Similarly, in 2002, the hospitals in the University of Michigan Health System started encouraging doctors to apologize for their mistakes. Since then, the System's attorney fees have dropped from $3 million to $1 million per year. The number of malpractice lawsuits and notices of intent to sue have dropped by almost 50%.[120]

A Sorry Works! pilot program has been enacted into law by the State of Illinois, under which the state will hold harmless two participating hospitals if they incur excess liability during a two-year trial period. During the trial period, doctors and hospital staff will determine if medical error caused a bad outcome, apologize, offer solutions to fix the problem, and offer compensation to the patient. The legislation establishes a working committee comprised of insurance, medical and legal experts, which will administer the program. The committee will develop standards and protocol to compare settlements and defense costs for cases handled with traditional risk management philosophies to cases handled by the two hospitals under the Sorry Works! program. If, in the opinion of the committee, a case results in excessive settlement costs because of the Sorry Works! protocol, the state will pay the difference to the hospital.

Similarly, a few malpractice insurers have implemented proactive risk management programs designed to mitigate medical error and enhance the patient-physician relationship, sometimes referred to as proactive risk management.[121] In Colorado, the state's largest medical malpractice carrier, Colorado Physicians Insurance Company (COPIC), has formalized a policy of teaching doctors how to discuss medical errors and apologize for potential claims of less than $30,000. The goal of the program is to both avoid costly lawsuits, and also to facilitate more creative solutions to patient complaints while avoiding the inefficiency of litigation. The program has been in place for four years and includes over 1,300 participating physicians, but it is unclear how the program has impacted claim frequency and claim severity. According to a 2004 newspaper article, in its first four years, COPIC's program has handled 433 claims and paid out from $100 to $26,000 in each one. Patients can still sue, but only two have chosen to do so.[122] COPIC is examining expanding the program to larger claims.

The Maine Department of Professional and Financial Regulation examined the physician apology laws and programs such as Sorry Works! in its report on medical malpractice in Maine.[123] As part of the study, Maine had an actuarial firm calculate potential impacts of implementing a Sorry Works! type program based on the assumption that such a program would result in between 30% and 50% savings in legal defense costs in claims under $30,000. Based on those assumptions, the actuarial firm predicted a 3.5% - 5.9% savings in total claim costs.[124] Without making any judgments about whether the assumptions applied in the Maine study are sound, Milliman calculated between a 2.3% and 3.8% savings in ALAE[125] in Vermont on losses up to $30,000 and between a 3.2% and 5.3% ALAE savings for losses up to $250,000.

4. Committee Resolution

On October 3, 2005, the Committee met and discussed apology immunity statutes and disclosure based programs such as Sorry Works! The Vermont Association of Hospitals and Health Systems did not attend this meeting.

The Committee passed a motion strongly supporting that the Legislature continue to explore the issue of safe apologies, including both excluding physician apologies from evidence and exploring the concept of a voluntary pilot program based on the concepts of apology and disclosure similar to the Sorry Works! program.

Medical Malpractice Study Committee Exhibits

Note: persons named in parenthesis are Committee members that submitted exhibit

Exhibit No.	**Exhibit Description**
	From August 24, 2004 Med Mal meeting:
1	Enabling Legislation
2	Medical Malpractice Study Committee member list
3	List of participating BISHCA staff and contact information
4	Technical support – Milliman, Inc.
5	United States General Accounting Office, *Medical Malpractice Insurance – Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June 2003)
6	Medical Malpractice Study Committee meeting schedule dates
7	Draft timeline by Milliman, Inc.
8	*Rising Medical Malpractice Insurance Premiums Impact Patient Care* (Paul Harrington)
9	Congressional Budget Office, Issue Brief, *Limiting Tort Liability for Medical Malpractice* (January 8, 2004). (Tom Sherrer)
10	Americans for Insurance Reform, *Letter to Insurance Commissioners* (May 11, 2004) (Tom Sherrer)
11	Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003*, (November, 2003) (Tom Sherrer)
12	Americans for Insurance Reform, *The Milliman Report: Fatally Flawed* (November 25, 2003) (Tom Sherrer)
13	Chad C. Karls, & Kevin J. Atinsky, Milliman USA, *Medical Malpractice Insurance: A Market in Transition* (Originally published in *The Physician Insurer*, Third Quarter, 2003) (Tom Sherrer)
14	Americans for Insurance Reform: *Tillinghast's 'Tort Cost' Figures Vastly Overstate the Cost of the American Legal System* (January 6, 2004) (Tom Sherrer)
15	Glossary of Insurance Terms (Milliman Consulting)
16	Med Mal Company Indicated Rate Level Change for Vermont Rates Effective 1/1/04 (Milliman Consulting)

17	Memo from Ken Carlton, Chris Tait, Christine Fleming, Re: Draft Mandatory Data Request, Pursuant to Act No. 122, Appropriations Act Fiscal Year 2005, H. 768, Section 292 (August 23, 2004) (Milliman Consulting)
18	Milliman slide presentation: OVERVIEW OF MEDICAL MALPRACTICE INSURANCE MARKETPLACE (Milliman Consulting)
19	August 24, 2004 Committee Meeting Minutes
	From Wed., September 29, 2004 Med Mal meeting
20	Meeting dates
21	Memo: Draft Mandatory Data Request Pursuant to Act No. 122, Appropriations Act Fiscal Year 2005, H. 768, Section 292 (August 23, 2004) (Milliman Consulting)
22	Act No. 122 (Milliman Consulting)
23	Approved Timetable of study committee
24	Christine Fleming, Memo: *Vermont Survey*, (September 30, 2004) (Milliman Consulting)
25	Insurer Survey on Vermont Medical Malpractice Marketplace (Milliman Consulting)
26	Letter to Med Mal Committee commenting on the draft Mandatory Data Request Proposal (October 1, 2004) (Laura Kersey, American Insurance Association)
27	Proposal Mark-up (Attachment to October 1, 2004 letter) (Laura Kersey, American Insurance Association)
28	Letter to Laura Kersey, AIA, regarding Draft Claims Survey (October 1, 2004) (J. Peter Yankowski, BISHCA)
29	Milliman Slide Presentation: SUMMARIES (Milliman Consulting)
30	Memo: *Ratemaking* (Milliman Consulting)
31	Milliman Slide Presentation: ITEM 6, STATE PROVIDED ASSISTANCE TO HEALTH CARE PROVIDERS (Milliman Consulting)
32	Milliman Slide Presentation: STATES WITH PROPOSED MEDICAL MALPRACTICE SUBSIDIES (Milliman Consulting)
33	Milliman Slide Presentation: ITEM 7, CREATING A FIXED COMPENSATION SYSTEM FOR MEDICAL MALPRACTICE CASES (Milliman Consulting)
34	Minutes from September 29, 2004 meeting

