Legislative Budget and Finance Committee

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

OFFICES: Room 400 • Finance Building • Harrisburg • Tel: (717) 783-1600 • Facsimile: (717) 787-5487
MAILING ADDRESS: P.O. Box 8737 • Harrisburg, PA 17105-8737

EXECUTIVE DIRECTOR
Philip R. Durgin

CHIEF ANALYST
John H. Rowe, Jr.

STUDY OF THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

June 1996

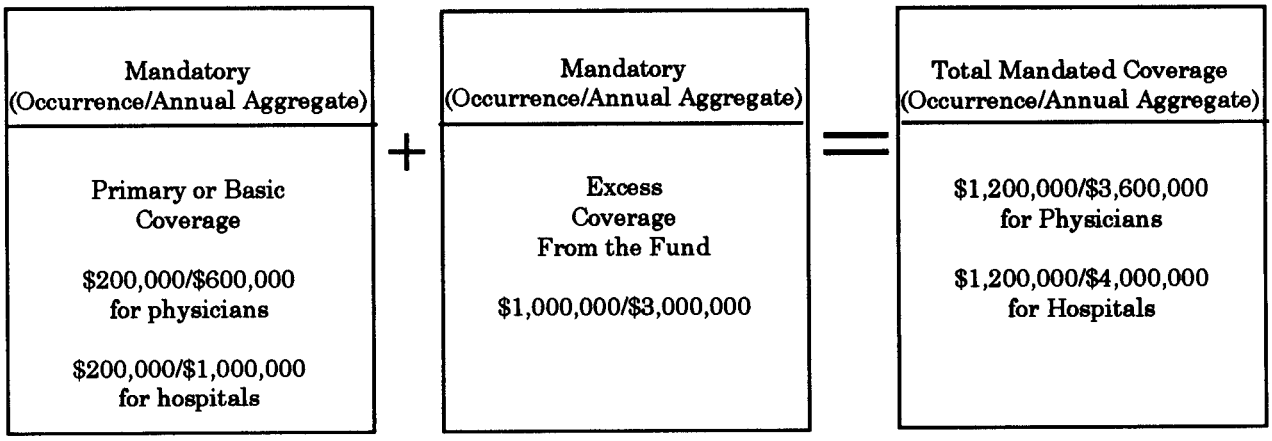
Table of Contents

Table of Contents
(Continued)

Report Findings and Conclusions and Options Available to the General Assembly

Pennsylvania is one of only eight states in the United States that mandate that physicians carry medical malpractice insurance. Although medical malpractice insurance is voluntary in most states, virtually all (98 percent) self-employed physicians carry some form of medical malpractice insurance. According to the American Medical Association, in 1993 coverage limits for these physicians averaged $1.2 million per occurrence and $2.8 million annual aggregate.

Pennsylvania physicians and hospitals are mandated to obtain primary insurance, either from commercial insurers or by self-insuring, and to purchase excess insurance from the state-operated Medical Professional Liability Catastrophe Loss Fund. Pennsylvania health care providers must obtain:



The Medical Professional Liability Catastrophe Loss Fund

The Pennsylvania General Assembly established the Medical Professional Liability Catastrophe Loss Fund in response to a crisis in the availability of medical malpractice insurance that occurred both nationally and in Pennsylvania during the 1970s. The purpose of the Fund was to create an environment to encourage commercial insurers to offer medical malpractice insurance at reasonable prices and to provide prompt and fair compensation to injured persons. With the Fund providing "excess" or catastrophic insurance, it was thought no single insurer would be faced with a series of catastrophic claims that could result in an insurer's insolvency. The legislation creating the Fund also contained provisions to address concerns commercial insurers had over the long "tail" associated with medical malpractice injuries that may take many years to be discovered and reported.

Although several states have established some form of patient compensation fund, Pennsylvania, Wisconsin and Kansas are the only states that require health care providers to participate in a state compensation fund.

Pennsylvania's Medical Professional Liability Catastrophe Loss Fund is financed entirely from surcharges imposed on the health care providers who participate in the Fund. No state revenues are used to support the operations of the Fund. The Fund operates on a "pay-as-you-go" basis, meaning that unlike commercial insurers, it does not maintain reserves to cover incurred losses that will have to be paid in future years. Rather, the Fund pays current year losses from current year revenues.

Recent increases in annual surcharges, concerns over Fund claims management practices, an estimated $1.95 billion unfunded liability, and a $106 million emergency surcharge in late 1995 have led to calls to reform, restructure, or terminate the Fund.

Report Findings and Conclusions

- **Several provisions of the original 1975 act have been declared unconstitutional and other court decisions have adversely affected the Fund.** Several provisions of Act 1975-111, the legislation that created the Medical Professional Liability Catastrophe Loss Fund, designed to achieve the goals of affordable insurance and prompt, reasonable payments to claimants have been declared unconstitutional. The provisions declared unconstitutional include arbitration panels, limits on attorney fees, and reducing awards by the amount of collateral payments from public sources. The Fund is also now liable for prejudgment delay damages and post-judgment interest payments. A key 1988 ruling that the Fund could not maintain a balance greater than $15 million appears to have been superseded by a 1996 Commonwealth Court decision that the $15 million balance cited in Act 111 is not a "cap."

- **The Fund's estimated unfunded liability may be understated.** An actuarial report released in April 1996 estimated the Fund's unfunded liability at $1.95 billion as of December 31, 1995. The estimate, however, does not include the liability the Fund has incurred as a result of 879 reported breast implant and 666 reported pedicle screw cases.[1] Although the actuaries noted that the Fund has experienced a substantial increase in reported claims for both these types of cases, they excluded them from the unfunded liability citing that these claims are likely to have different reporting patterns, settlement patterns, and average settlement values than the remaining body of claims reported to the

[1]Pedicles are the bony structures that extend toward the rear of the body from each vertebra. Pedicle screws are spinal fixation devices that consist of plates or rods which are affixed to the spine by means of bone screws inserted into the pedicles of the spine.

Fund and therefore cannot be meaningfully estimated. Two major medical malpractice insurers we contacted indicated, however, that they did reserve for these two types of claims.

The 1995 actuarial report also assumes that only 10 percent of the claims against the Fund will result in a Fund payout within eight years of their occurrence. This assumption is based primarily on a downward trend in the percentage of claims closed with a payment eight years or less after they were incurred. The actuaries noted that the unfunded liability will be understated if the downward trend simply reflects prolonged settlements rather than an actual decline in the percentage of claims being settled with a payout.

- **The Fund still faces a number of problems that were identified in a 1985 report to the Pennsylvania Select Committee on Medical Malpractice.** Issues that continue to confront the Fund include:

  - The lump-sum annual surcharge has become increasingly burdensome as the Fund has matured,

  - The flat surcharge rate charged by the Fund benefits the more aggressively competitive insurers and their policyholders by compounding premium differentials,

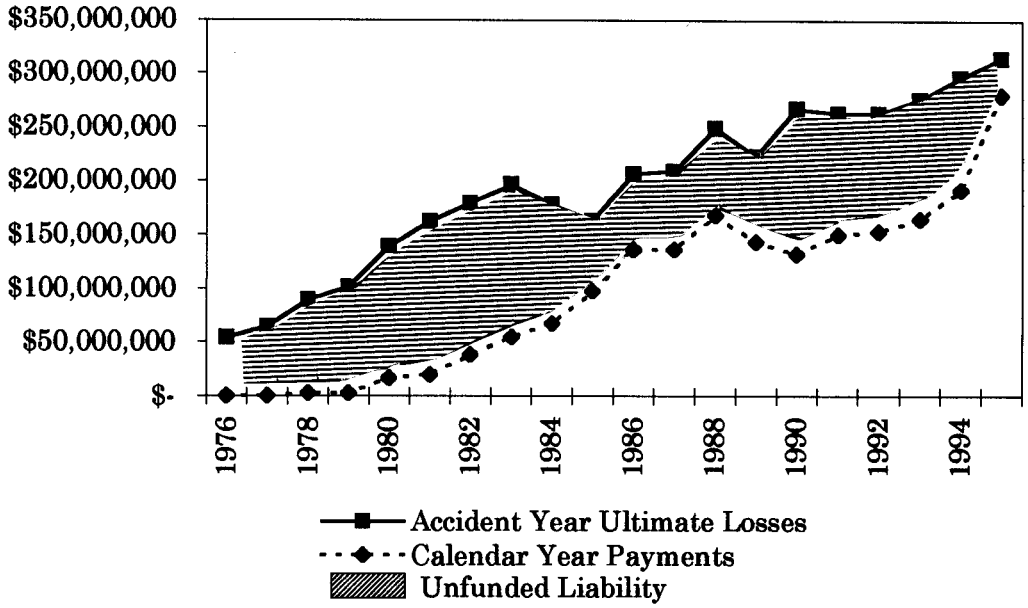
  - The $200,000 basic limit and the flat surcharge rate benefit high-severity risks, e.g., neurosurgeons and obstetrical surgeons, at the expense of other providers, and

  - Inadequate resources have been devoted to the Fund, particularly claims examiners.

  The intervening years have failed to produce fruitful efforts to alleviate these problems and have witnessed additional problems.

- **The Fund's policy during the late 1980s and early 1990s of delaying claim payments increased the unfunded liability.** As shown below, by the late 1980s the Fund was approaching a point of "maturity." Increases in the Fund's unfunded liability had decreased from an average of $132 million a year in the early 1980s to about $73 million a year from 1985 through 1989.

Fund Ultimate Loss and Claim Payment History



Even in a mature fund, relatively modest increases in the unfunded liability are to be expected due in part to increases in the cost of medical care. However, the trend of 6 to 7 percent increases in the unfunded liability suddenly reversed in 1990, when claim payments decreased despite a jump of 20 percent in projected ultimate losses for that year. Although projected annual losses have increased by no more than 7.5 percent in succeeding years, claim payments did not rise sufficiently to close the gap until 1995.

The widening gap between projected ultimate losses and claim payments occurred in large part because of the Fund's policy during the late 1980s and early 1990s of delaying claim settlements. By delaying payments, the Fund could avoid imposing emergency surcharges and stiff increases in the regular annual surcharge. However, we estimate that the Fund's practice of delaying claim settlements added at least $86 million to the unfunded liability between 1989 and 1994.

- **Fund surcharges will remain high and additional emergency surcharges are likely.** In 1994, the Fund assessed a surcharge of 93 percent of the primary premium base, generating $171 million. In 1995, the Fund assessed a 170 percent surcharge on providers (a 102 percent regular annual surcharge and a 68 percent emergency surcharge), generating $286 million. In 1996, the Fund assessed a 164 percent regular annual surcharge, expected to generate $300 million. The Fund estimates it will have average claim payments of about $241 million a year for the next three years (1996-1998) and that claim payments will reach $275 million by the year 2000. These amounts do not in-

clude Fund operating expenses (budgeted at $25.6 million for FY 1996-97) or any surcharges that would go toward increasing the Fund buffer.

In addition to continued high annual surcharges, because the Fund's statute provides for a surplus of only $15 million, future emergency surcharges are likely. When the $15 million statutory balance was established in 1980, it was roughly equivalent to the annual claim payout and provided a meaningful buffer against the unpredictability of malpractice litigation patterns. However, annual claims payouts are now about 15 times that amount ($230 million projected for 1996), rendering the $15 million surplus inadequate. In September 1995, an independent actuary hired by the Fund calculated that there is a one-in-four likelihood that the $15 million buffer will be insufficient to cover the annual increase in Fund payments and operating expenses.

- **Confidence in the ability of state government to manage the Fund has been eroding.** The current Fund director and staff are respected and have taken significant steps to improve the Fund. However, because of the way in which claims payments were delayed to prevent the imposition of an emergency surcharge and other claims management practices in recent years, health care providers' confidence in the ability of the Fund to properly manage claims has been eroding.

  Problematic claims management practices include:

  - not operating in good faith by delaying settlements, requiring providers to use their own funds to settle claims within the Fund's limits, and apportioning higher settlement costs to providers who have purchased additional excess insurance while not assigning the full limit of the Fund's coverage for codefendants;
  - not paying its proportionate share of pre-judgment delay damages above the Fund's coverage limits;
  - not paying post-judgment interest above the Fund's coverage limits; and
  - delaying the assignment of legal counsel for Section 605 cases, changing attorneys assigned to defend such cases when changes occur in the Administration, assigning inexperienced attorneys, and contracting with law firms that may have a conflict of interest.

  Although the new Fund director has changed or begun to address many of these practices, the Fund's policies are not established in law or regulation and can be changed at any time.

  Because of the way the Fund is structured, it also has several inherent problems, including:

- the ability, and hence the temptation, to minimize Fund payouts by shifting costs to others, particularly hospitals that carry excess insurance, and to delay claim settlements to minimize the political consequences of raising surcharges;

- the inability of the Fund to hire the personnel and obtain the resources it needs because of restrictions placed on state agencies; and

- the Fund no longer serves its original purpose as an "excess" insurer and is now an active, working layer of insurance that creates delays and redundant costs.

We also found that the medical malpractice market is substantially different from what it was when the Fund was originally created in 1975 and that the Fund may no longer be necessary. In particular, we found:

- **Medical malpractice insurance is readily available in Pennsylvania and is likely to remain available.** We found that 21 insurers wrote at least $2 million in direct medical malpractice premiums during 1994, including two carriers controlled by Pennsylvania hospitals and physicians, respectively. The availability of medical malpractice insurance is also guaranteed through the Pennsylvania Professional Liability Joint Underwriting Association (JUA) which was created in statute to provide insurance to those unable to purchase coverage through private companies. Additionally, self-insurance is now an option that major health care systems did not have in 1975.

- **The Fund has become much more involved in providing malpractice coverage than was originally intended.** Due to increases in medical costs and claim settlement values since the mid 1970s, the Fund no longer provides catastrophic coverage but rather is an active, working layer of insurance coverage. When Act 1975-111 was enacted, physicians were required to purchase $100,000 per occurrence and $300,000 annual aggregate in basic insurance. If the requirement to purchase basic insurance had increased at the same rate as the Consumer Price Index for medical care services, physicians would now be required to purchase $516,400 per occurrence and $1,549,200 annual aggregate in basic insurance.

- **Commercial carriers can provide the Fund's level of coverage to their current insureds at less cost.** Several major private insurers have recently reported to the Insurance Department that they can provide the Fund's layer of coverage through standard insurance policies for substantially less than the Fund's 1996 surcharge of 164 percent. Table 1 summarizes the six responses received as of May 20, 1996, that contained cost estimates for the Fund's level of coverage.

Table 1

Estimated Additional Cost of Fund-Level Coverage*

Company	Provider Category	Including §605 Claims	Excluding §605 Claims
A	Physicians	126% - 153%	82% - 100%
	Surgeons	156% - 182%	102% -118%
B	Physicians and Surgeons	100% - 125%	75% - 90%
C	Physicians and Surgeons	125% - 140%	--
D	Physicians and Surgeons	130%	--
E	Physicians and Surgeons	125%	--
F	Physicians and Surgeons	90%	--
	Hospitals	80%	--

*The Fund's surcharge in 1996 for Fund coverage is 164 percent.

Source: Developed from survey responses received by the Pennsylvania Department of Insurance.

It should be noted, however, that unlike a commercial insurance premium the Fund's annual surcharge does not provide a "reserve" for claims that will need to be paid in future years. Rather, the Fund's surcharge is intended to pay claims that will be settled during the collection year. Thus, providers could not simply "switch" coverage to a private insurer without some provision to pay for claims incurred while they participated in the Fund.

Finally,

- **Unlike many states, Pennsylvania has not implemented tort reforms.** During the 1980s many states implemented a variety of medical malpractice tort reforms. Pennsylvania is not among these states. Typical tort reforms include limiting total claim awards or capping nonmonetary damages (e.g., pain and suffering); modifying the collateral source rule; limiting attorney fees; changing the rules on joint and several liability; requiring periodic, rather than lump-sum, payments of settlement awards; and shortening the statute of limitations for filing a medical malpractice claim.[2]

[2]On May 14, 1996, the Pennsylvania House of Representatives amended Senate Bill 790 to provide for medical malpractice reform. The amended bill would limit punitive damages, eliminate pre-judgment delay damages, prevent double recovery of certain public and group benefits, modify Pennsylvania law on informed consent, establish qualifications for expert witnesses, and create a voluntary system for binding arbitration of medical malpractice claims. As of late May 1996, this bill was in the Senate Committee on Rules and Executive Nominations.

Options Available to the General Assembly

We concluded that the Pennsylvania General Assembly has three basic options with regard to the Medical Professional Liability Catastrophe Loss Fund: (1) reform the Fund, (2) restructure the Fund, or (3) terminate the Fund by privatizing its layer of coverage, either immediately or gradually. The main advantages and disadvantages of these options are discussed below and in more detail in Chapter V of this report.[3]

Option 1: Reform the Fund

Several proposals have been advanced to reform the Fund's statute while retaining the Fund's basic structure and operations. If enacted, many of these changes should help stabilize payment patterns and alleviate some inequities. However, the reforms being proposed may not be adequate to address several fundamental issues confronting the Fund, including:

- **The unfunded liability will continue to grow.** The Fund's unfunded liability, which now stands at $1.95 billion, has grown every year since the Fund's inception and will probably continue to grow every year the Fund exists. This is because the only way to reduce the unfunded liability is to collect more in surcharges than the Fund incurs in operating expenses and ultimate losses for that year. Such large surcharge increases are especially problematic given that commercial insurers have already reported that they can provide the Fund's layer of coverage to their insureds at less cost than the Fund.

- **Provider surcharge payments will continue to be unpredictable.** As discussed above, a $15 million Fund balance is inadequate to prevent future emergency surcharges. Without an adequate balance to provide a buffer, it is likely that the Fund will need to either borrow funds (if given statutory authority), require significant increases in the proposed annual or semi-annual surcharges (if the statute is changed), or impose another emergency surcharge sometime within the next four years. A recent court ruling would appear to give the Fund the authority to build a Fund balance above $15 million. However, in all likelihood, the Fund would be challenged if it attempted to impose surcharges adequate enough to build a balance significantly greater than $15 million.

- **Claims management will continue to be a problem.** Despite any reforms that might be enacted, the Fund will continue to be subject to many of the problems of the past, such as having little control over its personnel and other re-

[3]In Chapter V we also discuss the possibility of allowing health care providers the option of participating in the Fund (the "opt in/opt out" option) but concluded that this would be administratively complex and would probably lead to the collapse of the Fund. Given the severity of problems facing the Fund, we did not consider the "do nothing" option as viable.

sources and being subject to pressure to artificially hold down surcharges. More fundamentally, the Fund is often put in the position of having to make decisions in which it has a direct financial interest in the outcome. In the past, the Fund, at least on occasion, has taken advantage of this position to shift costs to other payers.

- **The Fund shifts costs to the future.** Because the Fund is set up on a pay-as-you-go basis, the Fund will be paying for some claims incurred ten or fifteen years ago out of surcharges collected in 1996. Similarly, claims incurred as a result of medical malpractice that occurs today will be paid over the next 15 to 20 years. New physicians, therefore, will be paying surcharges for much of their career to cover the cost of claims that may have occurred many years before they began practicing medicine.

  In 1995, for example, the Fund paid for no claims incurred in 1995 and only two claims from 1994. However, it paid eight claims for injuries which took place in 1976. The largest number of claims paid were for injuries which took place in 1988. (See Table 2.)

Table 2

1995 Claims Paid by Occurrence Year

Occurrence Year	Number of Paid Claims	% of Total	Occurrence Year	Number of Paid Claims	% of Total
1976	8	1%	1986	49	7
1977	1	a	1987	58	9
1978	3	a	1988	111	17
1979	6	1	1989	110	17
1980	5	1	1990	107	16
1981	12	2	1991	75	11
1982	10	2	1992	40	6
1983	13	2	1993	12	2
1984	23	3	1994	2	a
1985	20	3	1995	0	a
			Total	665	

[a]Less than 1 percent.
Source: Developed from the Fund's 1995 paid claims data.

Option 2: Restructure the Fund

Proposals have also been advanced to restructure the Fund and its operations. In addition to helping to stabilize payment patterns and alleviating some inequities, such a restructuring would make the Fund more accountable to health

care providers and the general public. Senate Bill 1122, the primary proposal in this regard, would restructure the Fund by:

- **Requiring that the Fund be administered by an independent governing board.** Pennsylvania currently is the only state whose compensation fund is administered as part of the Governor's Office. By turning responsibility for the administration of the Fund to an independent governing board, Pennsylvania would be following in the path taken by both other states (Wisconsin and Kansas) that have mandatory state compensation funds.

- **Shifting claims management responsibility to the private insurers.** Because the value of claims has increased, the Fund has become an active working layer of insurance. To prevent delays in the settlement of claims, S.B. 1122 proposes to shift responsibility for managing the Fund's "excess" claims to the health care provider's primary insurer. (Section 605 claims would remain with the Fund.)

- **Holding the Fund accountable for bad faith in its claims handling practices.** Because of their contractual relationship with their insureds, commercial insurers are obliged to act in the interest of their insureds when handling medical malpractice claims. In short, they are required to settle claims in good faith. The Fund, however, has no such legal obligation and, at least on occasion, has engaged in bad faith practices to the detriment of health care providers.

However, even such a restructuring may not be adequate to address some of the fundamental issues now confronting the Fund. The Fund's unfunded liability would continue to grow, although perhaps not as rapidly if claims were processed more timely than in the past. Proposals to subject the Fund to bad faith litigation and to create an independent governing board to oversee the Fund's practices would make the Fund more accountable but, in all likelihood, would also increase Fund payouts and expenses and hence increase Fund surcharges.

Proposals to shift the Fund's claims management responsibilities to commercial insurers and self-insurers also have met with objections. Some think that if insurers were responsible for handling the Fund's claims they would have no incentive to hold down settlement amounts to protect Fund dollars. To address this issue, another alternative has been advanced, known as "quota share," wherein the commercial insurer or self-insurer would have to contribute from its reserves a certain percentage (e.g., 20 percent) toward the Fund's settlement amount. Although this would provide some incentive to negotiate lower settlements, it would add administrative complexity.

Option 3: Terminate the Fund

The third basic option is to terminate the Fund by privatizing its layer of coverage. Providers would then need to obtain coverage for the Fund's layer of insurance from the private market or self-insure, either immediately or phased-in over a period of years. This option might or might not involve immediate termination of the Fund's operations, depending on when coverage would be privatized, who would have responsibility for managing the Fund's open and incurred but not reported claims, and who would be responsible for collecting revenue to pay such claims.

The primary advantage of this option is that it would remove the Commonwealth from the medical malpractice insurance business. As demonstrated in this report, we found this to be a function which, for a variety of reasons, the state has not performed well. Terminating the Fund's coverage would subject Pennsylvania's health care providers, like health care providers in virtually all other states in the nation, to the fluctuations of the private market. To some extent, private market forces would be tempered by the Joint Underwriting Association which would still exist to guarantee that coverage would be available to health care providers who could not obtain coverage through a commercial insurer.

Terminating the Fund's coverage does, however, create a major problem: paying off the Fund's unfunded liability.[4] This problem exists whether the Fund's coverage is privatized immediately or gradually.

- **Paying off the unfunded liability, even if amortized over a 30-year period, will impose a heavy financial burden on Pennsylvania's health care providers.** We estimated that almost 40 percent of the Fund's estimated $1.95 billion unfunded liability would need to be paid off within the next three years if the Fund's layer of coverage were to be privatized immediately. Unless a mechanism can be developed to smooth out these payments, we estimated that the Commonwealth's health care providers would need to pay surcharges averaging approximately $250 million a year for the next three years and $174 million a year for the following three years just to pay the claims that will be coming due over the next six years.[5] The surcharge would then gradually diminish

---

[4] Claims management issues must be addressed regardless of the decisions about the future of the Fund's coverage. If the Fund ceased providing coverage, provisions would need to be made for handling the approximately 9,000 claims currently open with the Fund and the large, but unknown, number of claims incurred but not yet reported for which the Fund is responsible. When Florida's fund ceased offering coverage in 1983, it retained the fund staff and structure to handle outstanding claims. The Florida fund is still in the process of closing out its claims. Some have proposed that the Fund be terminated and its claims management functions turned over to the Joint Underwriting Authority. The director of the JUA believes such a plan might be workable, assuming that it was provided with reasonable resources.

[5] Based on an estimated unfunded liability of $1.95 billion as of December 31, 1995, this represents 136 percent of 1996 primary premiums for the first three years and 95 percent of 1996 primary premiums for the following three years.

for the next 15 to 20 years as the longer-tailed claims are paid off. During this period, the providers would also need to purchase the full mandated amount of professional liability insurance from the private market (currently $1.2 million/$3.6 million for physicians and $1.2 million/$4 million for hospitals). Thus, at least for the first three years, provider payments for malpractice insurance and to pay off the unfunded liability would be approximately 1.5 times their 1996 payments.[6] Such a burden might be enough to discourage new physicians from locating in Pennsylvania or prompt physicians who are near retirement age to retire early.

The Hospital Association of Pennsylvania sponsored an initial study to assess the feasibility of a bond issue as a way to amortize the unfunded liability over a 30-year period. This study found that it would require approximately $124 million a year over a 30-year period to retire the Fund's unfunded liability.[7] This represents a 67 percent surcharge based on 1996 primary premiums--an amount that approximates the average annual surcharge payments between 1989 and 1991.

Another proposal that has been made to retire the unfunded liability is to require Fund participants to purchase new policies (or riders to existing policies) to cover their outstanding claims. Such policies might, however, be expensive because many of the claims covered under such policies would need to be paid in the relatively near future, thus not allowing insurers much time to accumulate reserves. A mechanism, such as an assigned risk plan, would also be needed to cover providers who have large claims already reported against them, as insurers may not be willing to cover these providers. It might also be difficult to enforce such a requirement on physicians who retire or move out of state because they would not be directly affected if they lost their license to practice in Pennsylvania.

- **Phase-in privatization plans would keep health care providers' primary insurance premiums somewhat lower than under immediate termination but would result in a higher unfunded liability.** Two main proposals have been advanced for a gradual phase-out of the Fund over a five-year period. One proposal, referred to as the "increasing basic limits" proposal calls for increasing the primary coverage by $200,000 a year until 2001, when private insurers would provide the full $1.2 million in coverage. An alternative proposal, referred to as "quota share," would keep the basic limits at $200,000 but insurers would pay a portion of each Fund loss, increasing from 20 percent in 1997 to full coverage in 2001.

---

[6]264 percent in 1996 (100% for primary coverage plus the Fund's surcharge of 164 percent) compared to 361 percent if the Fund was terminated (100% for primary coverage plus approximately 125 percent for private coverage of the Fund's layer of insurance, plus 136 percent a year for three years to pay off the unfunded liability).

[7]Based on an estimated unfunded liability of $1.9 billion as of December 31, 1995.

A gradual phase-out has the advantage of keeping health care providers' primary insurance premiums somewhat lower than what they would be under an immediate termination plan. This is important because the surcharge needed to retire the Fund's unfunded liability would be highest during the initial phase-out years. However, the providers would have to pay higher surcharges after the year 2000 than they would under immediate termination because losses incurred for the years 1997 through 2000 would add to the unfunded liability.

Another major drawback to gradual termination plans is that they are administratively complex in that they would require insurers to recalculate their risks and premium rates for each year of the phase-out. If the Fund ceased writing all coverage on one specific date, only one such adjustment would be necessary. Phase-out approaches also raise questions about who would be responsible for managing the Fund's claims and could result in redundant administrative costs.

I. Introduction

In June 1995 the officers of the Legislative Budget and Finance Committee authorized a study of the Medical Professional Liability Catastrophe Loss Fund. Activity on the study project started in September 1995, shortly after the Governor's appointment of a new Fund director.

Study Objectives

1. Provide historical information about the Fund, the reasons for its creation, legislative changes and judicial decisions which have affected its operations, changes in the availability of medical malpractice insurance in Pennsylvania, and factors influencing its continued availability.

2. Provide information on the current status of the Fund, including its financial and claims status, and its outstanding obligation to pay claims which have been incurred.

3. Identify issues relevant to the Fund's management, claims practices, and financial status.

4. Identify possible options to address problems with the Fund.

Study Scope and Methodology

To obtain information on the history of the Fund, LB&FC staff reviewed the legislative history, laws, regulations, rules, and judicial decisions related to the Fund and its operations. We also reviewed annual reports of the Department of Insurance identifying insurance carriers writing medical malpractice insurance in Pennsylvania and their volume of premiums written.

Information concerning the status of the Fund was obtained from a review of the Fund's bulletins, annual statistical and financial reports, and annual surcharge requests filed with the Insurance Department. We also reviewed all available actuarial reports (including a special report prepared for the Fund), the Fund's budget submissions to the Governor's Budget Office, Auditor General reports, outstanding litigation in which the Fund is a party, and special reports prepared from the Fund's database (including reports on paid and outstanding claims and surcharge collections).

To obtain information on the Fund's management practices and to identify possible options, LB&FC staff visited the Fund's Rosemont claims office where we had the opportunity to meet with claims staff and observe the operations of their

claims committee. We met with representatives of several hospitals and insurers who were able to provide their perspectives on the issues now before the Fund including claims management practices of the Fund in recent years. We also met with trial lawyers' representatives and spoke with a Joint Underwriting Association representative. We reviewed legislative proposals affecting the Fund and attended hearings and reviewed testimony from hearings at which these proposals were discussed.

Nationwide requirements and costs of medical professional liability insurance were provided by the American Medical Association. Information concerning states with compensation funds was provided by the individual states' funds. The US Department of Health and Human Services National Practitioner Data Bank resource files are the source of information reported on the medical malpractice claims payments on behalf of physicians.

Information on the Fund's projected payouts was provided by the Fund Director in January 1996. Estimates of the Fund's outstanding liability for open claims and claims incurred but not yet reported are taken from the report of the Fund's actuary as of December 31, 1995.

Important Notes About This Report

We wish to emphasize two points about this report. First, we did not conduct an actuarial study or financial audit of the Fund. Within the report we have, however, assigned numeric values to illustrate the consequences of fund practices, to compare various options, and to illustrate the dimension of the problems now confronting the Fund. In developing these numbers, we used the stated assumptions of the Fund's actuary and/or the Fund's actual historic trends. We did not make independent actuarial assumptions in developing the information contained in this report.

Within the report we have noted certain issues concerning the Fund's most recent actuarial report and the difficulties involved in establishing accurate estimates of the Fund's unfunded liability. We have also used the Fund's latest actuarial report to illustrate the relative difference among the various options for changing the Fund. We have used the Fund's report in this way because the relative differences among the various options to change the Fund are unlikely to change in any major way if the unfunded liability is actually greater than the Fund's current estimate.

Second, although we use the term "medical malpractice" throughout this report, medical malpractice is not synonymous with negligent medical care. Negligence is not the only basis for a medical malpractice claim in Pennsylvania. For example, the Pennsylvania Supreme Court has ruled that claims may be based on

lack of informed consent, notwithstanding the care exercised. The Federal District Court in Philadelphia also held that a hospital can be liable on a strict liability theory. In that case, the court found that the hospital could be liable for "selling" an unsafe product.

The Pennsylvania Supreme Court has also ruled that plaintiffs are not required to prove that the medical care provided directly caused their injuries. If a health care provider's actions may have simply increased the risk of harm that actually occurred, it is up to a jury to decide whether the care constituted a substantial factor contributing to the injury sustained.

Acknowledgments

We greatly appreciate the cooperation we received from the Director of the Medical Professional Liability Catastrophe Loss Fund, John H. Reed, and his staff, particularly Arthur F. McNulty, the Fund's Chief Counsel. Linda S. Kaiser, the Insurance Commissioner, and her staff assisted in the completion of this study, especially Timothy L. Knapp, the Department of Insurance's Legislative Counselor, and Randolph L. Rohrbaugh, the Director of the Bureau of Property and Casualty Rate and Policy Review. We also appreciate the cooperation we received from the Pennsylvania Medical Society, the Hospital Association of Pennsylvania, the Pennsylvania Medical Society Liability Insurance Company, and the PHICO Insurance Company.

This report was developed by LB&FC staff. The release of this report should not be construed as an indication that the Committee's members endorse any or all of the report's findings and conclusions. Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Fund History and Status Through December 31, 1995

During the mid-1970s, states throughout the nation took action to respond to a crisis in the availability of medical malpractice insurance. Pennsylvania was among the states affected by this crisis, with the two largest malpractice insurers withdrawing from the state during the 1970s. As a result, health care providers in some areas reported they could not obtain medical malpractice insurance.

In response to this crisis, in 1975 the Pennsylvania General Assembly passed Act 111. The goals of the act, which established the Pennsylvania Medical Professional Liability Catastrophe Loss Fund, were to make malpractice insurance available and affordable to health care providers and to establish a system through which persons injured through medical malpractice could obtain prompt and fair decisions regarding their claims.

The largest medical malpractice insurer of Pennsylvania providers in the early 1970s, Employers Mutual Liability Insurance Company of Wisconsin, completed its withdrawal from Pennsylvania in 1976. The Argonaut Insurance Company, the second leading writer, eventually stopped writing medical malpractice insurance in Pennsylvania in 1978. The company stopped doing business in Pennsylvania even though it had obtained premium increases of approximately 200 percent over the three-year period prior to its departure from the state.

In 1976 the Pennsylvania Hospital Insurance Company, an affiliate of the Pennsylvania Hospital Association, was formed and started to offer professional liability insurance to hospitals. Later, the Pennsylvania Medical Society formed the Pennsylvania Medical Society Liability Insurance Company to provide medical malpractice insurance to Pennsylvania physicians.

Provisions and Legal History of Act 111

Act 111 included many provisions to achieve the goals of affordable insurance and prompt, reasonable payments to claimants injured through medical malpractice. However, as noted below, several of the act's key provisions were declared unconstitutional, and other provisions have been amended over time.

To encourage commercial insurers to do business in Pennsylvania and offer malpractice insurance at affordable prices, Act 111 limited their financial exposure by creating a state fund known as the Medical Professional Liability Catastrophe Loss Fund (the Fund). The Fund was established as a state agency within the executive branch of state government to provide "excess" coverage beyond the basic, or primary, coverage limits which health care providers were mandated to purchase. With the existence of the Fund, it was thought that commercial companies could be

attracted to Pennsylvania because no single carrier would be faced with a series of catastrophic claims that could result in insolvency.

Act 111 mandated that Pennsylvania's health care providers purchase excess medical malpractice insurance from the newly created state Fund. The statute originally required basic coverage of $100,000 per occurrence with a $300,000 annual aggregate for physicians and hospitals, with the fund providing excess insurance coverage up to $1 million per occurrence and $3 million annual aggregate.

The Fund was created on a "pay-as-you-go" basis and was not required to establish reserves in anticipation of future payments for claims. The concept was that the mandatory nature of provider participation in the Fund guaranteed a source of future revenue, thus negating the need for reserves. The Fund was to be financed by an annual surcharge on health care providers which was to be actuarially determined based on "reasonably anticipated payment of claims and other expenses of the fund during the period for which the surcharge is made."

Act 111 provided that the annual surcharge could not exceed 10 percent of the cost of the provider's basic malpractice insurance or $100, whichever was greater. Act 111 also required that the Fund's balance at the end of the calendar year, after payment of all claims and expenses, could not exceed $15 million. If it did, the Fund administrator was to reduce the surcharges to maintain the balance at or below $15 million.

Claims Management

Except for claims known as Section 605 claims (discussed below), Act 111 mandated that the basic insurance carrier had full responsibility to defend claims against an insured. It also authorized the Fund's director to defend, litigate, settle and/or compromise any claim in excess of the basic coverage. The Fund's management, therefore, approves all settlements involving Fund moneys and may, at its option, join in the defense of a claim.

Originally, claims coming to the Fund were to be valued by arbitration panels. The Fund's payments were to be based on an arbitration panel's determination as to a health care provider's liability and the award for damages. Because the arbitration panels were later ruled to be unconstitutional, claim valuations and the apportionment of liability in claims involving multiple providers are now made internally by the Fund's management.

The act provided for the Fund to pay its claims once a year. Final claims were to be computed each year on December 31 and then paid within two weeks. If sufficient revenue was not available to pay all claims, the amount paid to each

claimant was to be prorated. Unpaid amounts were to be paid the following calendar year.

Claims-Made Policies

To allow insurers to better predict their future claims payouts, Act 111 authorized insurers to write "claims-made" policies in addition to "occurrence" type policies. Under an occurrence policy, the insurer is responsible for claims for injuries which occur during the policy period. For example, if a health care provider purchased an occurrence policy in 1990 and an injury occurred in 1990 but was not discovered and reported until 1994, the insurer issuing the occurrence policy in 1990 would be responsible for the claim regardless of the provider's current insurer.

In contrast, when a health care provider purchases a "claims-made" policy, the insurer is only responsible for those claims reported while the policy is in effect. Claims-made policies are generally less expensive than occurrence-type policies because the claims-made insurer is not responsible for claims reported after the provider stops coverage, even if the injury occurred during the policy period. Providers with claims-made policies can, however, purchase additional policies known as tail coverage to provide coverage equivalent to an occurrence policy.

Section 605 Claims

To further encourage medical malpractice insurers to offer policies in Pennsylvania, Act 111 made the Fund the primary insurer for all claims filed more than four years after the alleged malpractice occurred, so long as they are filed within Pennsylvania's statute of limitations. This provision is contained in Section 605 of the act. Claims qualifying for such coverage are therefore referred to as "Section 605" claims to distinguish them from the Fund's "excess" claims where primary coverage is provided by private insurers. Section 605 coverage applies to both occurrence and claims-made policies.

Section 605 was included in Act 111 because of the difficulty insurers have in predicting future losses in claims filed many years after the injury occurred, particularly in states with long statutes of limitations. Compared to some states, Pennsylvania has a relatively long statute of limitations for filing medical malpractice claims. In Pennsylvania, medical malpractice claims generally must be filed within two years of the date the plaintiff knew or reasonably should have known of the claim. If the individual entitled to bring the action is a minor, the two-year statute of limitation does not begin to run until the child reaches age 18.

Provision for the Fund to Cease Providing Coverage

Act 111 included a provision for the Fund to cease offering medical malpractice coverage if the Fund's balance fell below $7.5 million. If this happened, the Fund's director was to advise the Governor and the General Assembly. If they did not take action to continue the operation of the Fund within a specified period, it would cease offering medical malpractice coverage. The Fund would, however, continue to function and collect annual surcharges until such time as all outstanding liability for claims had been satisfied. The act specifically stated that obligations of the Medical Professional Liability Catastrophe Loss Fund did not constitute a debt of the General Fund of the Commonwealth or a charge against the Commonwealth.

Oversight Committee

Act 111 created a committee to provide oversight for the Fund. The committee consisted of the Commissioner of Insurance, the Secretary of Health and two members of the Senate to be appointed by the President pro tempore and two members of the House to be appointed by the Speaker of the House of Representatives. The committee was assigned several responsibilities including studying "all phases and the financial impact of the operations of the Medical Professional Liability Catastrophe Loss Fund" and reporting its findings and recommendations to the General Assembly on or before July 1, 1977. Documents available to the LB&FC staff show that the committee last met in 1987.

Key Legislative Changes to Act 1975-111

Act 111 has been amended on several occasions. Several of the changes are significant.

- *Self-Insurance.* Act 1976-207 for the first time allowed health care providers to self-insure. It also clarified that only providers who conduct more than 50 percent of their practice in the Commonwealth must participate in the Fund.

- *Increasing Basic Coverage Limits.* Act 1980-165 resulted in health care providers being required to purchase increased basic coverage.[1] The coverage limits increased from $100,000 per occurrence/$300,000 annual aggregate to $150,000/$450,000 for physicians and $150,000/$1,000,000 for hospitals in 1983. The basic coverage increased again in 1984 to the current limits of $200,000/$600,000 for physicians and $200,000/$1,000,000 for hospitals.

[1]The amendments required the basic coverage to increase when the Fund's annual payout reached $20 million and $30 million respectively.

The increases in the provider's primary or basic coverage limits resulted in an increase in the total insurance health care providers are required to purchase. For example, physicians who in 1976 were required to purchase $1.1 million per occurrence and $3.3 million annual aggregate (i.e., $100,000/$300,000 from a private insurer and $1 million/$3 million from the Fund) are now required to purchase $1.2 million per occurrence and $3.6 million annual aggregate (see Exhibit 1).

- *Surcharge Calculation and Claims Payment.* Act 1980-165 made important changes to the way in which the Fund's annual surcharge is calculated and when claims are paid. Act 165 removed the requirement that the surcharge be calculated based on actuarial principles and reasonably anticipated claims and operating costs. The act also removed the 10 percent surcharge cap. In place of these provisions, the amended act provided for a retrospective calculation of the annual surcharge based on claims paid and expenses incurred during the preceding calendar year. The act removed the $15 million fund balance restriction and allowed the Fund to maintain a $15 million balance as a cash flow buffer--an amount roughly equivalent to the Fund's annual claims payout level when the statute was amended. All final claims were to be paid on or before December 31 and they could not be carried over for payment the following year. Moreover, final claims were to be determined as of August 31 rather than on December 31.

Exhibit 1

Pennsylvania's Required Medical Professional Liability Insurance

Mandatory (Occurrence/Annual Aggregate)		Mandatory (Occurrence/Annual Aggregate)		Total Mandated Coverage (Occurrence/Annual Aggregate)
Primary or Basic Coverage $200,000/$600,000 for physicians $200,000/$1,000,000 for hospitals	+	Excess Coverage From the Fund $1,000,000/$3,000,000	=	$1,200,000/$3,600,000 for Physicians $1,200,000/$4,000,000 for Hospitals

Source: Developed from 40 P.S. §1301.701.

- *Emergency Surcharge.* The 1980 amendment also authorized the Insurance Commissioner to impose an emergency surcharge on health care providers should Fund revenues be insufficient to pay all claims settled during the year.

Judicial Decisions and Rules Affecting the Fund

The Pennsylvania Supreme Court has nullified several key provisions of the original 1975 act, such as arbitration panels, limits on attorney fees, and reducing awards by the amount of collateral payments from public sources.

Arbitration Panels

Act 111 created Arbitration Panels for Health Care as a mechanism for the prompt and reasonable settlement of claims. These panels, which included lay persons, two health care professionals, and two attorneys, were intended to resolve claims that could not be settled between patients and their health care providers' insurers. The arbitration panels were empowered to hear and decide claims and "make determinations as to liability and award of damages."

Arbitration panel decisions could be appealed to the courts of common pleas, which would newly (de novo) consider the claim. To discourage unnecessary appeals, Act 111 made the appellant liable for all costs of arbitration and trial, if the court found the appeal to be frivolous. These costs included record fees, arbitrator's compensation discovery fees, and expert witnesses.

In Mattos v. Thompson, the Pennsylvania Supreme Court declared the arbitration panels unconstitutional because they burdened the right to jury trial. The Court's opinion was unclear as to whether the arbitration panels per se were unconstitutional. The Attorney General issued an opinion finding that the court struck down only one section pertaining to the arbitration panels, but in 1984 the Supreme Court said that the effect of the Mattos decision was to nullify all of the arbitration procedures of the act.[2]

Limits on Attorney Fees

Act 111 also limited attorneys fees to 30 percent of the first $100,000 awarded, 25 percent of the second $100,000, and 20 percent of the balance of the award. This provision was included in a portion of the act pertaining to arbitration panels and was therefore invalidated when the Pennsylvania Supreme Court nullified the arbitration procedures of the act.

---

[2]In 1984, the arbitration hearing system was replaced by a conciliation conference service that conducted court-supervised settlement conferences. Funding for the Health Care Arbitration Panels continued until FY 1995-96. The arbitration provisions were repealed by Act 1996-10.

Collateral Payments

The act also provided that, for injured parties who had received payments from public sources for compensation or benefits, the value of that public support was to be deducted from the claimants' award. In 1984, this provision was also invalidated when the Pennsylvania Supreme Court nullified the act's arbitration procedures.

Mandated Insurance

With the passage of Act 111, Pennsylvania joined a minority of states in mandating that physicians, hospitals, and other health care providers[3] carry malpractice insurance. (See Chapter IV for additional information about other states.) To assure that health care providers would have such insurance available to them, the act provided for the creation of a Joint Underwriting Association to offer coverage for those unable to obtain it through commercial insurers.

On several occasions, the courts have upheld the provisions of the act mandating that health care providers purchase medical malpractice insurance from private insurers and excess insurance from the Fund.

Delay Damages

In 1978 the Pennsylvania Supreme Court adopted Rule of Civil Procedure 238. In its present form,[4] this rule provides for the awarding of pre-judgment delay damages for the period of time from one year after the case was filed to the date of an award, verdict, or decision. This period, however, excludes the period of time after the defendant offers to settle the case if the offer is at least 80 percent of the award. Such damages can be significant because they are calculated based on the prime rate plus one percent. Pre-judgment delay damages awards are discussed further in Chapter III.

Post-Judgment Interest

The courts have also recently ruled that the Fund is liable for payment of post-judgment interest. Thus, if a verdict is rendered on September 1, 1994, but is not paid by the Fund until December 31, 1995, the courts can require the Fund to pay interest for the period September 1994 through December 1995 on the amount

---

[3]In the current statute, health care providers include primary health centers or a person, corporation, facility, institution or other entity licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, an osteopathic physician or surgeon, a certified nurse midwife, a podiatrist, a hospital, a nursing home, or a birth center.

[4]This Rule was promulgated in 1978. It was suspended due to constitutional concerns in 1986 when the court fashioned a temporary rule. Rule 238 was formally amended in 1988.

due from the Fund. Post-judgment damage awards are discussed further in Chapter III.

Fund Balance

In 1988 the Commonwealth Court, in a one-judge unpublished decision resulting from litigation brought by the Pennsylvania Medical Society, determined that the Fund's 66 percent annual surcharge approved by the Insurance Commissioner should be reduced because the Fund's balance was greater than $15 million. At the time, the Fund had a year end balance of $56 million. The 1990 and 1991 annual surcharges proposed by the Fund were subsequently reduced by the Insurance Commissioner after the 1988 decision because the Fund's balance was above $15 million. By the end of 1991 the Fund's balance dropped below $15 million and the Insurance Commissioner approved the annual surcharge proposed by the Fund. (See Appendices A and B for information on proposed and approved annual surcharges in recent years and the Fund's year end balances.)

However, in January 1996, the Commonwealth Court ruled that the $15 million cash flow buffer provided for in the act should not be interpreted as a cap on the Fund's balance. The Fund believes this decision means its surcharge can reflect additional revenue as needed to make the surcharge adequate and actuarially sound.