From Wednesday, October 27, 2004 meeting

35 Hand-out: *Follow-up questions from September 29, 2004 meeting* (September 29, 2004) (BISHCA)

36 Hand-out: *Malpractice/Tort Reform* (Harvey Yorke, President & CEO, southwestern Vermont Healthcare)

37 Captive Insurance memo (Derick White, Director of Captive Insurance)

38 Medical Malpractice Company Contact list (BISHCA)

39 Letter to medical malpractice insurance companies requesting support to complete Vt. Medical Malpractice Insurance Study Data and Information Survey (October 22, 2004) (BISHCA)

40 Vt. Medical Malpractice Insurance Study Data and Information Survey (October 21, 2004) (Milliman Consulting)

41 Wyoming Healthcare Commission, *Projected Effect of Capping Non-economic damages on Physicians and Surgeons Professional Liability Costs* (October 13, 2004) (Milliman Consulting)

42 Milliman Slide Presentation: ITEM 7 – ADDENDUM (Milliman Consulting)

43 Milliman Slide Presentation: ITEM 7 – SUMMARY (Milliman Consulting)

44 Milliman Slide Presentation: ITEM 6 – STATE PROVIDED ASSISTANCE TO HEALTH CARE PROVIDERS (Milliman Consulting)

45 Milliman Slide Presentation: ITEM 4 – ADDITIONAL FACTORS WHICH EFFECT INSURANCE COSTS (Milliman Consulting)

46 Milliman Slide Presentation: STATES WITH PROPOSED MEDICAL MALPRACTICE SUBSIDIES (Milliman Consulting)

47 Minutes from October 27, 2004

From Tuesday, November 16, 2004 meeting

48 Memo to Medical Malpractice committee: *2004 Medical Malpractice Rate Increases* (November 10, 2004) (Tom Crompton, BISHCA)

49 Comparison and rate survey issue of Medical Liability Monitor – (Tom Crompton, BISHCA)

50 Letter from Commissioner John Crowley to PHICO requesting the company to complete data and information survey (October 22, 2004) (BISHCA)

51 PHICO Insurance Company response letter they no longer file reports because the company is in liquidation (October 25, 2004) (PHICO)

52	Memo: *ProMutual (Proselect) materials submitted to Med Mal Committee with errors* (November 15, 2004) (Jamie Feehan, Primmer & Piper). Memo regarding Paul Harrington's Vt. Medical Society submission to med mal committee (November 15, 2004) (ProMutualGroup)
53	Testimony of Richard W. Brewer, President and CEO, Proselect Insurance Company
54	Testimony of Ronald Trahan, Vice President of Underwriting and Insurance Services at Medical Mutual Insurance Company of Maine
55	Minutes from November 16, 2004 meeting
	From Wednesday, January 26, 2005 meeting
56	Memo by John McClaughry, President, Ethan Allen Institute, *Reforming the Medical Malpractice System* (January 26, 2005)
57	Lewis Laska & Kathryn Forrest, *Faulty Data and False Conclusions, The Myth of Skyrocketing Medical Malpractice* (October, 2004) (Tom Sherrer)
58	A.M. Best data related to Vt. Medical Malpractice insurance carriers' adjusted loss reserves. (Peter Yankowski)
59	Milliman Slide Presentation: ITEM 3, "WHETHER INSURANCE COSTS FOR VERMONT HEALTH CARE PROVIDERS ARE RISING WHILE THE PAYMENTS INSURERS MAKE FOR MEDICAL MALPRACTICE CLAIMS ARE DECREASING, AND IF SO, WHY THIS APPARENT DISCREPANCY EXISTS." (Milliman Consulting)
60	Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004* (October, 2004) (Milliman Consulting)
61	Milliman Slide Presentation: ITEM 10, "WHETHER ANY EFFORTS HAVE BEEN OR SHOULD BE UNDERTAKEN TO REDUCE THE INCIDENTS OF MEDICAL MALPRACTICE THROUGH THE UNDERWRITING PROCESS." (Milliman Consulting)
62	Milliman Slide Presentation: ITEM 13 – COSTS OF DEFENSIVE MEDICINE ((Milliman Consulting)
63	Milliman Slide Presentation: RESULTS OF MARKETING SURVEY (Milliman Consulting)
64	Minutes of January 26, 2005 meeting
	From Wednesday, March 2, 2005 meeting
65	Business Week commentary – regarding health providers forming medical malpractice captives ("A

Remedy for Malpractice Malaise", 2/7/05, page 38 (Peter Yankowski)

66 Milliman Slide Presentation: ITEM 1, IMPACT OF VERDICTS AND SETTLEMENTS ON INSURANCE COSTS (Milliman Consulting)

67 Milliman Slide Presentation: ITEM 2, IMPACT OF STATUTORY CHANGES ON INSURANCE COSTS (Milliman Consulting)

68 Milliman Slide Presentation: ITEM 5, CAPS ON DAMAGES (Milliman Consulting)

69 Milliman Slide Presentation: SUMMARY OF FINDINGS FROM MILLIMAN DATA CALL, VERMONT CLAIMS STUDY 1994 TO 2004 (Milliman Consulting)

70 Milliman Slide Presentation: FOLLOW-UP QUESTIONS (Milliman Consulting)

71 Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability system and Preventing Patient Injury* (2005) (Paul Harrington)

72 Minutes from March 2, 2005 meeting

From Wednesday, March 30, 2005 meeting

73 Memo: *Definition of Tail Coverage Liability Insurance* (DATE?) (Peter Yankowski)

74 Milliman Slide Presentation: ITEM 1, IMPACT OF VERDICTS AND SETTLEMENTS ON INSURANCE COSTS, REVISED 3/30/05 (Milliman Consulting)