Claims History

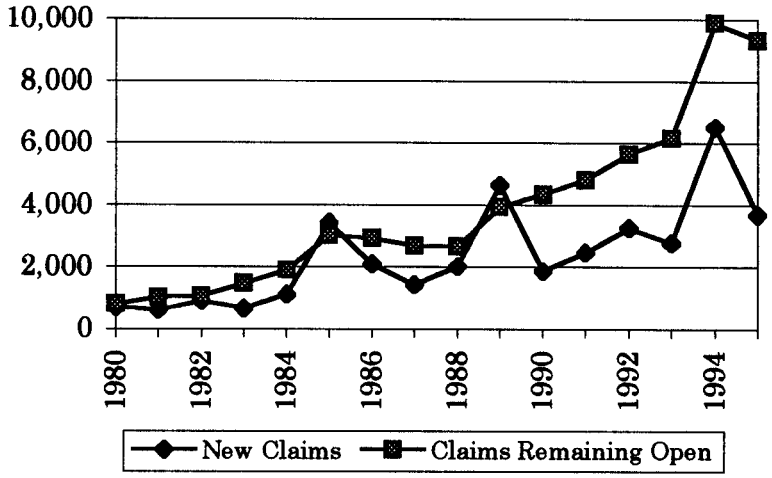
According to Fund records, a total of 39,258 claims have been filed with the Fund between 1976 and December 31, 1995. During this period the Fund has paid 5,453 claims.

As shown in Exhibit 2, the number of new claims filed with the Fund has increased from an annual average of 2,289 in 1984 and 1985 to an annual average of 4,347 for 1993, 1994, and 1995. Because the number of new claims filed is rising faster than the number of claims settled, the number of claims remaining open at the end of the year is also rising, from 3,033 at the end of 1985 to 9,333 at the end of 1995.

As shown in Exhibit 3, the number of claims paid has increased substantially since 1980. The number of claims paid remained fairly stable from 1986 through 1994, but shot up in 1995. The reasons for the 1995 increase are explained in Chapter III.

Exhibit 2

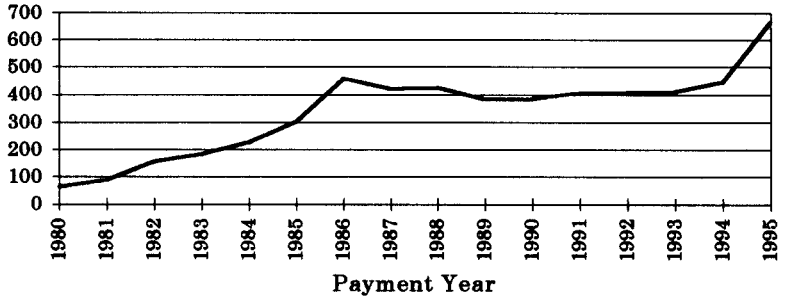
New Claims Opened and Claims Remaining Open at Year End
(1980 Through 1995)



Source: Developed from information reported in the Fund's Annual Statistical Reports and Fund Bulletins. The numbers used to generate this graph can be found in Appendix C.

Exhibit 3

Paid Claims*



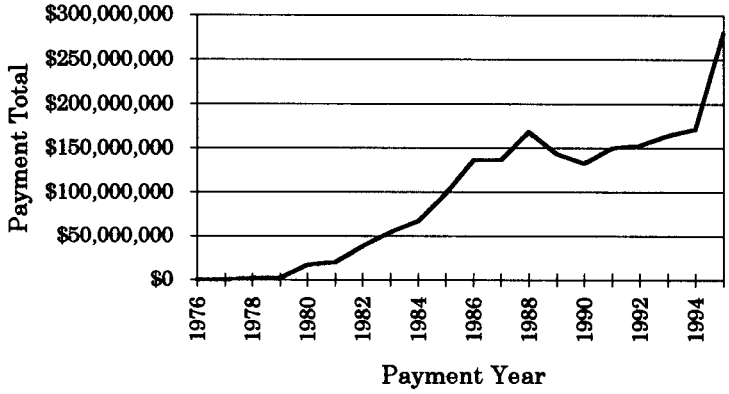
*This exhibit shows the number of Fund health care provider paid claims. Because the Fund pays claims against individual health care providers, one claimant can receive multiple payments from the Fund as a result of filing claims against more than one provider. See Appendix D for the number of claimants from 1978 through 1995.

Source: Developed from information reported in the Fund's Annual Statistical Reports and other Fund reports. The numbers used to generate this graph can be found in Appendix E.

As shown in Exhibit 4, Fund payouts have also increased significantly since the early 1980s. Total Fund payouts were $ 1.93 billion as of December 31, 1995.

Exhibit 4

Fund Payouts



Source: Developed from data in the Annual Reports of the Fund and other Fund reports. The numbers used to generate this graph can be found in Appendix E.

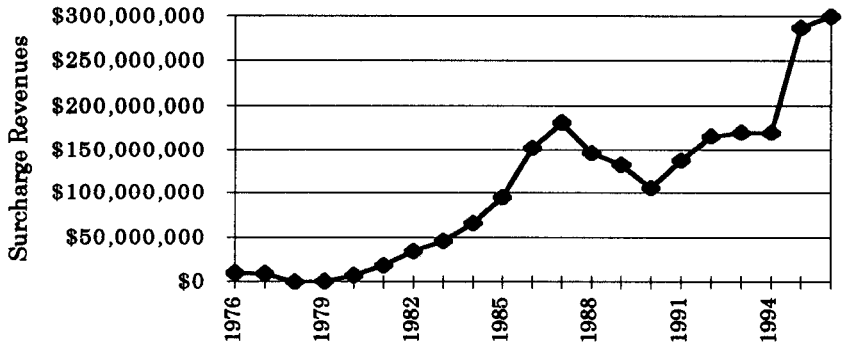
Surcharges and the Unfunded Liability

Surcharge Collections

Between 1976 and 1995, the Fund has collected over $1.94 billion in surcharge revenues from approximately 40,000 Pennsylvania health care providers on average annually. As shown in Exhibit 5, the amount collected ranged from zero dollars in 1978 to $286 million in 1995.

Exhibit 5

Fund Surcharge Collections and 1996 Estimate



Source: Developed from the Hofflander & Nye Malpractice Study for 1976 through 1983 and the Annual Reports of the Fund for 1983 through 1994; 1995 collections, which include the emergency surcharge, were provided by the Fund. The estimate for 1996 is taken from the Fund's 1996 Annual Surcharge Request. The numbers used to generate this graph can be found in Appendix F.

Unfunded Liability

Because the Fund operates on a pay-as-you-go-basis, it does not reserve funds to pay for claims filed but not yet settled or for claims incurred but not yet reported, known in the insurance industry as IBNR. Each year, however, the Fund contracts with an independent actuary to make an actuarial analysis of these potential liabilities. Table 3 shows the Fund's estimated ultimate losses, calendar year claim payments, and the resulting unfunded liability on December 31 of each year since the Fund's inception. As the table shows, the unfunded liability has grown every year since the Fund's inception. According to the Fund's most recent actuarial report, the unfunded liability was $1.95 billion as of December 31, 1995 ($1.46 billion present value on a 6 percent discount basis).

Table 3

The Fund's Most Recent Reported Unfunded Liability

Year	Accident Year Ultimate Losses	Calendar Year Claim Payments	Unfunded Liability as of December 31
1976	$ 53,354,214	--	$ 53,354,214
1977	64,033,801	--	117,388,015
1978	89,335,923	$ 2,450,717	204,273,221
1979	101,489,725	2,265,000	303,497,946
1980	139,262,388	16,333,839	426,426,495
1981	162,121,979	19,555,472	568,993,002
1982	179,236,160	38,076,060	710,153,102
1983	196,258,930	54,169,175	852,242,857
1984	177,996,635	66,786,997	963,452,495
1985	162,773,690	97,724,928	1,028,501,257
1986	205,952,270	136,064,199	1,098,389,328
1987	208,516,235	136,050,829	1,170,854,734
1988	248,307,228	168,327,197	1,250,834,765
1989	222,151,379	143,613,571	1,329,372,573
1990	266,808,959	132,059,492	1,464,122,040
1991	262,244,374	150,053,687	1,576,312,727
1992	262,356,442	153,221,558	1,685,447,611
1993	275,531,770	164,495,505	1,796,483,876
1994	295,791,778	171,842,345	1,920,433,309
1995	313,923,024	279,552,207	1,954,804,126

Source: Developed from the *Medical Professional Liability Catastrophe Loss Fund, Estimation of Unfunded Liability as of December 31, 1995*, prepared by Coopers & Lybrand, LLP.

Administrative and Operating Expenses

Table 4 shows that the Fund's operating expenses have increased from $3.2 million in 1986 to $17.9 million in 1994. In 1993 there was a sharp drop in the Fund's operating expenses due to the discontinuation of its reinsurance policy. As the table shows, much of the increase in the Fund's operating expenses is attributable to contracted legal costs associated with the Fund's Section 605 cases.

Table 4

The Fund's Operating Expenses

Calendar Years	Total Operating Expenses	Legal and Consulting Fees	Percent Legal and Consulting Fees
1982.....	$ 736,142	$ 70,790	10%
1983.....	1,178,708	286,689	24
1984.....	1,903,416	447,223	24
1985.....	2,021,072	500,683	25
1986.....	3,232,051	1,243,129	38
1987.....	3,956,934	1,870,582	47
1988.....	6,242,655	2,476,307	40
1989.....	6,260,861	2,364,365	38
1990.....	9,364,022	3,250,271	35
1991.....	11,824,080	4,681,545	40
1992.....	14,212,434	7,201,791	51
1993.....	9,223,427	7,069,151	77
1994.....	17,915,347	11,774,937	66
1995.....	13,408,464	9,455,573	71

Source: Developed from information in the Fund's Annual Statistical Reports and other Fund information.

As shown in Table 5, in FY 1995-96 the Fund anticipates spending $20 million in operating costs (all costs other than claims payment). The Fund has requested approval from the Governor's Budget Office to spend $25.6million for operating costs in FY 1996-97.

Table 5

FY 1995-96 Fund Budget

	Amount Budgeted
Personnel Services	$ 2,144,927
Consultant Fees	820,961
Legal Fees	9,000,000
Insurance Surety Fidelity Bond	7,500,000
Other	628,272
Fixed Assets	235,840
Total	$20,330,000

Source: Developed from data provided by the Fund.

III. Issues to Consider in Reforming, Restructuring, or Terminating the Fund

This chapter addresses what we believe to be the most significant issues that need to be considered in the debate over whether and how to reform, restructure, or terminate the Fund. The chapter is divided into five sections: general management issues, claims management issues, financial management issues, issues regarding the availability and affordability of medical malpractice insurance in Pennsylvania's current marketplace, and tort reform.

General Management Issues

State Administrative Requirements Imposed on the Fund

The Medical Professional Liability Catastrophe Loss Fund is an executive branch agency within the Governor's Executive Office and, as such, must comply with the statutes and policies governing state agencies under the Governor's jurisdiction. This means, for example, that all of the Fund's personnel and financial transactions must be approved by the Governor's Budget Office and the Office of Administration.[1] Such approvals are required even though Fund dollars are 100 percent health care provider funds and no tax dollars go to support its operations.

As a consequence, the Fund's director must operate within funding allotments and staffing levels established by the Governor's Budget Secretary. As shown in Table 6, historically the Fund's approved staffing levels have not equaled the number of positions the Fund director has thought it needed.

The current Fund director obtained permission from the Governor's Budget Office to increase the Fund's approved staff complement from 41 positions in 1994 to 52 positions and to assign Section 605 claims, previously handled by a contractor, to the newly hired Fund staff. Fifteen of the 52 positions, however, are limited term positions set to expire on June 30, 1997. As shown in Exhibit 6, as of April 4, 1996, the Fund had 52 approved positions of which 5 were vacant. If the 15 temporary positions, of which 5 are vacant, expire, the Fund's staff will be reduced by more than 20 percent.

[1]This requirement is contained in the Administrative Code (71 P.S. §235): "Each administrative department, board and commission . . . shall from time to time, as requested by the Governor, prepare and submit to the Secretary of the Budget, for approval or disapproval, an estimate of the amount of money required and the levels of activity and accomplishment for each program carried on by each department, board, or commission, during the ensuing month, quarter, or such other period as the Governor shall prescribe. . . . If such estimates do not meet with the approval of the Secretary of the Budget, it shall be revised as necessary and resubmitted for approval. The Secretary of the Budget may establish an authorized personnel complement level in conjunction with the approved expenditure estimate."

Table 6

Requested and Filled Complement

	Fund Requested Complement	Filled Staff Complement
1985	28	20
1986	28	22
1987	34	23
1988	36	30
1989	36	29
1990	36	31
1991	39	36
1992	39	36
1993	37	34
1994	41	33

Source: Developed from information contained in the Fund's annual submission to the Governor's Budget Office.

The Fund has also been criticized, at least in the past, for partisan hiring practices. For example, in documents filed in Commonwealth Court, a deputy director of the Fund for four years during the previous Administration is reported to have been employed without prior experience in the insurance industry and to have used certain Fund employees to do political work on state time. We should note, however, that virtually everyone we spoke to who was familiar with the Fund's current claims examiner staff were complimentary, characterizing them as knowledgeable and hardworking. As discussed on page 30, the Fund has also been criticized for partisan considerations in its selection of contracted legal counsel. These attorneys, however, are actually selected by the Office of General Counsel.

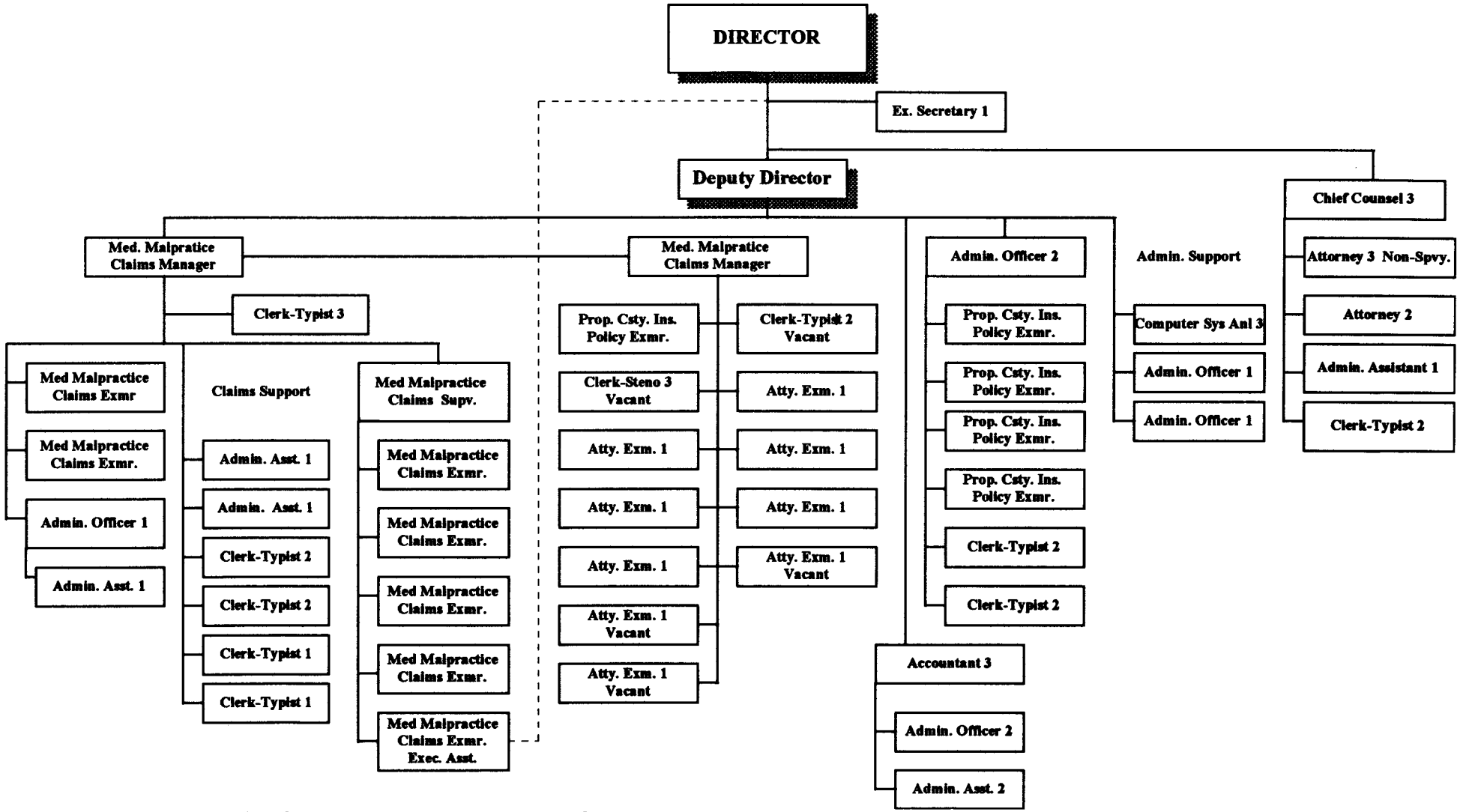
Until recently, the Fund also had no in-house computer capability, relying instead on services provided by the Commonwealth's Computer Management Information Center (CMIC). CMIC, however, has broad responsibilities to provide computer services for many state agencies. Within the past year the Fund hired a Computer Systems Analyst who, in the director's words, "is working diligently to bring the Fund's computer system into the nineties."

Lack of Continuity in Fund Policies

The director of the Medical Professional Liability Catastrophe Loss Fund establishes formal Fund policy by issuing documents known as Fund Bulletins. Unlike regulations, these policies do not undergo legislative review and can be changed at any time.

Exhibit 6

Medical Professional Liability Catastrophe Loss Fund
Organization Chart



Source: Medical Professional Liability Catastrophe Loss Fund, April 4, 1996.

For example, in 1992 the Fund's director instituted a policy whereby the Fund paid the legal costs to defend claims when a primary insurer had exceeded annual aggregate coverage limits (e.g., $600,000 for physicians). Three years later a new Fund director reversed this policy.[2] Such abrupt changes can cause disruption among medical malpractice insurers and their customers. In this instance, for example, some major professional liability insurers had provisions in their policies specifically limiting the insurer's responsibility for legal costs once the insured's policy coverage limits are exceeded.[3]

Another example is the Fund's informal policy concerning the timeliness of claims settlement. The current director, for example, has taken a different approach to settling claims than his predecessor, who often delayed settlement of claims. The current director has taken the position that it is in the best interest of the Fund, claimants, and health care providers to settle claims as early in the process as possible.

Health care providers have generally praised the current Fund director for taking a more aggressive approach in settling claims. However, they note that the Fund's philosophy about claims settlement can change whenever a new director is appointed, and a new director may reverse the policies now in place.

Little Opportunity for Public Input Into Fund Policies

The Fund has authority to issue rules and regulations "regarding the establishment and operation of the Fund including all procedures and the levying, payment, and collection of the surcharges," 40 P.S. §1301.701(e)(4). The Fund also has authority to "promulgate rules and regulations relating to procedures for the reporting of claims to the fund," 40 P.S. §1301.702(a). As noted above, however, most Fund policies are issued through Fund Bulletins rather than regulations. These bulletins are not required to undergo public or legislative review such as is required for regulations. As a result, there is little opportunity for formal public input into Fund policies.

When interested parties object to a policy issued by the Fund, they can resort to the courts to be heard. An example of this occurred in 1994 after the Fund's director issued Bulletin 64. Bulletin 64 required primary insurers to (1) evaluate a claim within 120 days of filing and to notify the Fund within 30 days thereafter if the insurer believed the claim exceeded the provider's primary coverage; (2) make a good faith effort to obtain the consent of the insured within 90 days of notifying the Fund; and (3) tender the case to the Fund at least 45 days before the scheduled

---

[2]Fund policies were set forth in Fund Bulletin 59 issued February 11, 1992, and Fund Bulletin 74 issued January 18, 1995.

[3]In July 1995, a hospital petitioned Commonwealth Court challenging the Fund's policy concerning nonpayment of provider legal costs when the insured's primary limits have been exceeded. This case is currently before the courts.

trial. Failure to comply with the bulletin could result in denial of Fund coverage or a suit by the Fund because of bad faith claims handling by the primary insurer.

The Fund claimed that Bulletin 64 was a statement of policy rather than a regulation. In Physicians Insurance Company v. Callahan, the Commonwealth Court disagreed, finding that the Bulletin was a regulation and not a policy statement. The court also held that the Fund lacked the authority to promulgate parts of the Bulletin even as a regulation. [4]

Another mechanism for providing input into Fund policies, which was created by the initial legislation establishing the Fund, is a committee to meet on an ad hoc basis to provide oversight to the Fund. This committee appears to have last met in 1987.

As discussed in Chapter IV of this report, the two other states that have mandatory participation funds, Wisconsin and Kansas, have governing boards that provide for formal input and participation by health care providers and other interested parties into the policies of their funds.

Inadequate Management Information

The Fund's data systems do not provide the historical data needed to accurately estimate the Fund's outstanding claims liabilities. In particular, the Fund does not have reliable estimated claim values from which to project future payments.[5] Maher Associates, Inc., the consulting actuaries for the Fund in 1994, reported that they tried to develop estimated claim values from Fund data files, but the Fund did not have sufficient data for occurrences prior to 1988. The lack of such data limited the actuaries' options for estimating the unfunded liability.

The Fund's automated data system also does not provide information needed for key management and policy decisions. For example, the Fund cannot provide information to compare surcharge receipts against claims settlement payouts by county. This cannot be done because the current data system is unable to identify health care providers who live in one county and work in another. Thus, if a Montgomery County physician receives his medical malpractice insurance bills at his home address but is involved in a medical malpractice case resulting from an incident at a Philadelphia hospital, the Fund would list the surcharge receipt as coming from Montgomery County but the claim liability as being from Philadelphia.

---

[4]In order for the Fund to have had authority to issue parts of the Bulletin as a regulation, the Generally Assembly would have to be willing to authorize the Fund to issue regulations concerning the tendering of cases and obtaining consent from an insured.

[5]The Fund initially assigns a flat $125,000 value to a claim and then revises it as the claim progresses. As a result, a large number of the Fund's claims are valued at the flat $125,000 amount. Many of these claims will ultimately be closed without payment. Others will be paid at substantially higher amounts.

This information would be important if the Legislature wished to use geography as a factor when assessing surcharges.

The Fund also does not consistently record whether payments were the result of a settlement or a jury verdict, which could be useful information in determining Fund policies regarding when to take a claim to trial. The Fund also does not capture information on whether the amount paid on behalf of a provider is due to a particular provider's actual liability for an injury or results from "joint and several liability." This data would be important if the Fund was given underwriting authority, as has been recently proposed.

Claims Management Practices

As health care costs and settlements escalate, more and more claims fall within the Fund's coverage limits, making the Fund's practices increasingly important. Health care providers and insurers have identified several concerns about the Fund's claims management practices that can result in higher costs to them to settle medical malpractice cases. As discussed below, the Fund's current director has modified or eliminated several, but not all, of these practices.

The most significant Fund practices of concern to health care providers and insurers are:

- not operating in good faith by delaying settlements, requiring providers to use their own funds to settle claims within the Fund's limits, and apportioning higher settlement costs to providers who have purchased additional excess insurance while not assigning the full limit of the Fund's coverage for codefendants;
- not paying the Fund's proportionate share of pre-judgment delay damages above the Fund's coverage limits;
- not paying post-judgment interest above the Fund's coverage limits; and
- delaying the assignment of legal counsel for Section 605 cases, changing attorneys assigned to defend such cases when changes occur in the Administration, assigning inexperienced attorneys, and contracting with law firms that may have a conflict of interest.

Concerns Related to Good Faith by the Fund

The relationship between the Fund and health care providers is fundamentally different than the relationship between commercial insurers and health care providers. In particular, the Health Care Services Malpractice Act (40 P.S. §1301.101 et seq.) does not establish a contractual relationship between the Fund

and the health care provider similar to that which exists between health care providers and commercial insurers.

Commercial insurers, because of their contractual and fiduciary relationship with their insureds, are obliged to act in the interest of their insureds when handling medical malpractice claims. In short, they are required by the courts to settle claims in good faith. If a Pennsylvania court determines that a private insurer has acted in bad faith, it can require the insurer to pay punitive damages and assess court costs and attorney fees.[6] Actions that constitute bad faith by a primary carrier include unreasonably refusing to settle a case when doing so is the prudent course of action, deliberately refusing to offer its policy limits in an obvious liability situation, and failing to conduct a proper and appropriate investigation of a claim.[7]

The Fund, however, is immune from bad faith damages. As a consequence, it has more latitude to delay settlement of cases, make low settlement offers (thereby risking the case going to a jury trial), and apportion liability among providers to keep Fund costs down without regard to an individual provider's responsibility for the malpractice.

Delaying Settlements. Prior to the appointment of the current Fund director, the Fund often delayed settlement of cases that had been tendered to the Fund. Tendered claims are those which are turned over to the Fund because the primary insurer believes the Fund's financial participation is necessary to reach a final settlement agreement. The Fund is then responsible for valuing and settling the case. (For detailed information on the Fund's claims management processes see Appendix G.) Delay in settling claims can be a serious problem for health care providers because it is generally accepted that the cost to settle a claim increases over time, in part because of the additional legal and discovery costs that are incurred. Also, settlement delays can increase the amount of delay damages awarded if the case is decided by a court arbitrator or a jury.

The Fund's current director has testified that when he came to the Fund he learned that

> . . . in an attempt to avoid an emergency surcharge, a plan was established [by previous directors] to stall settlements by limiting individual settlement authority; requiring that all Philadelphia cases, no matter how small, be reviewed by mini-claims committees; and claims

---

[6]A court can order the insurer to pay interest from the time the claim was made at the prime interest rate, plus three percent.

[7]If a private insurer engages in such practices to the detriment of the Fund, it can recover amounts it spends because of the insurer failing to act in good faith. In Judge v. Allentown and Sacred Heart Hospital (Commonwealth Court, 1985), the Fund sought to recover the amount it spent to settle a case. It claimed that the primary insurer failed to make a good faith investigation of the case and failed to make an offer to settle it in good faith. The Commonwealth Court held that the Fund stated a cause of action and so could recover the money it spent to settle the case.

examiners were to be unavailable to outside parties one business day per week (the theory being, if the examiner wasn't available, the case couldn't be settled).

When he was appointed in July 1995, the present Fund director instituted a new claims settlement philosophy. The new director requested Fund staff and insurance carriers to identify cases that needed urgent attention. He also directed staff to identify and settle those claims where serious medical injuries have occurred and to make conservative settlement offers early in the case before the positions of the claimant and the defendants become entrenched. By settling such cases early, the Fund hopes to hold down ultimate settlement costs. In part as a result of these efforts, the Fund paid 551 cases in 1995 compared to 370 cases the previous year.

Offering Low Settlements, Thereby Forcing Providers to Use Their Own Funds to Settle Cases. When the primary insurer and its insured health care provider agree that a claim should be settled but the proposed settlement is greater than the coverage available from the insured's primary carrier, the insurer tenders its coverage to the Fund.[8] The Fund then controls the claim negotiations. If the claimant demands more than the Fund is willing to pay to settle the claim, the Fund can allow the claimant to bring the case to trial (see Appendix G). Thus, it is important that the Fund make realistic offers to avoid subjecting the health care provider to the cost and uncertainty of a trial.

If the Fund's settlement offers are unrealistically low, health care providers may be, in effect, forced to contribute additional funds to avoid the uncertainty of a jury trial. Although several hospitals report that the Fund has engaged in such practices in recent years, we were not able to verify the extent to which such practices may have occurred. We did, however, review one such case that illustrates the difficulties that can arise for health care providers when the Fund can control settlement negotiations but is not obligated to act in good faith (see Case 1).

Apportioning High Settlement Amounts to Providers With Additional Layers of Excess Insurance. Claims involving multiple defendants are often costly to resolve. According to several insurers, to settle such claims the Fund will tender its full coverage to the provider with additional excess coverage--typically a hospital--but will not tender or will tender only limited coverage for the codefendants. This places the hospital with the excess coverage in the position of having to risk allowing the case to proceed to the court because of a low settlement offer or contributing additional hospital funds to make a higher, more reasonable, settlement offer.

---

[8]If the primary insurer and the insured do not believe that a claim should be settled, they do not tender the claim to the Fund and will prepare to defend the claim.

Case 1

This case was settled in the spring of 1994, for a total of $1,500,000. The hospital itself contributed a substantial sum to fund the settlement, after the CAT Fund made clear its intention to allow the matter to proceed to trial rather than close the gap between its offer and the plaintiffs' bottom line demand.

This case arose out of an HIV-tainted blood transfusion ordered for the plaintiff by her physician following the delivery of her first baby. The blood was supplied by a licensed supplier and transfused at the hospital. When the plaintiff was pregnant with her second child, she learned she was HIV positive. The HIV infection was attributed to the blood transfusion. Both of the children went on to develop the HIV virus, and the mother progressed to full-fledged AIDS. She was near death when the case was set to begin trial. The theory of liability as to the physician was that he was negligent in ordering the blood, because a transfusion was not really necessary. As to the hospital, it was claimed that inadequate policies existed for obtaining consent for the transfusions. The blood supplier was named a defendant as the provider of the tainted blood. As the trial date approached, serious settlement discussions were pursued, with active participation by the judge who was to try the case. Tenders of primary limits had been made by both the doctor and the hospital, meaning that the CAT Fund had control of the negotiations on behalf of both defendants. The blood supplier had earlier settled with the plaintiff. By Friday afternoon, with trial set to begin on Monday, the judge had persuaded the plaintiffs to accept $1,500,000 to settle the case. That figure was reached after considerable discussion with the attorneys, and the judge made it clear to the defendants that he would not press the plaintiffs for any further reduction in their demand. The proposed settlement was well within the $2,400,000 the CAT Fund had available to resolve the case. The Fund's representative was present for the conference. She called her office during the conference to report that the judge was urging settlement at the $1,500,000 figure and to recommend that the Fund agree to it.

Despite the strong recommendations of the hospital's defense attorney, the judge, and their own representative, the Fund refused to move from the $1,200,000 figure (which included the providers' primary limits) it had previously established as its "top dollar." Defense counsel had reported that the case was likely to result in a verdict for the plaintiff, with dollar potential in the range of $5,000,000 to $10,000,000. If the case did not settle that day, the trial would begin the following Monday (the day after Mother's Day). The tragic plight of this family was expected to be a dangerous influence on a jury.

In light of these concerns, and the fact that the hospital would be targeted as the "deep pocket," a decision was made that afternoon by the hospital to fund the $300,000 shortfall between the plaintiff's demand and the CAT Fund's final offer. The case did settle that afternoon, with the hospital's commitment to make a payment from its self-insured layer of coverage above the CAT Fund layer.

The commercial excess carrier for the hospital has now taken the position that the hospital's payment from its self-insured layer of coverage did not qualify as a payment eroding the aggregate for that layer, because it was "voluntary." The excess carrier's reasoning is that no payment was required of the hospital until the CAT Fund had paid in full the hospital limit, and the CAT Fund had not paid its limit in this case. This has resulted in further litigation expenses to the hospital, as it battles the excess carrier over the coverage issue.

Source: Developed from information provided by a health care administrator.

We reviewed one case which illustrates the Fund's inherent conflict of interest in providing coverage above the primary layer for all of the defendants in a malpractice suit. It also illustrates the inequitable apportionment of settlement shares that can result when the Fund has exclusive control of negotiations and puts its own interests ahead of those of the health care providers (see Case 2).

Hospitals have questioned how the Fund goes about assigning liability among providers, noting that the Fund's apportionment has often differed from theirs. We reviewed one case which illustrates how Fund apportionment differed not only from the hospital's but also a jury's (see Case 3). In these situations, the position of the hospital and others with excess coverage is further complicated by Pennsylvania's liability statutes and court decisions. In Pennsylvania when a medical malpractice case involves more than one defendant, responsibility for payment of judgments can be apportioned among all of the providers based on each one's degree of responsibility for the injury, or the courts can impose "joint and several" liability on the multiple defendants. Imposition of joint and several liability allows the person who has been injured to obtain the entire amount due from one of the several defendants, even if that one defendant contributed only a small part to the harm inflicted on the claimant.

To address the problem of apportioning liability in cases involving multiple defendants without having to resort to a jury trial, until recently, insurers had available a voluntary peer arbitration system that allowed independent medical reviewers to assess and apportion liability.[9] However, according to the official who coordinated this system, more often than not, the Fund took the position that they were not permitted to participate in situations where the arbitrators' decision could affect the total amount paid by the Fund.

Not Paying Pre-Judgment Delay Damages Above the Fund's Coverage Limits. To encourage timely settlement of claims, in 1978 the Pennsylvania Supreme Court adopted a rule to award pre-judgment delay damages in certain circumstances when a case must be decided by a court or court-appointed arbitrators. Pre-judgment delay damages are awarded for the period from one year after the case begins to the date of the decision, excluding any period after which the defendant offers to settle the case so long as the defendant made a settlement offer that was at least 80 percent of the amount awarded by the courts. Such damages can be quite high because they are calculated using the Federal Reserve Bank's prime interest rate published the first week in January each year plus an additional one percent.[10]

---

[9]The state official who coordinated this program was recently reassigned to other duties.

[10]For example, in January 1980, the prime rate used to calculate delay damages was 15 to 15.5 percent, and in January 1981 the rate was 20.5 to 21.5 percent. For 1996, the rate is 8.5 percent.

Case 2

This case arose out of the care provided to an infant during the period immediately before and after her delivery. She had severe respiratory difficulties from birth and, despite aggressive therapy, went into cardiac arrest the day after her birth. She was successfully resuscitated but suffered profound and permanent brain damage. Her suit originally named the attending pediatricians and the hospital. The obstetrician was brought into the case later.

As to the pediatricians, the theory was that they delayed in responding to the infant's worsening condition on the first day of life. As to the hospital, it was claimed that excessive time elapsed before a chest x-ray was taken following a STAT[a] order. As to the obstetrician, the theory was that the medications prescribed during the mother's pregnancy increased the risk of the cardiac arrest which occurred within hours of the baby's birth. Because the obstetrician had been brought into the case more than four years after the baby's birth, his defense was controlled by the Fund, pursuant to the provisions of Section 605.

Although the defendants had credible expert support on the liability issues, the magnitude of the injury was such that the health care providers believed a compromise settlement was appropriate. With the trial date rapidly approaching, the judge held a settlement conference in December 1994. He was recommending a figure of $1,750,000. The Fund had received tenders of primary limits from the hospital and the neonatologist, totaling $400,000. The Fund's limits for those defendants, together with its limit for the obstetrician under Section 605 thus gave the Fund a total of $3,400,000 available to settle the case.

After considerable discussion among the parties, with the continued participation of the judge, the Fund came up with a final offer of $1,600,000 to settle the case as to all defendants. This was comprised of $1,200,000 on behalf of the hospital and $400,000 on behalf of the neonatologist. No contribution was offered on behalf of the obstetrician, despite repeated requests from the doctor himself and the defense attorney. Having already moved substantially on their demand, the plaintiffs would not discuss a figure below the judge's recommended number. At that point, the Fund made a formal tender of its limit back to the hospital, calling upon the hospital to close the $150,000 gap between the plaintiff's demand and the Fund's final offer.

The Fund's offer represented an apportionment of 75% to the hospital, 25% to the neonatologist, and nothing to the obstetrician. The thrust of the expert opinions in the case in no way supported such an apportionment. The case had been targeted at the physicians, with the hospital in a secondary position. The Fund's tender back to the hospital would have increased the hospital's already disproportionate share of the settlement, and the hospital alone would bear the risk of a trial and runaway verdict. The hospital did offer additional money, and the case ultimately settled for $1,700,000.

---

[a]Abbreviation for the Latin word sta'tem, meaning immediately.

Source: Developed from information provided by a health care administrator.

Case 3

This case involved a prominent, successful 48 year old businessman who died during an outpatient stress test. At the time of the incident, the hospital identified potential problems with the resuscitation. Further investigation revealed the testing was improperly performed and arguably contra-indicated.

The case was filed in a Philadelphia court against the attending physician who had ordered the stress test, the resident who administered the test and was present for the resuscitation, and the hospital. From the outset it was clear the value of the case was high due to the patient's age, his high income, and the circumstances surrounding his death. The plaintiff initially demanded $10 million to settle the case. As discovery and trial preparation proceeded, defense counsel estimated a potential jury verdict in the range of $5 million to $8 million. Prior to the trial the Fund authorized a total settlement of $1.5 million. This included $600,000 in primary moneys for the three defendants and $900,000 of the potential $3 million in available Fund coverage. The Fund did not advise the hospital as to how it was apportioning the $900,000 in Fund dollars among the three defendants. Subsequently, the hospital determined that it had only $66,250 remaining from its aggregate primary coverage to go toward the settlement.

The Fund's $1.5 million offer was rejected by plaintiff's counsel. The Fund increased the total settlement offer to $2 million still without advising the hospital as to how it was apportioning Fund dollars. This offer was made the day before the trial, as the jury was selected, and it too was rejected. From the beginning the judge encouraged all parties to settle the case. Subsequently, plaintiff's counsel indicated that the case could be settled for $3 million, however, this offer would be withdrawn at the point final arguments began. The Fund refused to provide additional dollars and the trial started.

Trial began with plaintiff calling all the hospital witnesses. No problems with the resuscitation were raised. Plaintiff's efforts targeting the attending physician's order that the stress test be done and the resident's conduct during the procedure and the resuscitation were effective. At this point, defendants were concerned about a runaway jury verdict in excess of the $10 million settlement demand. Despite numerous calls made to the Fund by counsels for all defendants during the first days of the trial, the Fund refused to provide additional Fund moneys on behalf of the attending physician and, the hospital learned, had provided no Fund dollars on behalf of the resident. Instead the Fund continued to suggest that the hospital contribute additional funds despite the fact that the attending physician and the resident were the clear targets in the case. The hospital agreed to contribute $233,750 in hospital funds in addition to its $66,250 in primary insurance coverage, and the Fund then put up $300,000 in Fund dollars on behalf of the resident. At this point the Fund had made available $300,000 for the resident, $500,000 for the attending physician, and tendered its $1 million back to the hospital to settle the case. The Fund tendered back to the hospital even though it had made available only a total of $1.8 million of the $3 million in available Fund coverage to settle the case. With primary coverage, the hospital's contribution, and the $1.8 million in Fund dollars, this brought the total available for settlement purposes to $2.5 million--$500,000 short of the $3 million needed.

A decision was made to settle the case with the plaintiff for $3 million prior to the close of the plaintiff's case and the jury would listen to the defense attorneys' closing arguments and then apportion liability among the defendants. The Fund and the hospital agreed that the hospital would pay the extra $500,000 if the jury found it more than 43.3 percent responsible and the Fund would make the payment if the hospital found the hospital less than 43.3 percent liable. After closing arguments the jury found the attending physician 75 percent liable and the resident 25 percent liable. The jury found no liability for the hospital. Thus, the case settled for a reasonable amount because the hospital contributed $233,750 of its own Funds and agreed to risk another $500,000 if the jury had apportioned liability differently.

Source: Developed from information provided by a hospital administrator.

In May 1990 the Fund reversed its prior policy of not paying delay damages. It agreed to pay such damages so long as the payment plus the award did not cause the Fund to exceed its coverage limit of $1 million per occurrence and $3 million per annual aggregate.

Courts can require private insurers to pay delay damages even when such payments exceed their medical malpractice policy limits. The Fund, however, has not paid delay damages above its coverage limits. When the Fund does not pay its share of such damages, courts can hold health care providers and their insurers responsible for the Fund's share of the payment.

In 1994, a hospital and a physician entered a challenge to the Fund's position in Commonwealth Court. The hospital and physician are seeking to recover delay damages in excess of the Fund's liability limits for the period of time when the Fund had control of the claim and responsibility for negotiating a settlement with the claimant. Commonwealth Court, in a single judge opinion, agreed with the position of the Fund. This case, however, is still before the courts.

Not Paying Post-Judgment Interest Above the Fund's Coverage Limits. In 1992, Commonwealth Court held that the Fund is liable for payment of post-judgment interest. Post-judgment interest is the amount of interest the award could have earned from the date the award is made until it is finally paid. This is an important issue for the Fund because it pays awards only once a year (December 31 for awards finalized as of the prior August 31). Thus, under this ruling the Fund could be liable for as much as 16 months of interest on an award (e.g., from September 1, 1994, to December 31, 1995). The issue is important for health care providers and insurers because they can be held liable for the post-judgment interest if it is not paid by the Fund.

The Fund appealed the 1992 decision to the Pennsylvania Supreme Court. In July 1994 the Supreme Court upheld the decision of Commonwealth Court ruling that the Fund was not exempt from paying post-judgment interest. Following the Supreme Court's ruling, the Fund agreed to pay post-judgment interest when awarded by the courts to the extent that such interest, together with the damages awarded do not exceed its liability coverage limits ($1 million per occurrence/$3 million annual aggregate).

In a November 1995 preliminary ruling a three-judge Commonwealth Court panel sided with a hospital and a doctor challenging the Fund's position. The Court took the position that the Fund is liable for the payment of post-judgment interest even if it exceeds the Fund's statutory liability limits. The Fund is in the process of appealing this decision.

Delays in Accepting Section 605 Cases. The Fund, not the primary insurer, is responsible for the full defense of Section 605 claims. In brief, Section 605

claims are those which are filed more than four years after the alleged malpractice occurred but within Pennsylvania's statute of limitations.[11]

When insurers determine that a claim is a Section 605 claim, they are responsible for reporting it to the Fund. In December 1991 the Fund's director issued a policy stating that the Fund would not be responsible for any legal costs associated with a Section 605 claim until it had "opportunity to review and accept the claim"(emphasis in the original). This process, however, can take considerable time and legal matters that arise in the interim must be addressed.[12] Recognizing this, in 1991 the Fund's director required the health care provider's primary insurer to maintain a defense of the claim and the Fund during the interim period.

A health system administrator reported to us that his health system had been required to pay legal costs of $55,904 for 21 of the 25 Section 605 cases reported to the Fund over a 29-month period prior to January 1996. According to this administrator, if the Fund was a commercial insurance carrier, the health system would have been able to obtain reimbursement for these expenses. However, because of the Fund's immunity from legal action, providers cannot obtain reimbursement for the legal expenses they incur for Section 605 claims prior to the Commonwealth assigning an attorney to the case.

Health care providers have also raised concerns about the process used to assign legal counsel in Section 605 cases, the continuity of attorneys when Administrations change, the expertise of those assigned to defend health care providers, and the use of plaintiff firms to defend cases. Although we could not investigate all these charges, we did confirm that with the change in Administration in 1987 all contracts with law firms to defend health care providers in Section 605 cases were terminated.

The current Fund director has attempted to address many of the concerns over Section 605 cases. According to the director, the backlog in assigning cases has been addressed, law firms which have performed well in the past have been continued by the present Administration, and a conflict of interest provision has been included in contracts with law firms selected to defend Section 605 cases. In addition, a conflict of interest committee has been established within the Office of General Counsel to review situations where the potential for a conflict of interest exists.[13]

---

[11]See page 6 for additional information about Section 605 claims.

[12]For example if a provider is notified that he/she is being sued in court, the notice might indicate that action must be taken within 20 days after receipt of the complaint and notice by entering a written appearance personally or by attorney, and filing in writing with the court the provider's defenses or objections to the claim set forth against the provider. If the provider fails to take action the case may proceed without the provider and a judgment may be entered against the provider by the court without further notice. As a consequence the provider may lose money or property or other rights.

[13]This committee addresses potential conflicts of interest for any private counsel contracting with the state, not just attorneys working on behalf of the Fund.

Financial Management Issues

The Retrospective Formula the Fund Must Use to Determine Surcharges Makes Future Emergency Surcharges Likely

Act 1975-111, as amended, specifies that the Fund must base its projected need for operating revenue in the next calendar year on the following four values:

- Claim settlements to be paid by December 31 in the current year;
- Fund operating expenses for the current year;
- Deficits incurred by the Joint Underwriting Association (JUA);
- An amount sufficient to maintain an additional $15 million.

In practice, only three of the four values actually come into play, because the JUA has never incurred a deficit. The Fund has an actuary estimate the total basic limits premiums and determine the appropriate surcharge rate.

The statutory formula can contribute to shortfalls in Fund revenues because it is retrospective; the formula uses prior-year payments and operating expenses to determine the revenue the Fund can collect to pay bills in the upcoming year. As a result, the Fund can easily be placed in the position of collecting insufficient revenues to cover its costs because it can only collect enough to cover the last year's costs, not the projected costs for the current year.

For example, efforts by county courts to eliminate malpractice suit backlogs can cause annual claim payments to significantly exceed the previous year's total. The Philadelphia Court of Common Pleas implemented such a program, the Civil Case Delay Reduction Strategy, in 1992. It was designed to reduce the time from initial filing to final disposition of all major jury trials and bring Philadelphia's court into compliance with time-to-disposition standards set by the American Bar Association (ABA).

The Philadelphia strategy affects all civil cases where the amount at issue exceeds $50,000 and a jury trial has been demanded. Approximately 13,000 cases were cleared from the dockets, settled, or completely adjudicated between December 1992 and March 1994. According to court personnel, 15 percent of all major jury cases in Philadelphia are medical malpractice cases. The Fund's revenue formula provides no way for the Fund to anticipate and plan for increased claim payouts as a result of such court programs. Similarly, new developments in medical technology may result in new types of claims to be paid. For example, as of December 31, 1995, the Fund had 879 reported claims involving breast implants and 666 reported claims involving pedicle screws.[14]

---

[14]Pedicles are the bony structures that extend toward the rear of the body from each vertebra. Pedicle screws are spinal fixation devices that consist of plates or rods which are affixed to the spine by means of bone screws inserted into the pedicles of the spine.

Wisconsin, which also requires that medical providers participate in a state fund, addressed these issues by allowing their fund surcharges to yield an amount equal to the greater of estimated total payments for the upcoming year or 200 percent of the total amount paid during the preceding year.

In short, the statutory revenue formula combined with a low Fund balance (discussed below) does not give the Fund a sufficient operating margin to respond when uncontrollable variations occur from one year to the next. If claim payments and expenses seem likely to exceed available revenue, the Fund must choose between imposing an unpopular emergency surcharge or delaying claim payments. However, the decision to delay claims reduces the base for the next revenue estimate, virtually guaranteeing that the Fund will face the same dilemma 12 months later.