75 Follow-up questions from Committee

76 Milliman Slide Presentation: SUMMARY OF FINDINGS FOR ITEM 2, IMPACT OF STATUTORY CHANGES ON INSURANCE COSTS (Milliman Consulting)

77 Milliman Slide Presentation: ITEM 5, CAPS ON DAMAGES (REVISED 3/30/05) (Milliman Consulting)

78 Milliman Slide Presentation: ITEM 6, STATE PROVIDED ASSISTANCE TO HEALTH CARE PROVIDERS – NUMBER OF DOCTORS BY COUNTY (Milliman Consulting)

79 Milliman Slide Presentation: ITEM 11, OTHER REFORM MEASURES (Milliman Consulting)

80 State Enactments of Selected Health Care Liability Reforms (Peter Yankowski)

81 Bernard Black et al, *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, (2005) (Peter Yankowski)

82 Memo from Derick White, Director, Captive Insurance Companies, to M. Beatrice Grause, *Health Care Related Captive Insurance Companies* (BISHCA)

83	State of Washington, Office of Insurance Commissioner, *A Report to the Washington State Insurance Commissioner: Medical Malpractice Closed Claim Study, Claims Closed from July 1, 1994 through June 30, 2004* (February 2005) (Tom Sherrer)
84	Minutes from March 30, 2005 meeting
	From Wednesday, April 27, 2005 Meeting
85	Milliman Slide Presentation: FOLLOW-UP QUESTIONS FROM MARCH 30, 2005 MEETING (Milliman Consultants)
86	Milliman Slide Presentation: ITEM 12, "WHETHER LEGISLATIVE ACTION IS NECESSARY TO ADVISABLE IN THE AREA OF MEDICAL MALPRACTICE ACTIONS, AND, IF SO, PARTICULAR RECOMMENDATIONS FOR LEGISLATION" (Milliman Consultants)
87	Handout: *Medical Malpractice Filings (NOS Code 362) in USDC DVT as percentage of civil filings on an annual basis*, 1991-2004 (Dick Wasko, Vermont Federal Court)
88	JS44 Civil Cover Sheet to initiate civil docket (Dick Wasko, Vermont Federal Court)
89	Handout: United States District Court, District of Vermont, *Listing of civil jury verdicts* from 1/22/01 to 10/25/04 (Dick Wasko, Clerk, USDC, Vermont Federal Court)
90	Handout: Federal Court Rule 16.3 *Early Neutral Evaluation process* (Dick Wasko, Clerk, USDC, Vermont Federal Court)
91	Handout: *Vermont Trial Court Case Flow* FY1985 to FY2004(Lee Suskin, Vt. State Court Administrator)
92	Handout: *Case Trends in Superior Court*, 1985 to 2004 (Lee Suskin, Vt. State Court Administrator)
93	Handout: *Number of Civil Cases – Superior Court FY 02-04* (Lee Suskin, Vt. State Court Administrator)
94	National Center for State Courts publication, Civil Action, Vol. 4, No. 1, Spring 2005 (Lee Suskin, Vt. State Court Administrator)
95	Judgments Entered in Malpractice Cases, January 1, 2002 through April 26, 2005 (Lee Suskin, Vt. State Court Administrator)
96	Handout: *Alternative Dispute Resolution* Vermont Court Rules of Civil Procedures, Rule 16.3 (Chris Maley, Attorney)

97	Maine Department of Professional & Financial Regulation, *Medical Malpractice Insurance in Maine* March 30, 2005 (BISHCA)
98	Slide Presentation: STABILITY, NOT CRISIS: MEDICAL MALPRACTICE CLAIM OUTCOMES IN TEXAS, 1988-2002 (Professor Bernard Black, University of Texas)
99	Hand out: *Weiss Ratings Report on Medical Malpractice Caps Propagating the Myth that Non-Economic Damage Caps Don't Work*, July 8, 2005 (Bruce Wilson, Physician Insurers Association of America)
100	Slide Presentation: DATA SUPPORTING PROFESSOR BLACK'S STUDY WAS FUNDAMENTALLY FLAWED (Bruce Wilson, Physician Insurers Association of America)
101	Handout: Sorry Works! Program, from sorryworks.net/media4.phtml, April 26, 2005 (Tom Sherrer)
102	Handout: *States with Patient Compensation Funds vs. Vermont* April 27, 2005 (Thomas Crompton, BISHCA Rates & Forms Analyst)
103	Handout: *Proposed Format for Medical Malpractice Report to the General Assembly* (Rebecca Heintz, BISHCA Staff Attorney)
104	Memo: *Proposed Voting Questions and Procedures*, April 26, 2005 (Rebecca Heintz, BISHCA Staff Attorney)
105	Letter, American Insurance Association dated April 18, 2005 to Professor Bernard Black, Professor Charles Silver, Professor David Hyman, Professor William Sage (April 18, 2005) (John Hollar for AIA)
106	Handout: *Victim Compensation Without Litigation – the Lexington (KY) Experience*
107	Minutes from April 27, 2005 meeting
	From Monday, May 23, 2005 Meeting
108	Handout: Number of Physicians in Vermont: 1996-2003, American Medical Association, Physician Characteristics and Distribution in the U.S., Various Editions, (Tom Sherrer)
109	Memo, by J. Peter Yankowski, *PHICO impact on Vermont Med Mal insurance market*, May 16, 2005 (Peter Yankowski)
110	Milliman Slide Presentation: FOLLOW-UP QUESTIONS APRIL 27, 2005 MEETING AND RATE EXHIBITS (Milliman Consulting)

111	Handout: *Number of Vermont Doctors from 2000 to 2005,* AMA Database (Milliman Consulting)
112	Letter to Peter Yankowski from Senator Sears regarding “safe apology” by health care professionals, to include “Sorry works! Program, dated May 19, 2005, (BISHCA)
113	Vermont law versus Potential Reforms (Rebecca Heintz)
114	Financial/Operating/Market Trend data for Med Mal Insurance Industry (Peter Yankowski)
115	Handout: Expense Survey: What to Spend, What to Cut, Dorothy L. Pennachio, January 21, 2005, Medical Economics (John Evers)
116	Current Market Share data for Vermont from A.M. Best (Peter Yankowski)
117	Medical Malpractice Liability Study Committee Voting Guide (Peter Yankowski)
118	Health Grades Quality Study – Patient Safety in American Hospitals, July 2004 (Tom Sherrer)
119	Medical Mutual Insurance Company of Maine 2003 Annual Report, Paul Harrington
120	Minutes from May 23, 2005 meeting

Additional Exhibits

121	Milliman Data Call (Milliman Consulting)
122	Summary of Other Potential Reforms (Milliman Consulting)
123	National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis* (September 12, 2004)
124	BISHCA prepared spreadsheet detailing physician apology immunity laws
125	Milliman Slide Presentation: Follow-up Items to May 23, 2005 meeting (Milliman Consulting)
126	Milliman Slide Presentation: “I’m Sorry” Legislation and Programs (Milliman Consulting)
127	Handout: Follow-up of Historic Data Increases for Vermont Carriers (A.M. Best, Five Year Trend A7 Reports) BISHCA
128	Handout: Medical Mutual Insurance Company of Maine Financial Highlights, 2003 and 2004. (MMICM Annual Reports for 2003 and 2004.)

129	Handout: Letter to Commissioner Crowley of plan of withdrawal from writing medical malpractice liability insurance. (June 22, 2005, Chubb Group of Insurance Companies.)
130	Handout: Top Medical Malpractice Insurers by State, Market Share Percentages, dated June 27, 2005. (AM Best Five-Year Trend A7 Reports from 1993 data report to present. (BISHCA)
131	Handout: Vermont Medical Malpractice Committee Preliminary Draft Report, dated June 27, 2005. (BISHCA)
132	Handout: Potential Committee Arguments to the Vermont Medical Malpractice Committee Preliminary Draft Report. (BISHCA)
133	Handout: House bill (H.329), "Court procedure; medical malpractice, 2005-2006 Legislative Session. (Paul Harrington)
134	Minutes from June 29, 2005 meeting
135	Handout: "When Doctors Say, We're Sorry" Time Magazine article (Milliman)
136	Handout: Health Resource Allocation Plan for the State of Vermont, Adopted 8/2/05 by Gov. James Douglas (BISHCA)
137	Handout: Vermont Report of the Healthcare Workforce Partnership (BISHCA)
138	Handout: "When doctors say they're sorry" Boston Globe, (August 25, 2005 (BISHCA)
139	Handout: Responses to follow-up questions from September 7, 2005 meeting (BISHCA/Milliman)
140	Handout: "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry by Towers Perrin (BISHCA)
141	Proposed Senate bill to amend the public Health Service Act (Paul Harrington)
142	ProSelect Rate Changes for Selected Specialties
143	Minutes of September 7, 2005
144	Minutes of October 3, 2005 meeting

SUPPORTING TABLES

Table 1 below summarizes written premium in Vermont for the past 6 years (2004 Annual Statement data from National Underwriter Insurance Data Services from Highline Data).

Table 1. Vermont Medical MalPractice Top 10 Writers - Direct Written Premium (000s)*

	1999	2000	2001	2002	2003	2004
State Total	**7,247**	**10,110**	**10,340**	**18,752**	**16,619**	**17,614**
1 Medical Mutual Ins. Co.	1,812	1,861	3,127	4,575	5,926	6,780
2 Proselect Ins. Co.	246	959	2,960	3,737	4,342	5,526
3 Continental Casualty Co.	332	86	294	3,159	1,698	1,737
4 Doctors Co.	532	442	495	591	744	859
5 American Casualty Co.	202	218	209	238	268	300
6 Lexington Ins. Co.	0	0	252	2,223	415	283
7 Cincinnati Ins. Co.	57	148	254	261	283	248
8 Chicago Ins. Co.	211	199	199	200	217	227
9 Gulf Ins. Co.	209	198	85	81	76	205
10 National Union Fire Ins. Co.	0	0	0	87	136	204

*Excludes Columbia Casualty Company; writes non-Vermont business but reports in Vermont

2004 Annual Statement data from National Underwriter Insurance Data Services from Highline Data

The following table summarizes the impact of companies that withdrew from the Vermont medical malpractice market (PHICO and St. Paul).

Table 2. Vermont Medical MalPractice - Direct Written Premium (000s)*
Impact of PHICO and St. Paul

	PHICO	St.Paul	Combined PHICO+St. Paul	Industry Total	PHICO+St. Paul % of Industry
1995	5,273	1,451	6,724	9,652	69.7%
1996	4,794	1,095	5,889	8,857	66.5%
1997	3,107	1,140	4,247	7,709	55.1%
1998	2,288	896	3,184	7,373	43.2%
1999	2,118	372	2,490	7,246	34.4%
2000	2,202	329	2,531	10,110	25.0%
2001		375	375	10,340	3.6%
2002		53	53	18,752	0.3%
2003		14	14	16,619	0.1%

Annual Statement data from National Underwriter Insurance Data Services from Highline Data

GLOSSARY

Allocated Loss Adjustment Expenses (ALAE): Claim-related expenses incurred by the insurer over the course of settling a specific claim (e.g., legal defense costs and investigation expenses)

Case Incurred Losses: The sum of all paid losses and case reserves for a particular period at a specific point in time

Case Reserves: The insurance company's claims personnel's estimate of future payments on claims that have been reported to the insurance company for a particular period at a specific point in time

Combined Ratio: Incurred loss and loss adjustment expenses, underwriting expenses, and policyholder dividends as a percent of premium

Credibility: A measure of the predictive value in a given application that the actuary attaches to a particular body of data (predictive is used here in the statistical sense and not in the sense of predicting the future)

Current Rate: The current cost per unit of exposure upon which the basic premium is based (e.g., $10,000 per physician)

Defense and Cost Containment Expenses (DCC): Includes all defense and litigation-related expenses, whether internal or external to a company

Expected Loss & LAE Ratio: The loss and loss adjustment expense ratio that, when multiplied by premium, produces a dollar amount available to pay estimated loss and LAE

Exposures: The basic rating unit underlying the premium. Common medical malpractice exposures are number of doctors and number of beds

Frequency: Number of claims or number of claims per exposure

Full Credibility: The level at which the subject experience is assigned full predictive value based on a selected confidence interval

Incurred But Not Reported (IBNR) reserves: The loss reserve value established in recognition of the liability for future payments on losses that have occurred but that have not yet been reported, and for future development on the case reserves established for reported claims

Indicated Rate: The cost per unit of exposure that is indicated by a rate study

Investment Gain Ratio: Investment income and realized capital gains as a percent of premium

Loss Adjustment Expenses (LAE): The sum of allocated loss adjustment expenses and unallocated loss adjustment expenses
Loss and LAE Ratio: The ratio of ultimate loss and loss adjustment expense (LAE) to premium earned for the same period

Loss Development Factors (LDFs): Factors used to develop paid or incurred losses from their values at specific evaluation ages to their ultimate values. LDFs are estimated by reviewing the insurer's own loss development patterns, as well as industry benchmarks.