Estimated Insurance Premiums Provide an Uncertain Basis for Calculating the Fund's Surcharge Percentage Rate

Once the Fund's actuaries use the statutory formula to determine how much revenue the Fund can collect in the coming year, they must calculate the surcharge percentage rate that needs to be assessed to generate that amount of revenue. The actuaries must estimate the providers' total basic limits premiums by analyzing past surcharge collection trends and industry premium rate trends. In other words, the actuaries must try to predict what health care providers will pay for primary or basic coverage during the coming year because no one knows what individual providers will actually pay when they renew their policies. In addition, no one knows exactly how many providers will be purchasing coverage or the type of coverage they will purchase.

The surcharge may prove to be inadequate if the actuaries overestimate the size of the premium base and recommend a surcharge rate that turns out to be too low. The report on the actuarial analysis as of December 31, 1993, noted that if changes in the malpractice market reduced the estimated premium base by eight percent, the Fund would experience a $15 million loss of revenue. On the other hand, the Fund may have a surplus greater than $15 million if the actuaries underestimate the size of the premium base and recommend a surcharge rate that turns out to be too high.

The Statutory Balance the Fund Is Allowed to Carry Is Inadequate

Act 111 requires that the Fund's annual surcharge be no more than the claim payments and expenses of the previous year, plus an amount sufficient to increase its projected year-end surplus to $15 million. The $15 million "buffer" was intended to help the Fund pay obligations which exceed those of the previous year without having to resort to an emergency surcharge.

When it was included in an amendment to Act 111, the $15 million buffer was roughly equivalent to the Fund's claims payout level in 1980. However, the Fund's annual claims payout has increased dramatically. As a result, the current statutory buffer of $15 million now represents only 6 percent of the Fund's annual anticipated claims payout and is not adequate to cover the types of fluctuations in claims and expenses the Fund has experienced recently or is likely to experience in upcoming years.

Even the January 1996 court decision which indicated that the Fund's $15 million buffer is a floor and not a ceiling (Meier v. Maleski, Commonwealth Court 1996) does not specifically authorize the Fund to reserve funds. For the Fund to have avoided an emergency surcharge in 1995, it would had to have had a balance of $106 million. As discussed in Chapter V, the Fund director has proposed a statutory balance of 15 percent of the prior year's claims payments and expenses, which would provide for a buffer of $42.7 million in 1996.

Claims Management Practices in the Late 1980s and Early 1990s Contributed to an Unanticipated Increase in the Fund's Unfunded Liability

The 1985 report to the Pennsylvania Select Committee on Medical Malpractice (more commonly known as the Hofflander and Nye report) defined maturity for a pay-as-you-go fund as the time when "losses arising during the first year of operation have been fully reported and settled." Under this definition, the Fund was approaching maturity in the late 1980s. Specifically, the paid claims for occurrence year 1976 reached their first peak (34) in 1982 and tailed off quickly over the next three years. They reached a second peak (39) in 1986 because of the four-year lag associated with §605 claims and again tailed off quickly. The Fund then paid a total of only eight such claims between 1991 and 1993. It paid seven more in 1994 and another eight in 1995, but these claims may have been largely the result of the Fund's policy during the early 1990s of delaying claim settlements.

The annual rate of growth in the unfunded liability also provides a measure of Fund maturation, with mature funds experiencing relatively small annual increases in their unfunded liabilities.[15] Exhibit 7 illustrates the growth pattern of

[15]Actuaries estimate the unfunded liability by projecting the ultimate losses the Fund will have to pay for claims based on malpractice occurrences through the most recent year and subtracting payments made to date. The unpaid balance, which includes an estimate of claims incurred but not yet reported, is the unfunded liability.

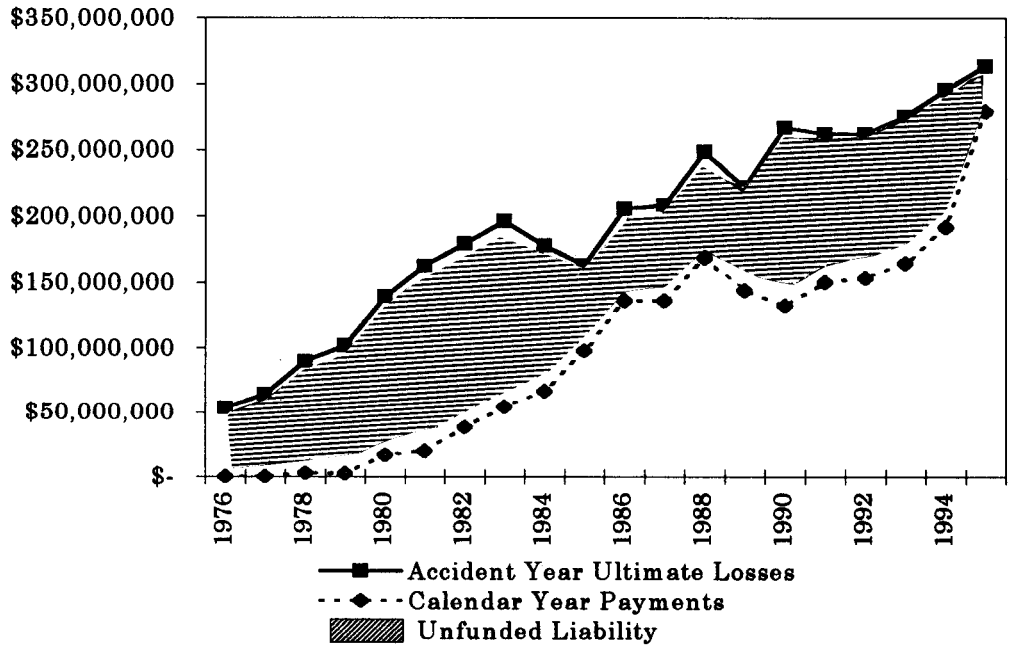
the unfunded liability by comparing the annual ultimate loss projections with the corresponding calendar year payments. As the exhibit shows, the unfunded liability accumulated rapidly from 1976 through 1979, a period when the Fund made less than $5 million in claim payments and providers paid little in surcharges. The pattern continued from 1980 through 1983 as the first §605 claims were being reported.

The annual growth in ultimate losses slowed in 1984 following the $50,000 increase in the basic limits per claim effective January 1, 1983. The growth rate slowed again in 1985 following another $50,000 increase in the basic coverage effective January 1, 1984. As the Hofflander and Nye report suggested, the Fund appeared to be approaching maturity after 1986, when the movement of the claim payments line mirrored the changes in the ultimate loss line.

The pattern of 6 to 7 percent growth in the unfunded liability that began in 1985 reversed suddenly in 1990, when claim payments decreased despite a jump of about 20 percent in the projected annual ultimate losses. Although the projected losses increased no more than 7.5 percent in succeeding years, claim payments did not rise sufficiently to close the gap until 1995. As a result, the unfunded liability grew at a faster rate than would have been expected between 1989 and 1994.

Exhibit 7

Fund Financial History
(1976 through 1995)



Source: Developed by LB&FC staff from the Fund's 1995 actuarial report. The numbers used to generate this graph can be found in Table 3 in Chapter II.

As shown in Table 7, year-to-year changes in the number of claims reported to the Fund fluctuate significantly. However, if the total claims reported from 1987 through 1989 were redistributed over the three years to form a smoother trend, the entire period from 1985 through 1992 would be marked by relatively gradual increases in claims reported, another indication that the Fund was reaching maturity. The unusual volume of claims reported in 1989 suggests that the Fund might have been catching up with claims that could have been processed in previous years. A similar jump occurred in 1994, a consequence of the Fund having delayed opening claims from late 1992 through early 1994. A December 1993 Fund bulletin urging insurers to avoid late tenders might also have contributed to the sharp increase in claims reported in 1994.

Table 7

Claims Reported to the Fund

Calendar Year	Number	% Change
1976	51	---
1977	188	269%
1978	317	69%
1979	422	33%
1980	617	46%
1981	591	-4%
1982	878	49%
1983	1,333	52%
1984	1,935	45%
1985	2,031	5%
1986	2,141	5%
1987	1,480	-31%
1988	2,065	40%
1989	3,916	90%
1990	2,586	-34%
1991	2,744	6%
1992	3,156	15%
1993	2,823	-11%
1994	5,799	105%
1995	3,507	-40%

Source: Developed from the *Medical Professional Liability Catastrophe Loss Fund, Estimation of Unfunded Liability as of December 31, 1995*, prepared by Coopers & Lybrand L. L. P.

We estimated that by delaying claim settlements, the Fund accrued an additional $86 million in unfunded liability. This estimate assumes that, had no claims been delayed, the Fund's unfunded liability would have grown at the average annual rate of the late 1980s (6.7 percent annually). Table 8 shows these calculations.

Table 8

Unfunded Liability Growth Rate

Year	Unfunded Liability	Percent Increase	1985-1989 Annual Rate	Unfunded Liability at 1985-1989 Rate	Paid Loss Deficit
1984	$ 963,452,495	13.0%	.....	.....	.....
1985	$1,028,501,257	6.8%	.....	.....	.....
1986	$1,098,389,328	6.8%	.....	.....	.....
1987	$1,170,854,734	6.6%	.....	.....	.....
1988	$1,250,834,765	6.8%	.....	.....	.....
1989	$1,329,372,573	6.3%	.....	.....	.....
1990	$1,464,122,040	10.1%	6.7%	$1,417,783,756	$46,338,284
1991	$1,576,312,727	7.7%	6.7%	$1,512,074,808	$64,237,919
1992	$1,685,447,611	6.9%	6.7%	$1,612,636,776	$72,810,835
1993	$1,796,483,876	6.6%	6.7%	$1,719,886,713	$76,597,163
1994	$1,920,433,309	6.9	6.7%	$1,834,269,408	$86,163,901
1995	$1,954,804,126	1.8%	6.7%	$1,956,259,233	.....

Source: Developed from *Medical Professional Liability Catastrophe Loss Fund, Estimation of Unfunded Liability as of December 31, 1995*, prepared by Coopers & Lybrand L.L.P.

A 1995 Emergency Surcharge Probably Would Have Been Necessary Even if Claims Had Not Been Delayed in Prior Years

As described previously in this chapter, during the early 1990s the Fund delayed claim settlements to hold down its annual surcharge to providers. This strategy caused a claims backlog to build up, ultimately contributing to the need for a 68 percent emergency surcharge in the fall of 1995.

Although the emergency surcharge generated $106 million in 1995 revenues, we estimated that only about $86 million was needed to pay off the additional unfunded liabilities resulting from the delayed claims.[16] Thus, even if the Fund had not delayed claims, it is likely that an emergency surcharge of about $20 million would have been needed to meet 1995 claim payments and expenses.

The Statutory Procedure for Assessing the Fund's Surcharge Has Created Inequities in the Medical Malpractice Insurance Market

Insurers collect the Fund's annual surcharge from their policyholders and forward it to the Fund. Providers pay the surcharge based on a flat percentage of

[16]The difference in the December 31, 1994, unfunded liability if it had continued to grow at 6.7 percent annually.

their gross premiums for the basic malpractice coverage required by Act 111. Self-insurers pay what providers of a similar kind, class, size, and risk category would have to pay, as determined by the Fund. This method of assessing the surcharge gives providers an added incentive to shop for lower premiums because the amount of the surcharge is directly proportional to the basic premium. Thus, if in 1996 a health care provider switched to an insurer whose premium for basic coverage was $1,000 less than his/her previous insurer's premium, total savings for the provider would be $2,640 ($1,000 + ($1,000 x 164%)).[17] This incentive to find lower-cost basic insurance sets off a spiral in which the Fund increases the surcharge percentage to maintain its revenues, which prompts more providers to switch to insurers who offer lower premiums. Consequently, providers who do not switch to low cost basic coverage end up paying an increasingly larger share of the surcharge, even though the premium for their basic coverage may remain the same.

The Fund's director also has concerns over tactics used by some insurers to encourage providers to take advantage of their lower basic premium rates and to evade paying the "proper" surcharge. According to the director, these tactics include canceling and rewriting physicians at lower rates, altering classifications of insureds, and offering reduced value policies (i.e., claims made versus occurrence).

The Timing of Claim Payments Can Create Problems for Claimants and the Timing of Surcharge Collections Can Create Problems for Providers

Claim Payments. The Fund pays claims only once each year rather than throughout the year as they are settled. Claims finalized between September 1 of the previous year and August 31 of the current year are paid on December 31. As a result, a plaintiff whose case is settled on September 1 has to wait 16 months before receiving payment from the Fund. From the Fund's perspective, once-a-year payments are advantageous in that they can place pressure on claimants and their attorneys to settle for a lower amount rather than holding out for higher settlements and risk having to wait a year or more for payment.

The Fund's once-a-year payment schedule can also affect health care providers who must pay post-judgment interest. If the courts hold that the Fund must pay the full cost of post-judgment interest, the advantage to the Fund of the once-a-year payout will be diminished (see page 29).

Surcharges. The Fund must determine the upcoming year's surcharge percentage and have it approved by the Insurance Commissioner in time to be published in the *Pennsylvania Bulletin* prior to December 1. Insurers bill their policyholders at the published surcharge rate at the time of their policy renewal. Health care providers must pay the surcharge in full within 60 days of the effective date of their policy. Because the annual surcharge percentage has not been stable (e.g.,

[17] The Fund's 1996 surcharge is 164 percent of the basic premium.

increasing from 50 percent in 1990 to 93 percent in 1994 to 164 percent in 1996), providers, particularly those with policy renewal dates early in the year, have little time to plan or set aside funds for their surcharge payments.

Emergency surcharges compound the problem. If the Fund anticipates its claim payments and operating expenses will exceed available revenues, the Insurance Commissioner must notify malpractice insurers of an emergency surcharge in September. Insurers, in turn, must notify health care providers of the emergency surcharge within 15 days. Health care providers then have 30 days to pay the surcharge. Emergency surcharges are particularly burdensome because the providers have no reason to anticipate the surcharge, let alone how large it might be, and they have very little time in which to pay it. If providers have policy renewal dates near the end of the year or the beginning of the next year, the financial impact may seem even greater because their next annual surcharge will be due at about the same time as the emergency surcharge.

Differing Actuarial Assumptions and Inadequate Historical Data Make the Fund's Unfunded Liability Difficult to Determine

Although the Medical Professional Liability Catastrophe Loss Fund does not hold reserve funds for incurred claims that will have to be paid in the future, it has an independent actuary estimate its unfunded liability annually. Most recently, Coopers & Lybrand L.L.P. prepared an actuarial estimate of the Fund's unfunded liability as of December 31, 1995. Coopers estimated the unfunded liability at $1.95 billion ($1.46 billion present value on a 6 percent discount basis).

The 1995 estimate, however, does not include the liability the Fund has incurred as a result of 879 reported breast implant and 666 reported pedicle screw cases. Although the actuaries noted that the Fund has experienced a substantial increase in reported claims for both breast implants and pedicle screw cases, they excluded these claims from their analysis because they believed these claims are likely to have different reporting patterns, settlement patterns, and average settlement values than the remaining body of claims reported to the Fund. According to the actuaries, "we do not believe that it is possible to determine the amount of additional liability, if any, that may develop [regarding these claims] due to the general risks inherent in major litigation, expanded theories of liability, and future court decisions on the existence and extent of insurance coverage." Two major medical malpractice insurers we contacted indicated, however, that they did reserve for these two types of claims.

The 1995 actuarial report also assumes that only 10 percent of the claims against the Fund will result in a Fund payout within eight years of their occurrence. This assumption is based primarily on a downward trend in the percentage of claims closed with a payment eight years or less after they were incurred. This trend was also noted in the 1994 actuarial report wherein it was assumed that be-

tween 11 and 12 percent of claims would be closed with a payment within eight years of being incurred (compared to percentages closer to 20 in 1980 and earlier years). This downward trend, combined with the decision to record some claims that were closed without payment in 1995 as having closed earlier (on the theory that they should have been closed in earlier years), led the actuaries to lower the expected rate of claims closing with payment to 10 percent, thus lowering the 1995 unfunded liability. The actuaries noted, however, that the unfunded liability will be understated if the downward trend simply reflects prolonged settlements rather than an actual decline in the percentage of claims being settled with a payout.

Although actuaries use the same general method of estimating the liability, they may make different assumptions about the growth patterns of claim payments. For example, the Fund analysis by Maher Associates, Inc., as of December 31, 1993, estimated that the unfunded liability had already reached nearly $2.04 billion ($1.45 billion present value on a 7 percent discount basis). However, the recent revisions by Coopers brought their 1993 unfunded liability estimate to $1.80 billion, a figure more than 10 percent lower than Maher's estimate.

Another actuarial consultant, William M. Mercer, Incorporated, completed an analysis of the Fund in September 1995. Mercer estimated the December 1994 unfunded liability at $2.18 billion, a figure more in line with Maher's 1993 estimate than Coopers's 1995 projections.

Although differing assumptions may account in part for these varying estimates, the lack of sufficient historical data on claims is also a contributing factor. Maher Associates reported problems obtaining historical estimated claim values during their analysis as of December 31, 1993. In particular, the Fund did not have any reports from which such values could be obtained and summarized on an occurrence-year basis before 1988. As a result, the actuaries made very limited use of the data and relied primarily on paid losses and claim counts.

In its 1995 report Coopers & Lybrand made clear that their report relies heavily on the accuracy of the paid loss and claim count data provided by the Fund. They note that they did not audit the data but did review it for reasonableness. (See Appendix H for additional information on the actuarial estimates of the Fund's unfunded liability.)

Issues Regarding Availability and Affordability

Unlike in the Mid-1970s, Pennsylvania Currently Has an Active and Competitive Medical Malpractice Insurance Market

To address the availability crisis of the mid-1970s, state governments took a variety of measures to stabilize their medical malpractice insurance markets. Act

1975-111 created two such programs for Pennsylvania, the Medical Professional Liability Catastrophe Loss Fund and the Pennsylvania Professional Liability Joint Underwriting Association (JUA), which guarantees the availability of basic coverage for health care providers.

Additionally, professional associations in Pennsylvania and other states formed "bedpan" insurance companies that offered malpractice coverage to their members whose insurers were withdrawing from the market. Two such companies, the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) and the Pennsylvania Hospital Insurance Company (now PHICO), were writing more than 50 percent of the premiums in the Commonwealth by 1978. PMSLIC and PHICO received excellent ratings for their financial condition and operating performance, in the *1995 Best's Insurance Reports--Property-Casualty*.

As shown in Appendix I, 21 insurers wrote at least $2 million in direct premiums during 1994. Moreover, health care providers now have the option of self-insuring or joining risk retention groups, owned and organized by the members of the group, to assume their professional liability risks.

Table 9 shows that competition in the Pennsylvania malpractice market has been increasing in recent years. The top four insurers, including three Pennsylvania-based companies, wrote almost 73 percent of the total premiums in 1990. However, their combined share had dropped to less than 54 percent by 1994. Meanwhile, four insurers from neighboring states entered the Pennsylvania market between 1988 and 1993, gaining a combined market share of almost 21 percent by 1994.

Table 9

Companies with Largest Market Shares in 1994

Company	Domicile	Market Share 1990	1992	1994
PHICO Insurance Co.	Pennsylvania	27.7%	26.6%	21.4%
PMS Liability Insurance Co.	Pennsylvania	14.8	13.6	12.4
Physicians Insurance Co.	Pennsylvania	19.9	18.9	12.1
Medical Protective Co.	Indiana	10.3	9.4	8.0
Total		72.7%	68.6%	53.8%

Companies Entering Pennsylvania Market Since 1987

Company	Domicile	Market Share 1990	1992	1994
Princeton Insurance Co.	New Jersey	1.6%	6.3%	6.3%
Medical Inter-Ins. Exchange	New Jersey	0.0	1.2	5.6
Steadfast Insurance Co.	Delaware	0.0	0.0	5.4
P-I-E Mutual Insurance Co.	Ohio	0.0	0.0	3.5
Total		1.6%	7.5%	20.8%

Source: Developed from information compiled by the National Association of Insurance Commissioners as provided by the PA Insurance Department.

The Fund's Low Threshold Distorts Liability Risks, Providing Advantages to Some Providers But Disadvantages to Others

Medical providers in specialties with larger malpractice paid claims (such as neurosurgeons and orthopedic and obstetrical surgeons) are attractive risks in Pennsylvania because the Fund covers losses in excess of $200,000. Conversely, providers in specialties with smaller paid claims (such as family practice physicians) are less attractive risks because their claims are less likely to involve payment from the Fund's coverage. By way of example, consider an insurer who in 1995 insured 100 obstetrical surgeons, two of whom had malpractice settlements of $1 million each. These settlements would cost the insurer a total of $400,000 (the $200,000 basic coverage for both doctors). If instead the insurer had insured 100 family practice physicians, five of whom had settlements of $100,000 each, the insurer's cost would be $500,000 ($100,000 in basic coverage for each physician).

Thus, while the total outlay for the five family practice physicians would be substantially less ($500,000 vs. $2 million), the insurer would incur all the costs for

the family practice physicians because none of the settlements reached into the Fund's excess layer of insurance. As a result, the cost to the insurer is $100,000 more for the five claims that settle for a total of $500,000 than for the two claims that settle for a total of $2 million. As a result of the Fund's low thresholds, aggressive insurers can offer substantial discounts to providers whose paid claims are likely to be high while still charging them substantially higher premiums than smaller claim providers.

Private Insurers Can Offer the Fund's Layer of Coverage for Less Cost

Some major private insurers have reported to the Department of Insurance that they can provide the Fund's layer of coverage through standard insurance policies for less than the Fund's 1996 surcharge of 164 percent. The companies provided this information in response to a request the Insurance Commissioner made in February 1996 for this information. Each insurer responded in terms of its particular mix of providers and policies (e.g., occurrence and claims-made), and their estimates vary accordingly. Table 10 summarizes their responses.

Table 10

Estimated Additional Cost of Fund-Level Coverage*

Company	Provider Category	Including §605 Claims	Excluding §605 Claims
A	Physicians	126% - 153%	82% - 100%
	Surgeons	156% - 182%	102% -118%
B	Physicians and Surgeons	100% - 125%	75% - 90%
C	Physicians and Surgeons	125% - 140%	-
D	Physicians and Surgeons	130%	-
E	Physicians and Surgeons	125%	-
F	Physicians and Surgeons	90%	-
	Hospitals	80%	

*The Fund's surcharge in 1996 for Fund coverage is 164 percent.

Source: Developed from survey responses received by the PA Department of Insurance.

Absence of Medical Malpractice Tort Reform in Pennsylvania

Medical malpractice claims are generally governed by state law. Between the mid-1970s and late 1995, every state in the nation enacted some form of tort reform.[18] (Pennsylvania adopted some tort reforms in Act 1975-111, but as discussed in Chapter II, these efforts were largely nullified by the PA Supreme Court.) These reforms were intended to reduce the cost of insurance by decreasing the number of

[18]During this period, no federal malpractice reforms were enacted.

claims filed, the size of awards and settlements, and the time and cost of resolving claims.

The adopted reforms varied considerably from state to state. A 1995 study by The Urban Institute listed 21 different types of tort reforms that were adopted by the states. These reforms included controlling attorney fees, capping awards, changing the rules on joint and several liability, limiting punitive damages and modifying the statute of limitations. Several of these tort reform measures are discussed below. Several of these reforms would result in savings for providers, insurers, and also for the Fund.