Operating Ratio: The combined ratio minus the investment gain ratio

Paid Losses: Those losses for a particular period that have actually been paid on all known claims

Policyholder Dividends: An amount returned to a policyholder by an insurance company

Policyholders' Surplus: The net worth of the company; the difference between assets and liabilities

Premium: The dollar amount produced by applying rates to the individual exposures of an insurance policy

Premium On-Leveling: The process of estimating what historical premium levels would be, had the insurance been written today

Premium-to-Surplus Ratio – the ratio of written premium to policyholders' surplus.

Present Value Factor (Discount Factor): A factor used to reduce ultimate loss estimates to account for the time value of money. In other words, a factor used to account for the fact that reserves that do not have to paid out until some future date can earn investment income

Reserve-to-Surplus Ratio: The ratio of an insurer's reserves to policyholders' surplus

Selected Rate (Proposed Rate): The cost per unit of exposure that an insurer will file with the regulators after performing a rate study

Severity: Average cost per claim

Trend Factors: Factors used to adjust the losses or exposures for any underlying trends that are expected to produce changes over time (e.g., growth in losses and/or payroll due to inflation)

Ultimate Losses: The sum of paid losses, case reserves, and incurred but not reported reserves for a particular period at a specific point in time

Unallocated Loss Adjustment Expenses (ULAE): Claim-related expenses incurred by the insurer which cannot be allocated to a specific claim (e.g., rent and salaries)

Underwriting Expense Ratio: General expenses, commissions, brokerage fees, production costs, taxes, licenses, and fees as a percent of premium

Endnotes

[1] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, at page 1 (June 2003).
[2] National Underwriter Highline Database; Year End 2003 Annual Statement data, page 8; Underwriting and Investment Exhibit, Part 1B ($8,460 million of claims-made medical malpractice premium and $2,636 million of occurrence medical malpractice premium).
[3] National Underwriter Highline Database; Year End 2003 Annual Statement data; $11.096 million of medical malpractice premium divided by $451.362 million of total property/casualty premium.
[4]Congressional Budget Office Economic and Budget Issue Brief, *Limiting Tort Liability for Medical Malpractice* (January 8, 2004). Vermont percentage is based on 2003 premium data from A.M. Best and the Milliman Data Call and 2003 resident cost data from the Vermont Health Care Expenditure Analysis Report published by the Vermont Health Care Division (p. 29).
[5] Best's Aggregates and Averages, Property and Casualty (2004 Edition).
[6] Best's Aggregates and Averages, Property and Casualty (2004 Edition).
[7] Medical Liability Monitor, Vol. 29, No. 10 (October 2004).
[8] 2004 Annual Statement data from National Underwriter Insurance Data Services from Highline Data.
[9] Actuarial Standard of Practice No. 25; Actuarial Standards Board.
[10] Congressional Budget Office Economic and Budget Issue Brief, *Limiting Tort Liability for Medical Malpractice* (January 8, 2004). Other studies have concluded that jury verdicts have "remained stable" including the study by Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004* (October 2004), and the a report by Weiss Ratings Inc., *Medical Malpractice Caps, the Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (June 3, 2003).
[11] General Accounting Office, *National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability*, GAO-01-130 (November 2000) (discussing problems with underreporting and finding malpractice payment reports were incomplete and included inappropriate information).
[12] In Vermont and countrywide, the majority of malpractice claims which go to trial are decided in favor of the defendant.
[13] The Committee requested data from the Phico liquidators, but such request was refused.
[14] Americans for Insurance Reforms is a project of the Center for Justice and Democracy. AIR is a national coalition of public interest organizations that support insurance industry reforms. The AIR website address: http://insurance-reform.org.
[15] Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004,* at page 1 (October 2004). *See also* Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003* (November 2003), *Exhibit 11.*
[16] Compare Slide Nine from *Exhibit 59* Milliman Slide Presentation "ITEM 3 'WHETHER INSURANCE COSTS FOR VERMONT HEALTH CARE PROVIDERS ARE RISING WHILE THE PAYMENTS INSURERS MAKE FOR MEDICAL MALPRACTICE CLAIMS ARE DECREASING, AND IF SO, WHY THIS APPARENT DISCREPANCY EXISTS," where A.M. Best paid losses (without defense containment costs) appear to match almost identically the paid losses numbers included in the AIR study. Slide 10 of the same Milliman presentation compares written premium to paid losses with and without DCC expenses.
[17] It should be noted that the AIR report asserts that insurance company profits are directly tied to investments made on past premiums collected (the "float") and that loss pay outs which exceed premiums (sometimes discussed in terms of loss ratios) are misleading; in times of positive economic conditions, premiums collected are sufficient to cover losses and provide strong profits because of investment earnings, and in poor economic conditions they are not. Exhibit 11**,** Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003,* at page 8 (November 2003).
[18] Due to certain accounting rules applicable to two insurance companies (Lexington Insurance Company and Continental Casualty Company), these companies report premiums and losses in their financial statements as Vermont medical malpractice business. However these companies

do not write insurance coverage for Vermont exposures (physicians or hospitals). Table 3.2 does not include the premium data reported from these two companies.

[19] Congressional Budget Office, Issue Brief, *Limiting Tort Liability for Medical Malpractice,* at page 3 (January 8, 2004).

[20] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702 (June 2003).

[21] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702, at pages 33-34 (June 2003).

[22] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates,* GAO-03-702, at page 33 (June 2003).

[23] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, page 27 (June 2003).

[24] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, page 25 (June 2003).

[25] Best's Aggregates and Averages, Property and Casualty; Medical Malpractice Composite (54 Organizations) (2004 Edition).

[26] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates,* page 25 (June 2003).