Limiting Damage Awards

As shown in Exhibit 8, some states "cap" the total amount that can be awarded to medical malpractice claimants and others cap just the nonmonetary damages (e.g., pain and suffering and punitive damages) that can be awarded. Senate Bill 790[19] would limit punitive damages by restricting the circumstances in which such damages can be recovered and by capping such damages at 200 percent of the compensatory damages awarded. The bill would not cap other types of nonmonetary damages. The bill also limits the ability of the courts to award prejudgment delay damages except as a sanction on deliberate, obdurate, or vexatious conduct. (See Chapters II and III for a discussion of prejudgment delay damages.)

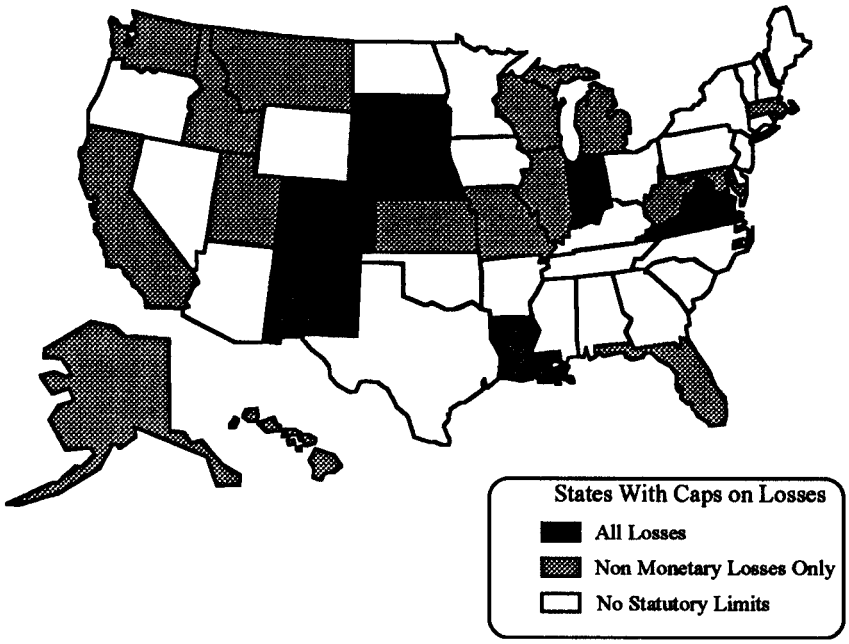
According to the president of the Pennsylvania Medical Society, plaintiff's attorneys use punitive damages to intimidate defendants. He believes this tactic is abusive because punitive damages are not covered by insurance or the Fund.

In contrast, the president of the Pennsylvania Bar Association opposes restrictions on punitive damages in medical malpractice cases, arguing that punitive damages are rarely awarded in such cases, so such a provision would have little effect on malpractice insurance rates. The president of the Pennsylvania Trial Lawyers Association opposes a cap on punitive damages, arguing that punitive damages are intended to penalize wrongful conduct, and courts should be free to impose such sanctions.

[19]On May 14, 1996, the PA House of Representatives amended and passed Senate Bill 790 and returned it to the Senate for its concurrence.

Exhibit 8

States With Flat "Caps" on Liability in Malpractice Cases



Source: The Urban Institute, Medical Malpractice: Problems & Reforms (Intergovernmental Health Policy Project, September 1995). Used by permission.

Collateral Source Rule

Act 111 originally stated, "the loss and damages awarded under this act shall be reduced by any public collateral source of compensation or benefits." This section was invalidated when the Pennsylvania Supreme Court found the portion of the act pertaining to arbitration panels to be unconstitutional; the Court did not specifically address the constitutionality of the collateral source rule. Senate Bill 790, as amended by the House, would generally prohibit plaintiffs from recovering as part of a medical malpractice award an amount equivalent to public benefits (such as workers' compensation benefits) that they have already received or will receive in the future. It would also generally prohibit plaintiffs from receiving certain group benefits (such as group hospital benefits) in a medical malpractice action unless such benefits had been paid by the plaintiff.

In testimony before the House Judiciary Committee, the President of the Pennsylvania Medical Society said: "Under present law it is not possible for defense attorneys to inform the jury of all the sources of compensation available to the plaintiff. The result is that frequently plaintiffs are compensated a second time for

expenses already paid under some form of insurance." Modifying the present collateral source rule would prevent plaintiffs from receiving such a "windfall."

Opponents argue that changing the collateral source rule would weaken the deterrence effect of malpractice awards because the provider would not bear the full economic cost of the injury. Instead, some of the costs would be paid by other parties such as health insurers.

Periodic Payment of Future Damages

In Pennsylvania, successful plaintiffs typically receive their awards in lump sum payments. More than half the states, however, require large awards for future damages to be paid in installments. Senate Bill 790, as amended by the House, would require awards of future damages over $200,000 to be paid in installments.

In testimony before the House Judiciary Committee, the president of the Pennsylvania Medical Society argued that present law can give plaintiffs a "windfall" because the compensation for future damages is received before costs are incurred. Requiring the compensation to be paid in periodic installments would prevent such a "windfall."

The Physician Payment Review Commission's *1995 Annual Report* also supports periodic payments. According to that report, "an annuity can be purchased to meet continuing needs resulting from permanent injuries. Annuities also permit tax-advantaged investment of an award."

The president of the Pennsylvania Trial Lawyers Association opposed a periodic payment requirement in her testimony before the House Judiciary Committee. She argued that such a requirement may leave a successful plaintiff without immediate compensation in part because the cost of litigation may exceed $200,000. She also said that such a requirement leaves the plaintiff financially dependent on the defendant even after a judgment has been won.

Statute of Limitations

Pennsylvania law currently allows a lawsuit to be filed within two years of the date the injured party knew or should have known of his injury. The statute of limitations can be extended under certain conditions, such as the health care provider engages in fraud or the patient is a minor. Shortening the statute of limitations would reduce the period of time in which a plaintiff can file a lawsuit. As a result, fewer lawsuits would be filed.

Senate Bill 790, as amended by the House, would generally require a medical malpractice claim to be filed by the earlier of four years from the date of the event,

or two years from the date the injured person knew or should have known of the injury and its cause.

Long statutes of limitations contribute to uncertainty, delay, and expense in insurance. Consequently, a shorter statute of limitations allows more accurate reserving and rate-setting. Reducing the statute of limitations, however, may prevent some plaintiffs with meritorious claims from receiving compensation for their injuries.

IV. Medical Malpractice Insurance in Other States

This chapter briefly addresses medical malpractice insurance requirements in other states, how state-administered funds operate in other states, the cost of medical malpractice insurance nationally, and the cost to resolve claims against physicians in other states.

Medical Malpractice Insurance Requirements in Other States

In most states medical malpractice insurance is voluntary and is generally handled through private commercial insurers. According to the American Medical Association (AMA), Pennsylvania is one of only eight states to mandate that physicians carry medical malpractice insurance.[1] The other states that mandate medical malpractice insurance are Colorado, Connecticut, Georgia, Kansas, Massachusetts, Rhode Island, and Wisconsin. Exhibit 9 shows a synopsis of the requirements in these states.

Although medical malpractice insurance is voluntary in most states, the AMA found that virtually all (97.9 percent) self-employed physicians carry some form of medical malpractice insurance. According to the AMA, in 1993 coverage limits for these physicians averaged $1.2 million per occurrence and $2.8 million annual aggregate.

States With Medical Malpractice Insurance Funds

Eight states currently have patient compensation funds covering both physicians and hospitals: Pennsylvania, Indiana, Kansas, Louisiana, Nebraska, New Mexico, South Carolina, and Wisconsin. Florida had such a fund, but it ceased offering coverage on July 1, 1983. Since 1983, Florida's Fund has been in the process of closing out. Key features of the various funds are discussed below.

Voluntary vs. Mandatory Fund Participation

Only three states--Pennsylvania, Kansas, and Wisconsin--require that health care providers participate in the state-administered fund. Participation is voluntary in other states. In the voluntary states, providers are typically given strong incentives in the form of tort reform to participate in the fund. In these states, the provider's liability is limited to the amount of the provider's primary coverage, and the state fund's compensation functions as a cap on medical malpractice awards for participating providers.

[1]According to information provided by the Hospital Association of Pennsylvania, hospitals are mandated to purchase a specific amount of basic medical malpractice coverage only in states that have a mandated state patient compensation fund. In states without such funds hospitals can select their own limits of coverage.

Exhibit 9

State Mandated Primary Coverage Insurance Requirements for Physicians

State	Required Medical Malpractice Coverage[a]
Colorado	$500,000/$1,500,000 - Premiums inapplicable to health care professionals who are public employees. Lesser requirements may apply to health care professionals in the military or who perform limited to occasional services.
Connecticut	$500,000/$1,500,000
Georgia	$1,000,000
Kansas	$200,000/$600,000[b]
Massachusetts	$100,000/$300,000
Pennsylvania	$200,000/$600,000[c]
Rhode Island	Professional corporations must carry $50,000 per professional employee but not less than $100,000 nor more than $500,000.
Wisconsin	$400,000/$1,000,000[d]

[a]Washington state required purchase of a minimum level of malpractice insurance coverage as part of a comprehensive reform plan. This section of the plan was repealed by the legislature in 1995. Florida discontinued its requirement in 1996.

[b]Health care providers are also mandated to purchase at least $100,000/$300,000 additional excess coverage from a state fund.

[c]Health care providers are also mandated to purchase $1 million/$3 million in additional excess coverage from a state fund.

[d]Health care providers are also mandated to purchase unlimited additional excess coverage from a state compensation fund. A bill which recently passed the Wisconsin Senate would increase Wisconsin's primary coverage requirements from $400,000/$1,000,000 to $1,000,000/$8,000,000.

Source: American Medical Association, Division of State Legislation, April 1996, with supplemental information provided to the LB&FC by Massachusetts, Washington, and Wisconsin.

For example, in Indiana if a physician voluntarily purchases $100,000 per occurrence and $300,000 annual aggregate in primary coverage and pays an annual surcharge to participate in the state's patient compensation fund that physician (and his or her insurer) can only be required to pay up to $100,000 for an occurrence of malpractice. Moreover, the total amount recoverable for an injury or death

of a patient cannot exceed $750,000. In contrast, if the physician does not participate in the state fund, awards can exceed $750,000.

Coverage

Primary Coverage Limits. Kansas, Nebraska, and New Mexico have established primary coverage limits for physicians similar to those in Pennsylvania. All of the remaining states with compensation funds, with the exception of Wisconsin, have lower primary coverage limits for physicians. In Wisconsin, the primary coverage requirements are $400,000 per incidence and $1,000,000 per annual aggregate. A bill which recently passed the Wisconsin Senate would increase the state's primary coverage requirements to $1 million per incidence and $8 million per annual aggregate effective July 1, 1996. Wisconsin seeks to maintain a high level of primary coverage to ensure its fund's coverage remains catastrophic, not an active working coverage layer.

Kansas, Louisiana, South Carolina and Wisconsin have established similar primary coverage limits for physicians and for hospitals. In the remaining states, primary coverage requirements are different for hospitals and physicians. Nebraska's primary coverage requirements for hospitals are the same as Pennsylvania's. In Indiana, hospitals with fewer than 100 beds must purchase $1 million/$2 million in primary coverage, and hospitals with more than 100 beds must purchase $1 million/$3 million in coverage. In New Mexico each hospital's coverage requirement is determined on an individual basis.

Fund Coverage. Unlike Pennsylvania's fund, most state compensation funds generally provide full excess coverage for fund participants. The states which provide full excess coverage include Indiana, Louisiana, Nebraska, New Mexico, South Carolina, and Wisconsin. These state funds can offer full coverage because their states have some form of statutory caps on medical malpractice awards and hence have limited fund exposure.

In Kansas providers must participate in the state's compensation fund but they are free to select the level of coverage they will purchase from the state fund. They have the option to purchase $100,000 per occurrence/$300,000 annual aggregate coverage; $300,000/$1,000,000; or $800,000/$2,400,000. The surcharge which each provider pays in Kansas varies depending on the amount of coverage they purchase from the fund.

Administrative Placement

Pennsylvania is the only state that has a patient compensation fund administered as part of the Governor's executive offices. In Indiana, Nebraska, and New Mexico the funds operate as part of the state's insurance department. South Carolina and Louisiana have governing boards. Governing boards are also responsible

for the state funds in Kansas and Wisconsin--the only states like Pennsylvania where the state requires health care providers to purchase excess insurance from the state fund.

Kansas. In 1991 Kansas enacted legislation providing for the "phase-out" of its fund on or before July 1, 1994, if certain conditions were met. The conditions included, for example, ensuring that medical malpractice insurance would be available for residents at a state-run teaching hospital. Since the phase-out was not implemented, Kansas enacted legislation transferring administrative responsibility for the Fund from the Insurance Department to an independent governing board on January 1, 1995.

The board of governors consists of three medical physicians, three hospital representatives, two osteopathic physicians, one licensed chiropractor, and one registered nurse anesthetist. The members are appointed by the insurance commissioner and must be selected from lists of candidates provided by relevant state associations; the chairman of the board is a physician.

Wisconsin. The Wisconsin Fund's governing board also serves as the board for Wisconsin's equivalent to Pennsylvania's Joint Underwriting Association. Its board of governors consists of :

- the insurance commissioner or a designated representative employed by the office of the commissioner,
- three representatives of the insurance industry appointed by and to serve at the pleasure of the commissioner.
- a person to be named by the state bar association,
- a person to be named by the Wisconsin academy of trial lawyers,
- two persons to be named by the Wisconsin medical society,
- a person to be named by the Wisconsin hospital association, and
- four public members (at least 2 of whom are not attorneys or physicians and are not professionally affiliated with any hospital or insurance company) appointed by the Governor.

The Board is chaired by the Commissioner of Insurance, whom the Board has designated to serve as the Fund's administrator. The Board, however, contracts for Fund actuarial, claims, and risk management services.

In June 1994, a special committee formed by the Board issued a report on the Fund's purpose and operations. The report concurred with an earlier one completed by the Wisconsin Medical Society and Hospital Association suggesting that the existing structure of the Fund be continued. The special committee also recommended that the board:

- develop a 25-year amortization schedule to retire the fund's "deficit".
- introduce legislation to establish a cap on non-economic damages of $250,000 (a $350,000 cap was later enacted into law).
- pursue statutory changes to allow for periodic payments of future medical expenses.
- pursue statutory changes to impose a minimum fee level[2] to ensure that the Fund's deficit would not increase in the future.

Claims Management in States with Mandatory Funds

Wisconsin. The Wisconsin Fund has established an "outside" claims committee to assist the Board in claims-related activities, including valuing claims and authorizing settlement amounts. The committee includes representatives of the state medical society and hospital association as well as legal and claims staff from state insurers who are not members of the board of governors. The chair of the committee is a representative of the state medical society who sits on the fund's governing board.

The committee is responsible for developing guidelines for the Fund's contracted claims management personnel. Among other duties, the committee is:

> . . . to review all (emphasis added) claims involving alleged sexual misconduct, neurological impairment, quadriplegia, and those claims which the contractor has set reserves of $500,000 or more and provide settlement authorization and advise on those claims where settlement value exceeds $1 million or when the contractor has a claim management question.

To carry out responsibilities related to individual cases, the committee receives information about the case including recommendations for settlement authority from the claims management staff and the health care provider's defense attorney. The Fund pays for defense costs when a claim cannot be settled within the primary insurer's coverage limits. The Fund's claims management staff are responsible to update the claims review committee whenever there is a "significant" change with the claim. Such changes include:

- a serious demand from a plaintiff;
- a change in the condition or status of the plaintiff;
- a change in the evaluation of the case by either fund staff or defense counsel;
- a conflict with the primary insurer as it relates to the Fund's evaluation of a claim, including tendering of limits;

---

[2]The minimum fee level would be set equal to the actuarially determined break-even level as approved by the Board of Governors.

- an expert opinion differing from original testimony and/or discussions; or
- a change in the status of coverage.

The committee has rules governing its operations, including requirements related to conflict of interest and confidentiality. The rules include procedures for making decisions in an emergency when the full committee cannot be convened. In such cases the Fund's claims staff, the health care provider's defense attorney, and the chairman or vice-chairman of the committee are authorized to make a decision. (In the absence of the chairman or vice-chairman, the Chairman of the Governing Board is involved.) In emergency situations a full report must be made at the next meeting of the claims committee.

From July 1, 1975, through December 31, 1994, 3,260 claims were filed involving the Wisconsin Fund. During the same period, the Fund's number of paid claims totaled 435, and 2,467 claims were closed without payment. Thus, the Wisconsin Fund is much smaller than Pennsylvania's Fund, which has received 39,258 claims as of December 31, 1995.

Kansas. In Kansas the state Fund's staff is responsible for claims management under the supervision of the Fund's governing board. Staff attorneys participate in settlement discussions and mandatory settlement conferences where there is a potential Fund exposure. The health care provider's defense attorney plays an important role in settling claims, and the Fund is responsible for paying the health care provider's defense attorney fees once the claim has been tendered to the Fund. In most situations, the Fund continues the provider's defense with the same attorney used by the basic coverage insurer.

In 1994 the Kansas Fund opened 247 cases (compared to 6,543 for Pennsylvania in 1994) and closed 268. Kansas' Fund had 389 active cases in 1994.

Financial Management in States With Mandatory Funds

Wisconsin. The Wisconsin Fund had a deficit of $67.9 million as of June 30, 1994. According to a consultant to the Board's Special Committee, the fund's deficit was largely incurred in its first 11 years of operation. Between 1975 and 1980, the Wisconsin Fund operated as Pennsylvania's does on a "pay-as-you-go" or cash basis. In March 1980 Wisconsin's statutes were revised to require the Fund's balance sheet to reflect a full accrual of its unpaid claim liabilities, discounted to their present value. Wisconsin also lifted certain restrictions which were in place on the amount of surcharge revenues to be collected and allowed the Fund to collect more than its prior year expenses subject to certain restrictions.

Wisconsin's Surcharge. Proposed surcharges are developed by the fund's actuary and the actuarial committee of the board.[3] The Fund's surcharges cannot exceed certain thresholds set forth in statute.[4]

Wisconsin's statute provides for up to four payment classifications. Payment classifications are based on the amount and type of surgery performed and the risk of the diagnostic and therapeutic services provided. The four classes are established in regulation. Class 1 includes, for example, family or general practitioners who do not perform surgery. Class 4 includes only neurologic surgeons and obstetrical and gynecological surgeons.

The statute also provides that health care providers with high loss and expense experience can have their fees increased. The amount of the increase and the time for which it can be imposed are set forth in regulation. The increase can be waived by the governing board based on the recommendation of the Wisconsin Fund's peer review council. This council consists of five persons including three physicians. The council is responsible for making recommendations to the board of governors and the insurance commissioner concerning the assessment of additional fees against individual health care providers based on their paid claims experience. In making this recommendation, the council must review patient records and consult with appropriate specialists to determine if the appropriate standard of care was met.

If the peer review council recommends that a provider's surcharge be increased, the provider can request a hearing before a hearing examiner. If not satisfied, the health care provider can appeal the board's decision in the courts.

Wisconsin's regulations provide for lower surcharges for residents and medical college full-time faculty. Physicians who practice fewer than 500 hours during the fiscal year, whose practice is limited to office practice and nursing home and house calls, and who do not practice obstetrics or surgery or assist in surgical procedure also have lower surcharges.

Kansas. Originally established as a "pay-as-you-go" fund, Kansas enacted legislation in 1984 requiring the fund to operate on an accrual basis or as what is referred to as an "actuarially" sound fund. As a result the Kansas Fund does not currently have a deficit or unfunded liability.

---

[3]Wisconsin has established mediation panels and fees are charged to health care providers to fund their operations.

[4]The amounts assessed cannot exceed the greater of the following: (1) the estimated total dollar amount of claims to be paid during that particular fiscal year; (2) the fees assessed for the fiscal year preceding that particular fiscal year, adjusted by the commissioner of insurance to reflect changes in the consumer price index for all urban consumers, US city average, for the medical care group, as determined by the US Department of Labor; or (3) two hundred percent of the total dollar amount disbursed for claims during the calendar year preceding that particular fiscal year.

Kansas Surcharge. Kansas' surcharge is based on actuarial estimates of the costs of claims which will ultimately have to be paid for Fund participants in a given year. The surcharge is developed by the Fund's actuary in part based on:

- current rate filings of the basic professional liability insurers;
- a summary of all open claims filed against Kansas health care providers;
- a summary of all closed claims filed against the Fund for the previous five years;
- financial statements of the Kansas JUA;
- Kansas data on written and earned premiums and paid and incurred losses for the past calendar year; and
- a cash flow analysis of the Fund for the past fiscal years.

In Kansas health care providers pay a flat surcharge percentage. The percentage varies, however, based on the amount of coverage the provider elects to receive from the Kansas Fund.

Medical Malpractice Premiums in Other States

Nationally, medical malpractice insurance premiums have increased at a somewhat faster rate than physician practice revenues. Medical malpractice insurance premiums increased at an overall annual rate of 8.6 percent between 1982 and 1993 whereas total practice revenues increased at an overall annual rate of 7.2 percent. As shown in Table 11, in 1993, the most recent figures available, insurance premiums as a percent of total practice revenue were relatively low, 3.6 percent.

Table 12 shows that the amounts physicians pay in medical malpractice premiums vary widely by specialty and by region. Additionally, the premiums presented in Table 12 are not standardized by the amount of coverage (i.e., the average premium is simply how much the physician paid for insurance regardless of the amount of coverage purchased).

We could not find information to make valid comparisons regarding the cost of medical malpractice insurance in Pennsylvania versus other states. We attempted three methods to make such a comparison but concluded that all three methods were seriously flawed.[5] First, we attempted to use information collected by the American Medical Association such as that presented above. The AMA reports information on the amount paid by self-employed physicians for medical malpractice insurance in Pennsylvania and many other states. However, this information is based on a national sample and is not designed to report reliable information at the state level (only 109 respondents from Pennsylvania were included in the

[5]Valid comparisons with other states using past years data are also difficult because Pennsylvania, unlike other states, has accrued a large unfunded liability, which has acted, in effect, as a subsidy to hold premiums below actual market rates.

sample in 1993). Moreover, the data which is reported is not broken down by specialty or by regions in a state. Without this level of detail, the average premium amounts reported have little value for comparison purposes.

Table 11

Average Professional Liability Insurance Premiums Paid and Total Practice Revenue of Self-Employed Physicians

($000)

	Insurance Premiums	Total Practice Revenue	Premiums as a Percent of Revenue
1982	$5.8	$186.0	3.1%
1983	6.9	199.3	3.5
1984	8.4	212.2	4.0
1985	10.5	226.8	4.6
1986	12.8	249.5	5.1
1987	15.0	269.9	5.6
1988	15.9	300.7	5.3
1989	15.5	323.7	4.8
1990	14.5	332.4	4.7
1991	14.9	356.8	4.2
1992	13.8	393.4	3.5
1993	14.4	400.9	3.6

Source: AMA Center for Health Policy Research.

Table 12

Average Professional Liability Premiums Paid by Self-Employed Physicians, by Specialty and Region

($000)

Specialty		Region	
General/Family Practice	$ 7.9	New England	$13.8
Internal Medicine	9.0	Middle Atlantic	18.2
Surgery	22.7	East North Central	15.9
Pediatrics	8.6	West North Central	12.6
Obstetrics/Gynecology	33.7	East South Central	11.4
Radiology	10.4	West South Central	12.9
Psychiatry	4.1	Mountain	15.1
Anesthesiology	16.7	Pacific	12.8
Pathology	6.2		
Other	10.0		
All Physicians	**$14.4**	**All Regions**	**$14.4**

Source: AMA Center for Health Policy Research.