[27] United States General Accounting Office, *Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702, page 27 (June 2003).

[28] Bureau of Insurance, *Medical Malpractice Insurance in Maine*, at page 2 (March 30, 2005).

[29] Wyoming Healthcare Commission, *Projected Effect of Capping Non-Economic Damages on Physicians' and Surgeons' Professional Liability Costs,* page 2 (October 13, 2004) attached as *Exhibit 41*.

[30] Bureau of Insurance, *Medical Malpractice Insurance in Maine*, at page 11 (March 30, 2005).

[31] Congressional Budget Office, *H.R. 5, Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003,* page 3 (March 10, 2003).

[32] *Id.*

[33] Congressional Budget Office, Issue Brief, *Limiting Tort Liability for Medical Malpractice,* page 1 (January 8, 2004).

[34] Weiss Ratings, Inc., *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (June 3, 2003).

[35] *Id.*

[36] *Id.*

[37] Amitabh Chandra, Shantanu Nundy, and Seth A. Seabury, *The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank*, pages W5-246 to W5-248 (May 31, 2005); Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, pages 35-34 (2005). The Physician Insurers Association of America (PIAA) a trade organization of professional liability insurers, has been highly critical of both the methodology and the conclusions of the *Weiss* Report and the Texas study. The PIAA's responses to both studies are attached as *Exhibit 98* and *100.*

[38] Wyoming Healthcare Commission, *Projected Effect of Capping Non-Economic Damages on Physicians' and Surgeons' Professional Liability Costs,* page 2 (October 13, 2004).

[39] Rand Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials,* at page 38 (2004).

[40] Joint Economic Committee, United States Congress, *Liability for Medical Malpractice: Issues and Evidence,* at page 19 (May 2003); Insurance Services Offices, Inc., *Medical Professional Liability Insurance A Discussion of Non-Economic Damages Caps,* at page 17 (2004).

[41] In terms of premium history, the evidence on this issue is ambiguous. Following the enactment of MICRA, malpractice premiums in California decreased slightly from 1976 to 1983, then increased sharply between 1983 and 1988. Following the passage of Proposition 103 in 1988, malpractice premiums dropped dramatically until 1992, then increased slightly from 1992 to 1998, and remained flat between 1998 and 2001. In 2004, according to the Medical Liability Monitor, California saw some of the largest malpractice rate decreases in the country. *See Exhibit 76* at page 22.

[42] Assumes a 9% per annum rate of inflation. Data regarding non-economic damages was only available for 63.2% of loss data reviewed by Milliman.
[43] *See Exhibit 69* for a summary of Milliman Vermont Data Call findings.
[44] *Exhibit 85* at page 25.
[45] W. VA. CODE § 11-13P-1 *et seq*.
[46] H.B. 3680 (2003) at O.R.S. § 656.780 (Note).
[47] According to the Oregon Health Sciences University web site, seven liability insurers have chosen to participate in the program. *See* http://www.ohsu.edu/oregonruralhealth/mmrippg.html.
[48] 2 carriers represent 70% of the current voluntary Vermont marketplace (based on 2004 Annual Statement data from National Underwriter Insurance Data Services from Highline Data).
[49] The Milliman Data Call specifically asked the respondents about their future marketing plans in Vermont. None of the nine insurance companies that responded to the data call indicated that they planned to reduce their premium writings in Vermont.
[50] *See* Troyen A. Brennan and Michelle M. Mello, *Patient Safety and Medical Malpractice: A Case Study*, 139 ANNALS OF INTERNAL MEDICINE, pages 267 – 273 (August 19, 2004, Volume No. 4) (advocating for a no-fault system to improve patient safety and patient compensation).
[51] For a historical summary of the development of the Birth Injury Fund and an assessment of its successes and shortcomings, see the Joint Legislative Audit and Review Commission of the Virginia General Assembly, *Review of the Virginia Birth-Related Neurological Injury Compensation Program* (January 15, 2003) available on the web at http://jlarc.state.va.us/Reports/Rpt284.pdf.
[52] Virginia recently passed SB 1323, HB 1505 which amends the Birth Injury Fund to create a rebuttable presumption that when an infant is born weighing less than 1800 grams at birth or prior to 32 weeks gestation, any alleged injury is not a "birth-related injury" (qualifying for coverage), but the result of premature birth. However, industry groups such as the Virginia Hospital and Healthcare Association complain that such amendments were purely administrative and have vowed to push for more meaningful reforms going forward.
[53] JLARC Report Summary No. 284, at page 3 (November 2002) available at http://jlarc.state.va.us/Summary/Rpt284/BirthInj.HTM.
[54] *See* Connecticut Office of Legal Research, *Birth Injury Compensation Funds*, Report 2004-R-0134 (February 13, 2004) (discussing the impact of the Birth Injury Fund and analyzing the adoption of such a concept in Connecticut).
[55] JLARC Report Summary No. 284, at page 5, (November 2002) available at http://jlarc.state.va.us/Summary/Rpt284/BirthInj.HTM.
[56] NGA Center for Best Practices, Issue Brief, *Addressing the Medical Malpractice Insurance Crisis*, at page 7 (December 5, 2002).
[57] NGA Center for Best Practices, Issue Brief, *Addressing the Medical Malpractice Insurance Crisis*, at page 7 (December 5, 2002).
[58] Harvard School of Public Health, Press Release, *Harvard School of Public Health and Common Good to Develop New Medical Injury Compensation System* (January 10, 2005). The pilot project is funded by a $1.5 million grant from the Robert Wood Johnson Foundation and will focus on exploring the concept of health courts and developing potential mechanisms for health courts to employ.
[59] The Medical Liability Procedural Reform Act of 2005, H.R. 1546, referred to the House Judiciary Committee on April 11, 2005.
[60] Mark A. Hoffman, *'Health courts' touted as malpractice claim option*, Business Insurance, June 13, 2005, at pages 4-6.
[61] Of the health court idea as envisioned by Common Good, a spokesman for the Association of Trial Lawyers of America said it "demonstrates that the advocates of special nonjury health courts have a fundamental distrust of the American people. They want to substitute the judgment of insurance executives and politicians for that of 12 men and women who hear all the facts." Mark A. Hoffman, *'Health courts' touted as malpractice claim option*, Business Insurance (June 13, 1005) at page 6.
[62] Casualty Actuarial Society, FOUNDATIONS OF CASUALTY ACTUARIAL SCIENCE, page 162 (4th ed. 2001).