We also explored the possibility of collecting actual premium information from one or more companies that wrote malpractice insurance in several states. However, two of Pennsylvania's three largest insurers--PMSLIC and Physicians Insurance Company write policies only in Pennsylvania. Although it might have been possible to collect information from smaller insurers, the information could present a significantly distorted picture of the actual average cost paid by the majority of Pennsylvania health care providers.

As a third methodology, we attempted to compare filed rates from several malpractice insurers who write policies in Pennsylvania and other states. Again we encountered the problem of two of Pennsylvania's largest physician insurers only writing policies in Pennsylvania. Moreover, companies vary widely in how they discount actual premiums from their filed rates. For example, one company may file high rates, but then offer steep discounts to physicians with good past experience. Another insurer, or even that same insurer in another state, may choose to file low rates but add a surcharge for physicians with poor claims experience. For these and other reasons, we concluded that a state-by-state comparison using filed rates as a proxy for actual premiums was not valid.

State Information on the Cost to Resolve Medical Malpractice Claims

According to the U.S. Department of Health and Human Services' National Practitioners Data Bank, the average cost to resolve a medical malpractice claim against a Pennsylvania physician from 1991 through 1995 was $181,035. The median cost was $125,000. Some claims were settled for as little as $250, while others were settled for as much as $4.5 million.

The National Practitioners Data Bank data can, however, understate the total cost to settle a claim against a physician because of the way the data is gathered. If a malpractice insurer and a state fund both make payment on behalf of a health care provider, the physician's record shows the payment made by the provider's insurer and the payment made by the Fund. As a result the average claim payment amount reported by the National Practitioners Data could be understated because the denominator (number of claims paid) would include some claims that had been counted two or more times (e.g., once as a physician claim and once as a Fund claim).[6] Moreover, the available data do not include information on hospital costs to settle claims. Because of these problems, total costs to settle medical malpractice claims are not comparable from one state to another.

---

[6]The Pennsylvania Fund's records indicate that in 1995 it cost on average $615, 264 in total to resolve an excess claim before the Fund involving a single physician. It cost $994,818 on average to resolve a similar claim involving a single hospital and $2 million on average to resolve a claim involving multiple health care providers. (For detailed information about the cost to settle claims involving the Fund in 1995 see Appendix J.)

We did, however, attempt to compare average claim payouts for physicians for those states that have a state-administered compensation fund. As shown in Table 13 the median cost to settle claims against physicians in Pennsylvania from 1991 through 1995 was higher than in any of the other states with state patient compensation funds. The average (mean) to settle such claims was higher only in Wisconsin; however, averages, particularly in a state like Wisconsin which has relatively few claims, can be distorted by a few claims with very low or very high settlement amounts.

Table 13

Average Medical Malpractice Claim Payouts for Physicians
1991-1995

State	Median	Mean
Pennsylvania	$125,000	$181,035
Indiana	32,500	49,778
Kansas	100,000	163,806
Louisiana	67,662	114,839
Nebraska	50,000	109,041
New Mexico	85,000	122,129
South Carolina	78,009	148,437
Wisconsin	100,000	280,137

Source: U.S. Department of Health and Human Services, National Practitioner Data Bank Research File, December 31, 1995.

V. Possible Options for the General Assembly to Consider

Over the past two years, several proposals have been advanced to reform, restructure, or terminate the Pennsylvania Medical Professional Liability Catastrophe Loss Fund. This chapter outlines key elements of these proposals and our analysis of the main advantages and disadvantages that should be considered before enacting such changes.

Implement Reforms but Maintain the Existing Fund Structure

The Fund's director has proposed a series of legislative and administrative changes to improve the efficiency and effectiveness of the Fund's operations. These changes would significantly alter Fund operations, but the Fund's basic structure and responsibilities would remain intact. The key legislative changes proposed by the Fund's director are:

- enhancing the Fund's existing organization,
- enhancing the Fund's claims management practices,
- modifying the Fund's coverage benefits so as to decrease the Fund's claims payouts,
- moving up the date for payment of the annual surcharge,
- modifying the basis for calculating a health care provider's annual surcharge,
- eliminating the emergency surcharge and granting the Fund borrowing authority,
- increasing the Fund's statutory buffer, and
- granting the Fund underwriting authority.

Organizational Enhancements

The Fund director proposes to create an advisory board with nine members--five appointed by the Governor and four appointed by the majority and minority leaders in the House and Senate. The chairman of the advisory board would be appointed by the Governor. The Fund would remain as an executive branch agency within the Governor's Office.

Advantages/Disadvantages: An advisory board could provide the Fund director with valuable technical and policy guidance and would provide a formal mechanism for public input into the Fund's operations. Although an advisory board

could provide some limited oversight, it would have no real authority to ensure that its recommendations were implemented. Moreover, the quality of its advice would depend on the Fund's willingness to share information openly and in a timely manner with the members.

Claims Management Enhancements

The Fund is not proposing to make major changes in how it values and settles claims but would use the proposed advisory board to adopt reasonable standards for prompt investigation and settlement of claims before the Fund. These standards would include providing for reasonable and accurate explanations of the basis for claim denials and settlement offers.

Advantages/Disadvantages: Under this proposal the Fund would use the advisory board to seek advice on its approach to claims management. The proposal does not, however, ensure that claim settlements will not be delayed to reduce payouts, which has been a problem in the past. Also, health care providers would remain unable to sue the Fund for bad faith practices in valuing and settling claims, which is an advantage to the Fund but a disadvantage to providers and commercial insurers.

Changing the Fund's Coverage Benefits to Decrease Payouts

The Fund has proposed several changes to its current coverage benefits. They include:

- Reducing the Fund's per occurrence coverage for excess claims from $1,000,000 to $900,000[1] and increasing the total primary coverage limits health care providers must purchase (for physicians, from $200,000 per occurrence /$600,000 annual aggregate to $300,000/$900,000; for hospitals, from $200,000/$1,000,000 to $300,000/$1,500,000).

- Reducing the number of Section 605 claims before the Fund by classifying certain claims as excess claims rather than Section 605 claims.

- Introducing statutory language to assure that courts cannot require the Fund to pay delay damages or post-judgment interest above its reduced coverage limits.

Advantages/Disadvantages of Increasing Primary Coverage Limits: The Fund's proposal has the advantage of slowing the increase in the Fund's claim

[1]For Section 605 claims the Fund's coverage would remain at $1 million per occurrence.

payouts in future years. We calculated that the Fund would have saved $51.7 million in claim payouts if all the aspects of this proposal had been fully in effect in 1995.[2]

The proposed change could also have the public relations advantage of reducing the surcharge percentage. The published surcharge percent could be reduced substantially since the surcharge would be calculated from a higher primary premium base due to the increase in primary coverage limits.

The Fund's proposal, however, has several significant drawbacks. First, it would increase the cost to providers for their primary insurance. Rather than buying $200,000/$600,000 in coverage, physicians would be required to purchase $300,000/$900,000. Required primary coverage for hospitals would increase from $200,000/$1 million to $300,000/$1.5 million. Provider costs for primary insurance will increase because the lower layers of insurance which are used most often are the most expensive layers to purchase. In addition, the cost of primary insurance will increase because the Fund proposes to increase the annual aggregate amount of malpractice insurance Pennsylvania health care providers are required to purchase.

Dr. Hobart of the Pennsylvania Medical Society, in testimony before the House Insurance Committee in early April 1996, estimated that the increased coverage amount would add about 25 percent to a physician's primary insurance premium. These increased costs would not begin to be offset by lower Fund payouts for at least three to six years because it would take that long before the claims incurred under the new limits would begin to be settled and paid.

Moreover, by increasing the amount of annual aggregate coverage, the Fund's proposal would expand the legislative mandate for providers to carry medical malpractice insurance even though such mandates do not exist in most other states. The present mandate would appear to be sufficient in that nationally in 1993 the average self-employed physician was insured for $1.2 million per occurrence and $2.8 million annual aggregate. When both the primary carrier and the Fund's coverage levels are combined, Pennsylvania's physicians currently purchase $1.2 million per occurrence and $3.6 million annual aggregate.

The proposal to increase the primary coverage limits on January 1, 1997, may also create administrative burdens for insurers who would have little time to

---

[2]Savings in the Fund's claim payouts due to increased primary retention limits are not immediately realized because changes in claims coverage cannot be made retroactively. Thus, it would take several years before any savings resulting from a change in coverage limits was reflected in the Fund's claim payout. Because of this time delay, to some extent the savings realized may be offset by inflation and any increase in the severity of claims paid. See Appendix K for information about how the $51.7 million is derived as well as information about the effects of increased Fund retention limits based on 1995 claims payment data.

amend their rate filings with the Department of Insurance and issue new billings and adjustments to their subscribers.

Another difficulty with this proposal as currently written is that the Fund's reduced coverage is retroactive and would take effect with the passage of the Fund's proposed amendments. As currently written, the reduced Fund coverage would appear to apply to all claims paid after January 1, 1997. Virtually all of these claims during the next few years would have occurred under the lower primary coverage limits. This change would not present particular problems for providers with claims-made policies and self-insureds. However, it will be a problem for those who have purchased occurrence-based policies. Insurers could not be held responsible for such a retroactive change in an occurrence-based coverage, potentially making the health care provider personally liable for the coverage layer no longer provided by the Fund (i.e., the $100,000 layer between $200,000 and $300,000).

Advantages/Disadvantages of Reducing the Number of Section 605 Claims. The Fund has proposed that certain claims be considered excess claims rather than Section 605 claims.[3] This proposal has the advantage of reducing the Fund's payout because the primary insurer would be responsible for the first $200,000 of the claim settlement[4] ($300,000 under the Fund's proposal for increased primary coverage). Under current law, the Fund is responsible for the full amount of a Section 605 claim up to the Fund's coverage limits; primary insurers are not required to participate in the cost to settle Section 605 claims.

As with the proposed change in coverage limits, this proposal could present problems for health care providers as their primary insurers would not have included such coverage in policies sold before the effective date of the provision. Because the provision as written applies to past insurance coverage and not just to policies issued from January 1, 1997, forward, this provision could result in health care providers having to personally assume responsibility for added costs related to such claims. This change would also result in increased costs to health care providers to purchase basic insurance coverage on January 1, 1997, due to the added costs to insurers to provide coverage for the newly classified excess claims.

Advantages/Disadvantages of Limiting the Fund's Liability for Delay Damages and Post-Judgment Interest. The Fund has proposed statutory language to prevent courts from ordering the Fund to pay delay damages and post-judgment interest above the Fund's coverage limits. Whether the proposed amendments would apply to outstanding cases is unclear. If the Fund's amendments are enacted as proposed, the courts could make health care providers responsible for the Fund's proportionate share of such payments. This could occur even if the delays were due

---

[3]This proposal would affect claims involving multiple treatments and consultations, when the last treatments and consultations took place less than four years before the date on which the health care provider and insurer received notice of the claim.

[4]Assuming the insurer has not exceeded the annual aggregate.

to actions of the Fund that were outside of the health care provider's control. Health care providers would, therefore, need to purchase additional coverage beyond their basic and excess coverage to avoid being held personally responsible for such payments.

Moving Up the Date for Provider Payment of the Surcharge

The Fund is proposing to make its annual surcharge due on January 1st rather than throughout the year as policies become due for renewal. Providers would have to pay the surcharge in 20 days, though they would be allowed to pay in installments, with interest.

Advantages/Disadvantages: Moving up the surcharge payment date results in the Fund collecting virtually all of its surcharge revenue at the beginning of the year. This increases the Fund's revenues by allowing the Fund to earn interest on its annual surcharge collections until the end of the year when the surcharge revenues are used to pay claims.

The disadvantage is to health care providers, particularly those whose policy renewal dates are near the end of the year. Under the proposal, such providers would have to pay their premiums in January 1997 rather than near the end of 1997. To ease the financial burden on providers, the Fund is proposing to develop a system which, for the first time, will allow installment payments. However, the installment plan would require health care providers to pay interest on the unpaid balance.

Basing the Annual Surcharge on the JUA's Filed Rates

The Fund is proposing to base the providers' annual surcharge on the Joint Underwriting Association's (JUA) filed rates rather than the actual premium paid. This proposal seeks to address the widespread concern that the current law, which requires that the surcharge be a percentage of actual premiums, creates inequities between similarly situated providers.

Advantages/Disadvantages: The use of the JUA filed rates as a basis for calculating an individual health care provider's surcharge has the advantage of making the surcharge more equitable in the sense that two health care providers in the same specialty, at the same location, practicing medicine for the same number of years, and with the same claims experience would pay the same annual surcharge. Use of the JUA's filed rates would also provide greater predictability to the Fund's annual surcharge revenues because it would eliminate discounts as a variable affecting surcharge collections. Using filed rates would also have the public relations advantage of allowing the Fund to significantly reduce the surcharge percentage (but not necessarily the dollar amount paid by health care providers) because the

percentage would be calculated using a much higher base rate. This would be especially true if JUA filed rates are used as the base because the JUA tends to insure the higher risk providers.

Health care providers in specialties that have received large discounts may find this proposal costly. While the use of the JUA rates will be more equitable for providers over all, specialists who have benefited from insurer discounting practices can expect to pay substantially higher annual surcharges based on JUA filed rates. The specialists most likely to be negatively affected by this change would include, for example, neurosurgeons and obstetricians.

Other physicians, such as those who are retired but want to maintain their license, research and teaching physicians, and residents in Pennsylvania's teaching hospitals, may also find their surcharge amounts increasing sharply. This would occur because the JUA does not have separate filed rates for these classes. Wisconsin provides for lower surcharges for such physicians (see Chapter IV).

Eliminating the Emergency Surcharge and Granting the Fund Borrowing Authority

The Fund is proposing to eliminate the emergency surcharge. The Fund believes the emergency surcharge will no longer be needed in part as a result of Meier v. Maleski (Commonwealth Court 1996) and because the Fund is proposing that it be granted borrowing authority.

Advantages/Disadvantages: Eliminating the emergency surcharge will ensure that health care providers will not be faced, as they were in 1995, with having to pay substantial additional surcharges within a 30-day period or losing their license to practice. Under the Fund's proposal, if money were needed to pay claims at the end of the year, reserve funds, if available, could be used or it could be borrowed from a financial institution.

Provider groups, in particular, are concerned over prospects that the Fund will begin assessing surcharges that are significantly greater than needed to pay off their immediate liabilities. Such an increase in surcharge revenues would be essential if the Fund is to build up an adequate balance to prevent the need for an emergency surcharge. Also, there are no limits on the Fund's proposed borrowing authority, and any such borrowing would create debt expense which would have to be paid through higher surcharges in future years.

Increasing the Fund's Statutory Buffer

The Fund has proposed increasing the statutory buffer in the surcharge calculation from $15 million to 15 percent of the final claims and expenses incurred during the preceding claim period.[5]

Advantages/Disadvantages: This proposal increases the Fund's buffer, which is necessary to meet unanticipated increases in claims payments from one year to the next. The primary disadvantage of this proposal is that it would increase the amount providers would have to pay in surcharges (to reach the 15 percent target, the Fund balance would need to be $42.7 million in 1996) at a time when providers are already paying high surcharges. Also, even if the proposed buffer had been in place in 1995, it would not have been sufficient to prevent the need for an emergency surcharge. In 1994 the Fund paid $172 million in claims and had operating expenses totaling $17.9 million. This would have allowed for a $28.5 million buffer--far below the $106 million needed from the 1995 emergency surcharge.

Granting the Fund Underwriting Authority

The Fund has proposed that it be granted discretionary underwriting authority. Under one part of its proposal, the Fund would be allowed to increase or decrease the amount of the surcharge paid by an individual provider. Such increases or decreases could not result in more than a 25 percent increase or decrease in the amount of the surcharge paid by the provider and would be granted or imposed based on the individual provider's frequency of paid claims compared to similar classes of providers, of similar risk and kind, within the same geographic region. All such adjustments would have to be approved by the Insurance Department.

The Fund has also proposed that it be given the authority to adjust the surcharge paid by certain specialties based on their total claims loss experience. Adjustments for such specialties would be made only for specialty groups that had Fund payouts averaging less than 30 percent of their surcharge payments over the preceding ten-year period.

Advantages/Disadvantages: Granting the Fund limited underwriting authority would allow it to alleviate, on a case by case basis, some of the hardships that would result from using the JUA filed rates as the basis for the Fund's annual surcharge. It would also allow the Fund to assess higher surcharges against providers who have had multiple paid claims. However, it is unclear how the Fund

---

[5]Senate Bill 1122 provides for a buffer "to provide an amount necessary to maintain (emphasis added) an additional 15 percent of the final claims and expenses incurred during the preceding claims period." The Fund proposal provides "an additional 15 percent."

would be able to carry out its underwriting proposals. The Fund does not currently collect all the data it would need for such underwriting decisions and has no experience in this area. Moreover, the proposed language does not require the Fund to reduce or increase the surcharge for all individual health care providers who meet certain criteria. As a consequence, health care providers have no assurance that providers in similar circumstances will be given equal treatment. In Wisconsin where the Fund has certain underwriting authority, the basis and procedures are set forth in statute and regulations. These procedures require that decisions to penalize physicians be made only after review of the case by the physician's peers and a determination that the appropriate standard of care was not met by the provider (see Chapter IV).

The Pennsylvania Medical Society has also voiced concerns about the Fund being granted underwriting authority. While the Society supports a pay-as-you-go fund for paying large claims, it does not believe the Fund has the experience of a private insurer to do underwriting and does not support "a statewide monopolistic insurance company with all the trappings of underwriters and actuaries." The Society also notes that the Fund is not subject to the competitive market checks and balances but is subject to political pressures. According to the Society, while it believes that the current director has done an excellent job and would appropriately exercise underwriting discretion, "in the long term, however, [Society members] are not comfortable allowing the Fund Director to determine who must pay more and who may pay less than the statutory formula."

Change the Fund's Structure and Operational Responsibilities

Proposals have also been made that would significantly alter the Fund's structure and operational responsibilities. Such proposals would continue the Fund, but as a fundamentally different entity. Key features of such proposals are discussed below.

Establishing a Governing Board

Establishing an independent governing board to administer the Fund and employ the director and necessary staff would alter the structure and management of the Fund. One approach is contained in Senate Bill 1122, which creates a Fund governing board consisting of seven members appointed by the Governor.[6] The board includes various health care providers, an insurer, and a representative of the public-at-large.

[6]Under SB 1122, the board would be part of the executive branch of state government but would not be subject to the Governor's jurisdiction to the same extent as the present Fund. The Board would supervise and administer the Fund and appoint a director and staff.

Advantages/Disadvantages: An independent governing board would provide for oversight of the Fund from those with both an interest and expertise in the medical malpractice area. Board member input into the operations of the Fund would be assured since the role of members would be more than just advisory. An independent governing board similar, for example, to Pennsylvania's Insurance Fraud Prevention Authority[7] would also be better positioned to manage the Fund without some of the inherent inefficiencies and conflicts that confront other executive branch agencies.

If responsibility for the administration of the Medical Professional Liability Catastrophe Loss Fund were given to a governing board, Pennsylvania would be following the path taken by Kansas and Wisconsin, the two other states in which provider participation in the state fund is mandated (see Chapter IV). The Fund director is opposed to the creation of an independent governing board, at least in part because he supports the Administration's efforts to reduce the number of independent boards and commissions within state government.

Shifting or Restructuring the Fund's Claims Handling Practices and Responsibilities

The importance of the claims management function has grown over the past decade because the Fund no longer provides "catastrophic" coverage but rather is an active working layer of insurance. To alleviate the problems caused by delays and the Fund's growing involvement in claims management, proposals have been made to shift responsibility for managing the Fund's coverage level to the health care provider's primary insurer and to improve the Fund's accountability for those claims it does manage. For example, Senate Bill 1122 would:

- shift responsibility for managing the Fund's layer of excess coverage to a health care provider's primary insurance carrier;
- make the Fund liable for "bad faith" actions and omissions, and
- provide for the voluntary use of mediators in certain cases.

Other possible options include:

- reintroducing the use of independent arbitration panels to value claims and assess provider liability; and
- creating an "outside" claims review committee to value claims and authorize settlement amounts.

---

[7]The Insurance Fraud Prevention Authority administers the Insurance Fraud Prevention Trust Fund, which is financed by assessments on insurers according to a statutory formula. The Authority's board controls its expenditures and staffing. The Budget Secretary does not preapprove expenditures nor does the Governor have authority over staffing decisions.

Advantages/Disadvantages of Shifting Responsibility for Managing the Fund's Layer of Coverage to the Primary Insurer. Primary insurance carriers are responsible for the management and legal defense of all excess claims before the Fund. Since private carriers maintain their claims management and legal defense responsibilities even after a claim is turned over to the Fund, the Fund's involvement in the claim can complicate the claim settlement negotiations. If claims management responsibilities were carried out by the primary insurer, there would no longer be disputes between the Fund and the primary carrier about the value of a claim for settlement purposes or whether claims should be allowed to proceed to a jury trial. If the savings from such increased efficiency were passed on to the health care providers, they too would realize savings.

Turning over the Fund's responsibilities for valuing and settling claims to private carriers is not without problems. As stated by the Fund's director,

> In my opinion, if a carrier is given settlement authority over the Fund's coverage, the Fund's $1,000,000 layer will always be expended by the carrier, in order to protect other primary policies which may be exposed as well as its own excess coverage. In short, private carriers will utilize public [i.e., Medical Professional Liability Catastrophe Loss Fund] moneys in order to protect additional private (excess) money.

Proponents for turning over the Fund's claims management to primary insurers generally acknowledge that problems could result if private insurers were given full responsibility to manage the Fund's coverage layer. To help safeguard against abuses, Senate Bill 1122 provides for review of certain individual carriers' practices when using Fund dollars. It further restricts the authority of a primary carrier to manage Fund claims if the carrier has been found to have engaged in abusive practices. These provisions, however, would not necessarily identify all instances in which abusive practices might occur, and their effectiveness in preventing such abuses would be limited since they would apply only after the abuse occurred.

Another option to address the concerns over the inappropriate use of Fund money by private insurers is contained in a recent suggested amendment to Senate Bill 1122. This proposal, known as "quota share," makes the primary carrier responsible for 20 percent of the cost to settle a claim within the Fund's coverage limits. If a private insurer agreed to settle a claim for $1.2 million it would cost the insurer $400,000 ($200,0000 for basic coverage plus 20 percent of $1 million) rather than just $200,000. This would provide at least some financial incentive for the primary insurer to minimize Fund payouts.

Advantages/Disadvantages of Making the Fund Liable for Bad Faith. To make the Fund more accountable for its claim management practices, Senate Bill

1122 contains a provision which would subject the Fund to bad faith penalties. When the Fund was created in 1975, the General Assembly did not have to be concerned about the accountability of the Fund to health care providers who were defendants in medical malpractice claims. Initially, there was little opportunity for the Fund to engage in actions which courts might consider "bad faith" since the Fund did not value claims. Rather, claims were valued by independent arbitration panels that included health care professionals. The Fund, therefore, paid excess claims after their value had been established by independent arbitration panels or the courts.

With the constitutionality of the arbitration panels in question,[8] the Fund developed its own Claims Committee in 1981 to carry out tasks similar to those of private insurers. Like a private insurer, the Fund now both values claims for settlement purposes and pays the claim. Since the Fund now has responsibilities similar to a private insurer, subjecting the Fund to similar bad faith penalties would appear reasonable.