[63] 2003 Annual Statement Data from National Underwriter Insurance Data Services from Highline Data at page 15.
[64] Milliman Vermont Data Call.
[65] BARRON'S DICTIONARY OF INSURANCE TERMS 155 (3rd Ed. 1995).
[66] Milliman Vermont Data Call results.
[67] Milliman Vermont Data Call results.
[68] February 17, 2005 conversation between Pete Yankowski (BISHCA) and Barbara Fitzgerald (San Francisco Rate Filing Bureau Chief).
[69] *See* CALIFORNIA INS. CODE, § 1861.05c and related Regulation 2646.4.
[70] February 17, 2005 conversation between Pete Yankowski (BISHCA) and Barbara Fitzgerald (San Francisco Rate Filing Bureau Chief).
[71] The amendment proposed to 8 V.S.A. § 4688(e) reads: "(e) Filings open to inspection. All rates, supplementary rate information, and any supporting information for risks filed under this chapter shall, as soon as filed ~~or after approval for those matters subject to prefiling~~, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge in the manner and amount prescribed by the commissioner."
[72] The compensation fund utilizes four rate classifications for coverage greater than one million. *See* State of Wisconsin Patient's Compensation Fund website at http://oci.wi.gov/pcf.htm. In comparison, carriers in Vermont typically apply between 10 and 18 rate classifications.
[73] *See, e.g.,* Deborah Chollet, Ph.D, *The Role of Reinsurance in State Efforts to Expand Coverage*, STATE COVERAGES INITIATIVES ISSUE BRIEF, Volume V, No. 4 (October 2004).
[74] Schedule D of an insurer's Annual Statement includes investment and dividend income information.
[75] National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study Of Market Conditions And Potential Solutions To The Recent Crisis*, at page 49 (September 12, 2004).
[76] Vermont Rule of Evidence 702.
[77] Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Injury*, page 16 (2005).
[78] RAND Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials; California Jury Verdicts Under MICRA,* at summary page XXIII (2004).
[79] RAND Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials; California Jury Verdicts Under MICRA,* at summary page XXV, Figure S.2 (2004).
[80] RAND Institute for Civil Justice, *Capping Non-Economic Awards in Medical Malpractice Trials; California Jury Verdicts Under MICRA,* at summary page XXIV-XXV (2004).The study indicated that net recoveries for cases with verdicts under $250,000 in non-economic damages were increased by 19%, while those with non-economic damages awards greater than $1 million were reduced by 28%.
[81] National Association of Insurance Commissioners, *Medical Malpractice Insurance Report: A Study Of Market Conditions And Potential Solutions To The Recent Crisis*, page 50 (September 12, 2004).
[82] According to the PIAA, these states are Alabama, Arkansas, Alaska, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, Nevada, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Washington, and Wisconsin. However, several of these states appear to allow them on a discretionary basis, which is not different from the present situation in Vermont.
[83] Alaska, Arizona, Connecticut, Delaware, Indiana, Kansas, Maine, Massachusetts, Montana, Nebraska, New Mexico, Utah, Virginia and Wyoming.
[84] In Maine, all medical liability actions must be brought before the pre-litigation screening panel. 24 M.R.S.A. § 2851 *et seq.* Although the rules of evidence are relaxed, the panel hears witness testimony, reviews exhibits and allows motions. The parties may agree to make the panel's findings binding, although if the panel is unanimous the findings are admissible in any subsequent

court proceeding. The panel must decide, by a preponderance of the evidence, whether the defendant's conduct deviated from the applicable standard of care, whether such negligence was the proximate cause of the harm and whether the patient's negligence exceeded that of the defendant. For a general description, *see* Maine Bureau of Insurance, Department of Professional & Financial Regulation, *Medical Malpractice Insurance in Maine*, at pages 3 – 5 (March 30, 2005).

[85] MASS. GEN. L., ch. 231, § 60B. Under Massachusetts law, if the tribunal finds in the defendant's favor, in order to proceed with the claim, the plaintiff must post a $6,000 bond with the court to pay for the defense costs in the event the plaintiff does not prevail in the malpractice action.

[86] NGA Center for Best Practices, Issue Brief, *Addressing the Medical Malpractice Insurance Crisis*, at page 12 (December 5, 2002).

[87] For example, Wisconsin law requires that all medical malpractice claims go through a mediation procedure with a panel consisting of an attorney, a health care provider and a lay person. The plaintiff must initiate mediation prior to filing a lawsuit or 15 days after filing. WIS. STAT. § 655.42 *et seq.* Mediation occurs prior to any discovery. Surveys conducted by the court indicate mixed results regarding the effectiveness of this tool to resolve cases more timely. See http://www.wicourts.gov/about/organization/offices/mmp.htm.

[88] *Exhibits 89-90.*

[89] *Exhibits 89-90.*

[90] *Exhibit 90.*

[91] Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury*, at pages 35-36 (2005). The Joint Commission argues that the tort system fails to adequately enhance patient safety and that changes to the present system must focus on patient safety, among other factors.

[92] *See, e.g.,* the United States Department of Health and Human Services, Agency for Healthcare Research and Quality's web site, identifying numerous studies examining the effectiveness of medical guidelines in a clinical setting (www.ahrq.gov/clinic/medteprp/list7.htm).

[93] Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury,* page 8 (2005) (discussing studies which show a decrease in litigation upon the use of medical guidelines and advocating encouraging appropriate adherence to clinical guidelines to improve quality of healthcare).

[94] For an in-depth discussion of the Maine program (before project completion), see General Accounting Office, *Medical Malpractice: Maine's Use of Practice Guidelines to Reduce Costs*, GAO/HRD-94-8 (October 25, 1993); *see also* General Accounting Office, *Maine Practice Guidelines,* GAO/HEHS-95-118R (letter to Senator William S. Cohen, stating that data limitations would prevent meaningful study of impact of guidelines on quality of healthcare and detailing those limitations).

[95] NGA Center for Best Practices, Issue Brief, *Addressing the Medical Malpractice Insurance Crisis"*, at page 10 (December 5, 2002).

[96] *In re: Rural Medical Access Program*, Order as to Required Assessment, Docket No. INS 00-3044 (December 19, 2000).

[97] Congressional Budget Office Economic and Budget Issue Brief, *Limiting Tort Liability for Medical Malpractice*, at page 6 (January 8, 2004).

[98] United States General Accounting Office, *MEDICAL MALPRACTICE: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, at page 29 (August 2003).

[99] United States General Accounting Office, *MEDICAL MALPRACTICE: Implications of Rising Premiums on Access to Health Care*, GAO-03-836, at pages 26-30 (August 2003).

[100] Baicker, Katherine and Chandra, Amitabh, *The Effect of Malpractice Liability on the Delivery of Healthcare*, National Bureau of Economic Research Working Paper No. 10709 (August 2004).

[101] Kessler, Daniel P. and McClellan, Mark B., "Medical Liability, Managed Care, and Defensive Medicine," Stanford Law School, John M. Olin Program in Law and Economics Working Paper No. 191, February 2000.

[102] Bureau of Insurance, Department of Professional and Financial Regulation, *Medical Malpractice Insurance in Maine*, at p. 22, n.9 (March 30, 2005), *citing* Mazor et al., *Health Plan*

Members' Views about Disclosure of Medical Errors, ANNALS OF INTERNAL MEDICINE, Volume 140, pp. 409-418 (2004).
[103] Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Injury* (2005).
[104] H.B. 475 (2005) requires that a health care provider apologize within 72 hours from when he or she knew or should have known of the potential cause of the unanticipated outcome.
[105] Kraman, Steve S. and Hamm, Ginny, J.D., "Risk Management: Extreme Honesty May Be the Best Policy", *Annals of Internal Medicine,* Vol. 131, No. 12 (December 21, 1999). Unless otherwise noted, all information regarding the Lexington program is from this article.
[106] Kraman, Steve S. and Hamm, Ginny, J.D., "Risk Management: Extreme Honesty May Be the Best Policy", *Annals of Internal Medicine,* Vol. 131, No. 12 (December 21, 1999).
[107] Kraman, Steve S., MD, and Hamm, Ginny, JD, *Risk Management: Extreme Honesty May Be the Best Policy,* ANNALS OF INTERNAL MEDICINE Vol. 131, No. 12, at p. 963 (December 21, 1999).
[108] Kraman, Steve S., MD, and Hamm, Ginny, JD, *Risk Management: Extreme Honesty May Be the Best Policy,* ANNALS OF INTERNAL MEDICINE Vol. 131, No. 12, at p. 964 (December 21, 1999).
[109] Kraman, Steve S., MD, and Hamm, Ginny, JD, *Risk Management: Extreme Honesty May Be the Best Policy,* ANNALS OF INTERNAL MEDICINE Vol. 131, No. 12, at p. 964 (December 21, 1999).
[110] Kraman, Steve S., MD, and Hamm, Ginny, JD, *Risk Management: Extreme Honesty May Be the Best Policy,* ANNALS OF INTERNAL MEDICINE Vol. 131, No. 12, at p. 965 (December 21, 1999).
[111] "Why Sorry Works! Works: Overview of Sorry Works! Program for the Medical Malpractice Crisis," *Victims and Families United*, www.victimsandfamilies.com, November 11, 2004.
[112] *Id.*
[113] Kraman, Steve S., MD, and Hamm, Ginny, JD, *Risk Management: Extreme Honesty May Be the Best Policy,* ANNALS OF INTERNAL MEDICINE Vol. 131, No. 12, at pp. 964-65 (December 21, 1999).
[114] Kraman, Steve S., MD, and Hamm, Ginny, JD, *Risk Management: Extreme Honesty May Be the Best Policy,* ANNALS OF INTERNAL MEDICINE Vol. 131, No. 12, at pp. 966 (December 21, 1999). It should also be noted that because the Lexington facility is a VA hospital, subject to the protections of the Federal Tort Claims Act, no punitive damages could be awarded at trial.
[115] The VA system provides comprehensive, free universal coverage including benefits such as remedial treatment and monthly disability payments. Government health care practitioners are protected from personal liability by the Federal Tort Claims Act. Government health care practitioners pay no malpractice premiums. The government is not liable for punitive damages pursuant to the Federal Tort Claims Act.
[116] Mazor, Simon and Gurwitz, Id. at p. 1694 n. 38, *citing* Vincent C., Young M., Phillips A. *Why do people sue doctors? A study of patients and relatives taking legal action*, THE LANCET Vol. 343, pp. 1609-1613 (1994).
[117] Mazor, Kathleen M., Ed.D, Simon, Steve R., M.D., and Gurwitz, Jerry H., M.D., *Communicating with Disclosure of Medical Errors: A Review of the Literature*, ARCHIVES OF INTERNAL MEDICINE, Vol. 164, pp 1690-1697 (August 2004).
[118] *Id.*
[119] Zimmerman, Rachel, *Doctors New Tool to Fight Lawsuits: Saying I'm Sorry,* Associated Press, May 18, 2004. Can be viewed at www.grif.com.au/Why.81.0.html.
[120] Tanner, Lindsey, *Doctors Advised: An Apology A Day Keeps the Lawyer Away*, Associated Press (November 12, 2004). Can be viewed at http://www.law.com/jsp/article.jsp?id=1100137001367.
[121] Pawlson, Gregory L., MD, MPH, and O'Kane, Margaret E., MS, *Malpractice Prevention: Patient Safety, and Quality of Care: A Critical Linkage*, THE AMERICAN JOURNAL OF MANAGED CARE, Vol. 10, No. 4 at p. 281 (April 2004).
[122] Brand, Rachel, *Medical Insurance Company Seeks More Disclosure, Cut in Malpractice Lawsuits*, CORTEZ JOURNAL, April 1, 2004.
[123] Bureau of Insurance, Department of Professional and Financial Regulation, *Medical Malpractice Insurance in Maine*, at pages 19-22 (March 30, 2005).
[124] Bureau of Insurance, Department of Professional and Financial Regulation, *Medical Malpractice Insurance in Maine*, at page 22 (March 30, 2005).

[125] ALAE stands for “allocated loss adjustment expenses” and refers to claim-related expenses incurred by the insurer over the course of settling a specific claim (e.g., legal defense costs and investigation expenses).