One disadvantage of this proposal is that subjecting the Fund to bad faith penalties may result in the Fund's overall claims payment costs increasing if the courts determine that the Fund has engaged in bad faith practices. Such costs, however, would not be incurred if the Fund did not engage in "bad faith" actions.

Even if the Fund does not act in bad faith, some increase in Fund claims payout levels could occur since the Fund might feel forced to make higher settlement offers to avoid charges of bad faith. Although this might drive up costs to the Fund, it would not necessarily drive up the overall costs to health care providers. With the Fund making higher payments to settle claims, some of the costs which are now placed on health care providers would simply be shifted back to the Fund.

Another disadvantage to subjecting the Fund to bad faith is concern over the possible precedent it would set. The Fund is a state agency and, according to the Fund director, the precedent of subjecting any state agency to bad faith penalties is problematic.

Advantages/Disadvantages of Using Mediators. Some of the most difficult claims to settle are those involving multiple health care providers, each with different primary insurers. The Fund now attempts to reach "global settlements" involving all involved health care providers rather than settle claims individually. However, as described on page 26, the Fund is not a disinterested party in such settlements. Senate Bill 1122 attempts to alleviate the potential conflicts that can arise between multiple providers and multiple insurers through voluntary mediation, with the decision of the mediators binding on the parties if the parties so agree. The role of the mediator would be to assign liability among providers after a settle-

[8]The arbitration panels were finally declared unconstitutional after a series of court decisions.

ment amount had been agreed to by all parties. Since under Senate Bill 1122 the primary carriers would be responsible for managing the Fund's layer of coverage, Fund dollars would also be included in the independent mediation.[9]

Although mediation may result in a fairer allocation of financial responsibility, the disadvantage to the Fund is that it loses control over its ability to assign liability in a manner favorable to protecting Fund dollars. Moreover, under Senate Bill 1122 mediators can only apportion liability after the value of a case has been agreed to; they are not able to mediate conflicts concerning the value of the claim.

The Advantages and Disadvantages of Using Independent Arbitration Panels. In his testimony before the Senate Banking and Insurance Committee in September 1995, the President of the Insurance Federation of Pennsylvania (IFP) recommended that the General Assembly consider reintroducing the use of independent arbitration panels. As noted earlier, independent arbitration panels were an integral part of the effort at tort reform in the 1970s but were ruled unconstitutional due primarily to the panels' delays in hearing cases. According to the courts, such delays denied injured parties timely access to the courts. Arbitration panel decisions were not timely because of the many calendar conflicts which occurred due to the large number of individuals required to serve on the panels, according to the IFP President. To address this problem, the General Assembly reduced the number of arbitration panel members and simplified the panel selection process. Shortly thereafter, however, the section of the act creating the panels was declared unconstitutional and they were never tried again.

Independent arbitrators would have broader authority than the mediators proposed in Senate Bill 1122 and in proposals made by the Fund. They could both assess liability and determine the value of a claim. As such, the arbitrators could save both time and money. An important disadvantage, however, is that the courts might again declare them to be unconstitutional.

Advantages/Disadvantages of an "Outside" Claims Review Committee. A model for this approach is currently available in Wisconsin. Wisconsin's Patient Compensation Fund's Board of Governors has appointed an "outside" Claims Committee to assist the Board in claims-related activities, including valuing claims and authorizing settlement amounts. Those appointed include representatives of the medical society and hospital association as well as legal and claims staff from state insurers. The chair of the committee is the representative of the state medical society who also sits on Wisconsin's fund governing board. (See Chapter IV for additional information about the operation of this committee in Wisconsin.)

---

[9]The Fund has also proposed an amendment which would provide for the use of voluntary mediation with the Fund's concurrence when Fund dollars are involved.

Establishing an outside claims review committee to review certain types of claims before the Fund is an alternative to shifting the Fund's claims management responsibilities to the primary carriers. It offers some assurances to health care providers and their insurers that their concerns would be addressed by the Fund when valuing a claim and determining whether it should be litigated. An outside claims review committee could also offer some assurances to health care providers and their insurers that decisions about claims settlement would be driven by the value of the claim rather than the Fund's cash flow concerns.

One disadvantage to such an approach is the commitment it requires of those assigned to the committee. This would be especially true in Pennsylvania, which settles many more claims than Wisconsin. Moreover, the model was developed for use by a fund with a governing board, and Pennsylvania's fund currently does not have such a board.

Clarify the Fund's Coverage Responsibilities

Proposed changes to the Fund's coverage responsibilities include:

- requiring the Fund to pay its proportionate share of delay damages when such damages are awarded by the courts even when such payments would require payments above the Fund's coverage limits;
- requiring the Fund to pay post-judgment interest when awarded by the courts even when such payments would require payments above the Fund's coverage limits; and
- requiring the Fund to pay a health care provider's legal defense costs when the primary carrier's coverage has been exceeded.

Advantages/Disadvantages of Requiring the Fund to Pay Delay Damages and Post-Judgment Interest. Senate Bill 1122 would make the Fund responsible for payment of its proportionate share of delay damages awarded by the courts. Courts can require private insurers to pay delay damages above the primary carrier's coverage limits. Placing similar requirements on the Fund would place the Fund in the same position as a private insurer. Requiring the Fund to pay its proportionate share of such damages would also assure that health care providers and those with additional private excess insurance would not have to pay the Fund's share of such costs. Such a change in the Fund's coverage limits, however, could increase the Fund's total claims payout costs.

Senate Bill 1122 also contains a provision which clarifies that the Fund is responsible for the payment of post-judgment interest, even if the interest exceeds

the Fund's coverage limits.[10] The advantages and disadvantages of the proposal are similar to those for payment of delay damages--it would reduce potential costs to health care providers but increase costs to the Fund.

Advantages/Disadvantages of Fund Payments for Attorney Fees When a Health Care Provider's Primary Coverage Benefits Are Exceeded. Senate Bill 1122 would require the Fund to pay the legal costs to defend a claim against a health care provider whose basic insurance annual aggregate limit has been exhausted. Thus, the Fund would be required to pay the legal costs to defend a claim against a hospital if the hospital had judgments exceeding $1 million (the basic coverage annual aggregate limit for a hospital) in a given claims year.

If the Fund was required to pay the legal costs to defend health care providers who have exceeded their primary coverage limits, health care providers would not have to pay for the defense of such cases, and a defense of the Fund would be assured.[11] This provision would, however, increase the Fund's total costs which, in turn, would increase the surcharge payments needed to support the Fund.

Allow Providers to Opt Out of the Fund

If participation in the Fund was made optional, dissatisfied health care providers could withdraw from the Fund. After withdrawing from the Fund, they would carry the mandatory malpractice coverage required of Fund participants through private companies or self-insurance plans.

Under an "Opt In/Opt Out" plan providers would have the opportunity to declare whether or not they would continue to participate in the Fund as of a specified date. In effect, two funds would exist after the option date: one for the open and unreported claims under the mandatory program and another for the new claims under the voluntary program. Providers choosing to leave would continue to be responsible for paying their portion of the unfunded liability, i.e., losses incurred but not paid while they participated in the Fund.

Advantages/Disadvantages. Allowing providers the option of participating in the Fund might or might not result in the Fund's collapse. The outcome would depend on whether the departure of some health care providers would prompt the rest to leave. For example, another state fund created in 1975, the Florida Patient's Compensation Fund, terminated in 1983 because it did not have enough participants to continue offering coverage.

---

[10]Commonwealth Court has ruled that the Fund is responsible for the payment of post-judgment interest above its coverage limits; however, the Fund is appealing the decision.

[11]The PA Insurance Department has approved medical malpractice policies which do not obligate the insurer to pay any claim or judgment or to defend any claim or suit after the applicable limit of the primary insurer's liability has been exhausted by payment of judgments or settlements.

The primary advantage of an optional fund is that it gives some providers an opportunity to reduce their medical malpractice costs by opting out of the Fund. The primary disadvantage is that, in all likelihood, the best risks would leave the Fund to take advantage of discounts offered by commercial insurers, leaving the Fund with a high proportion of marginal risks. This would prevent the Fund from spreading its risks over a large population of providers. The Fund's director has predicted that this would almost assuredly lead to the Fund's collapse.

States that have voluntary participation funds, such as Indiana and Nebraska, typically offer tort reform incentives to encourage providers to join their funds (see Chapter IV). Thus, the idea of a voluntary fund would appear more feasible if the Commonwealth offered significant tort reform incentives to join the new fund.

Terminate the Fund

Recent increases in the Fund's annual surcharge, together with the 1995 emergency surcharge, have brought forth calls to terminate the Fund by privatizing its layer of coverage. Fully privatizing medical malpractice coverage would resolve many of the issues surrounding the Fund. However, it also raises new questions about (1) how the transition to private coverage could best be accomplished, (2) how it would affect insurers' marketing strategies and rate filings, and (3) how the former participants would pay off the unfunded liability. This section discusses proposals for both the immediate and gradual termination of the Fund.

Within this section we have used the report of the unfunded liability as of December 31, 1995, to illustrate the relative difference among the various options for terminating the Fund. The actuaries based their estimate on data provided by the Fund and, although they assessed its reasonableness, they did not audit the data to verify its accuracy. Also, as noted on page 38, some of the assumptions made in the 1995 report are problematic. A more stringent analysis of the Fund's financial condition, including an independently funded claims and actuarial audit, would probably be necessary to evaluate the feasibility of any of the various proposals discussed below for terminating the Fund.

Immediate Termination

Under the immediate termination option, the Fund would cease offering medical malpractice coverage on a specific date. All future surcharges would go toward paying operating expenses and reducing the unfunded liability, which would represent the estimated value of all claims incurred but not yet paid as of the date the Fund ceased providing new coverage. Health care providers would have to purchase the full $1.2 million/$3.6 million of coverage through private insurance companies or equivalent self-insurance plans.

Advantages/Disadvantages. One advantage of the immediate termination option is that it would quickly remove the state from the medical malpractice insurance business, a function which for a variety of reasons the Commonwealth has not performed well. Another advantage of the immediate termination option is that the Fund's unfunded liability would stop growing and, therefore, could be retired more quickly than through options for gradual termination. (See Table 16.)

Under any proposal to shift all or part of the Fund's coverage to the private malpractice insurance market, insurers would have to decide how to structure, price, and market their malpractice insurance products for the Fund's coverage level. Immediate termination of the Fund's coverage is much less complex than other proposals which shift only part of the Fund's coverage to the private market because the basic decisions would need to be made only once. Immediate termination also appears feasible in that private insurers have reported to the Insurance Department that they can provide the Fund's layer of coverage through standard insurance policies for less than the Fund's 1996 surcharge of 164 percent (see Table 10 on page 42).

The issue of future claims management would largely be resolved under immediate termination because private carriers or self-insurers would manage all new claims incurred after the termination date. Claims outstanding as of the Fund's termination date could be managed either by the primary carriers, the Fund, or another agency given the responsibility for administering the remaining claims.

The biggest disadvantage to immediate termination would be the need to pay off more than half of the unfunded liability within three to six years. Payment patterns for claims incurred before 1987 illustrate why the providers would have to pay the largest surcharges in the first few years after the Fund closed. For example, if the Fund had terminated on August 31, 1986, the participating health care providers would have been faced with paying off an unfunded liability of approximately $1.10 billion. Subsequent claim payments for the occurrence years 1976 through 1986 show that almost 40 percent of the unfunded liability at that time was paid off over the next three years. About 65 percent was paid off within six years. (See Table 14.)

Table 14

Claim Payments if Fund Had Terminated as of August 31, 1986

Year	Claim Payments	Unfunded Liability as of December 31
1986	$136,064,199	$1,098,389,328
1987	$135,987,902	$ 962,401,426
1988	$160,074,270	$ 802,327,156
1989	$124,754,403	$ 677,572,753
1990	$ 98,077,737	$ 579,495,016
1991	$ 97,620,074	$ 481,874,942
1992	$ 97,195,738	$ 384,679,204
1993	$ 66,757,203	$ 317,922,001
1994	$ 59,177,800	$ 258,744,201
1995	$ 52,335,461	$ 206,408,740

Source: Developed from *Medical Professional Liability Catastrophe Loss Fund, Estimation of Unfunded Liability as of December 31, 1995*, prepared by Coopers & Lybrand L. L. P.

Similar payment patterns to retire the current unfunded liability estimated at $1.95 billion would require average annual surcharges of $250 million for the first three years and $174 million for the following three years to pay off 65 percent of the $1.95 billion unfunded liability.[12] This translates into a 136 percent annual surcharge and a 95 percent annual surcharge, respectively, based on the 1996 annual premium base.

A bond issue has been proposed as a way to amortize the unfunded liability in equal installments over a 30-year period. Such a plan would allow the Fund to be terminated immediately without imposing inordinate costs on providers during the initial years after termination. A bond issue would also make payments from health care providers predictable from year to year.

An initial study to assess the feasibility of a bond issue was sponsored by the Hospital Association of Pennsylvania. It concluded that an unfunded liability of $1.9 billion as of December 31, 1995, could be paid off with approximately $124 million a year (67 percent of the 1996 premium base) for 30 years. Careful consideration of a bond issue would be necessary before pursuing such an option. For example, the proposed bond issue would probably be feasible only if it qualified for federal tax exemption, which remains an open question. Unanticipated technical problems might also arise because a bond has never been issued for such a purpose, and constitutional questions might be raised regarding imposing a surcharge on health care providers who have not benefited directly from the Fund.

[12]See page 38 regarding LB&FC concerns that the unfunded liability might be underestimated.

In a February 7, 1996, letter to medical malpractice insurers, the Insurance Commissioner requested input on what it would cost to retire the unfunded liability under 1, 5, 10, and 20 year scenarios. As of May 15, 1996, four insurers had provided such information (see Table 15). The responses varied depending on the assumptions each insurer made about changes in the premium base and the appropriate discount rate to reflect earnings on investments.

Table 15

Estimated Annual Surcharge Rates to Pay Off the Unfunded Liability

Years	Company A[a]	Company B[a]	Company C	Company D
1	815%	764%	764%	652%
5	183%	171%	159%	146%
10	105%	98%	83%	84%
20	69%	63%	46%	54%

[a]Based on 1996 primary premiums and assuming no change in subsequent years' premiums. Estimates by companies C and D assume an increasing premium base.
Source: Developed from survey responses received by the Department of Insurance. Insurers were asked to assume a $1.87 billion unfunded liability as of December 31, 1994.

Another alternative that has been proposed would involve requiring health care providers to purchase new policies (or riders to existing policies) to cover outstanding claims as of the Fund's termination date. Such policies would probably be expensive, however, because many of the claims covered under the policies would need to be paid in the relatively near future, thus not allowing insurers much time to accumulate reserves. A mechanism, such as an assigned risk pool, would also be needed to cover providers who have claims already reported that are likely to result in large settlements, as insurers may not be willing to cover these providers. It would also be difficult to require physicians who retire or move out of state to purchase such policies because they would not be directly affected if their license to practice were revoked.

Other suggestions made by insurers if they should be required to insure outstanding claims include:

- Allowing insurers to form self-insurance groups to reduce their risk;
- Allowing insurers to adjust individual providers' surcharges based on their years of participation in the Fund;
- Allowing insurers to charge special assessments if the surcharge revenues turn out to be insufficient;

- Making a guarantee similar to reinsurance or placing a cap on each insurer's paid losses.

The insurers also raised several important questions that would need to be resolved before they could structure policies to cover the Fund's outstanding claims, including:

- Will the unfunded liability be allocated among insurers based on their share of the medical malpractice insurance market, their current number of individual Fund participants, or their past claims experience with the Fund?

- Will insurers leaving the Pennsylvania medical malpractice insurance market continue to have responsibility for their share of the unfunded liability?
- If a health care provider moves from one insurer to another, which insurer will have responsibility for the provider's share of the unfunded liability?
- How will the share of the unfunded liability for Fund participants who leave the state, retire, become disabled, or are now deceased be funded?

Gradual Termination

Suggestions for the gradual termination of the Fund generally involve one of two methods for phasing out its operations: (1) the basic limits phase-out which would increase the primary insurance coverage incrementally until it reached $1.2 million or (2) a "quota share" phase-out which would require the primary insurer to pay an increasingly larger percentage of all Fund settlements until the insurer's share reached 100 percent.

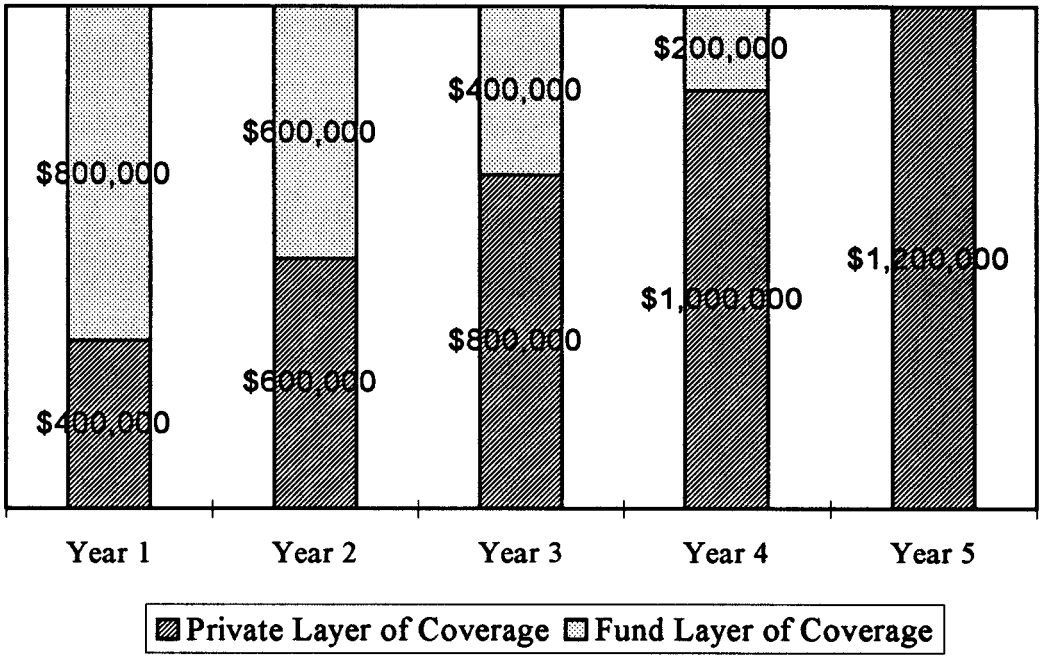
House Bill 2294 would increase the basic limits to be covered by a primary insurer or self-insurer $200,000 a year for five years. At the end of five years, the Fund's layer of coverage would be fully privatized.

The quota share method differs from the approach described above in that the basic limits would remain at $200,000 throughout the phase-out. However, the primary insurer would pay an increasing percentage of the Fund settlement costs. The Pennsylvania Podiatric Medical Association has proposed a five-year phase-out during which the primary insurers' share of Fund payments would increase by 20 percent each year. For example, the primary insurers would be responsible for 40 percent of the losses paid by the Fund during the second year of a quota share phase-out. Accordingly, if a total settlement came to $700,000, the insurer would pay the $200,000 basic limits plus another $200,000 (i.e., 40 percent of $500,000) and the Fund would pay the remaining $300,000. The basic limits and quota share proposals are illustrated graphically in Exhibit 10.

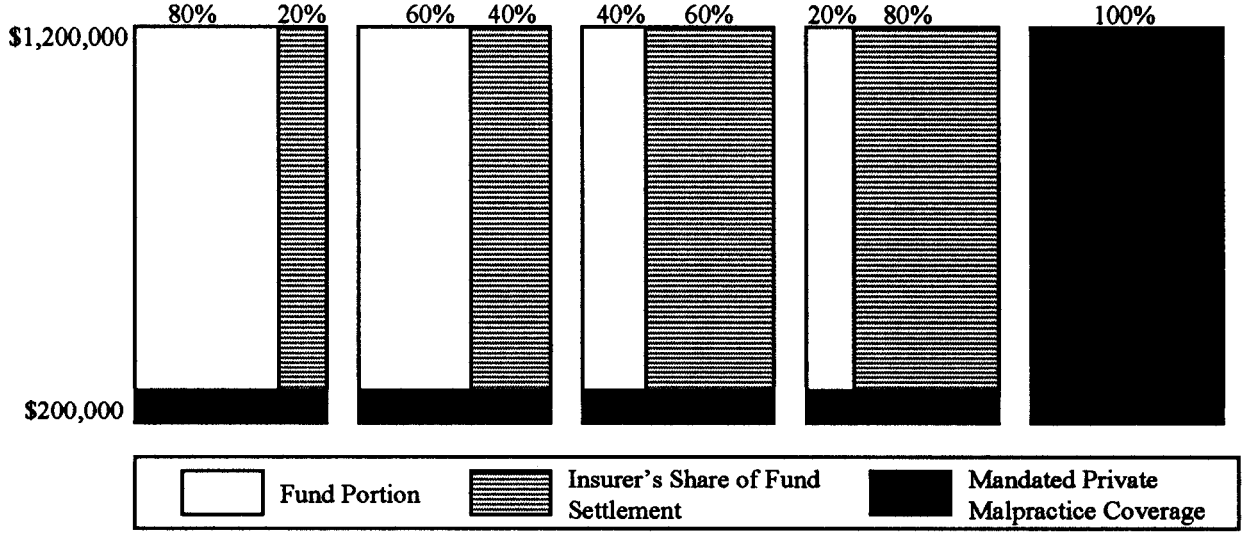
Exhibit 10

Basic Limit and Quota Share Phase-Out Plans

Basic Limit Phase-Out Plan



Quota Share Phase-Out Plan



Source: Developed based on HB 2294 (for the basic limits plan) and a proposal made by the Pennsylvania Podiatric Medical Association (for the quota share plan).

The basic limits phase-out plan in H.B. 2294 would give insurers and self-insured providers full responsibility for managing new claims while the Fund would continue to manage its unsettled claims. After the phase-out, the unsettled claims from prior occurrence years would become the responsibility of the JUA. The quota share plan of the Podiatric Medical Association contains a similar provision.

The settlement of Fund claims would represent a new responsibility for the JUA, a responsibility the director of the JUA believes it can handle if given reasonable additional resources. Other proposals have called for keeping Fund operations intact and letting it manage the outstanding claims, some of which may not be reported and settled for 20 years or more.

Advantages/Disadvantages. The quota share proposal has the advantage of addressing a claims management issue raised by the Fund director. Phasing out the Fund's coverage layer through quota share puts a portion of the insurers' reserves at risk. Thus, primary insurers, who would presumably manage the claims, would have an incentive to defend claims in the Fund's coverage layer.

A gradual phase-out of the Fund's coverage layer has the advantage over immediate privatization of keeping health care providers' primary insurance premiums somewhat lower during the initial years than if they had to purchase full coverage from the private insurers. The Fund's annual surcharge, however, would not be reduced because, at least for the first few years, there would be little or no change in the number or dollar value of the claims it would have to pay. As a result, providers would find the total cost of malpractice coverage only slightly less burdensome during the phase-out years.

Differences in the providers' costs under the two gradual phase-out proposals would probably not be significant. Insurers would be likely to incur more losses under the basic limits phase-out (because the lower layers of coverage are the most frequently-used layers) and would have to charge higher premiums than they would under the quota share phase-out.

On the other hand, the Fund would incur more losses under quota share and the unfunded liability to be paid off after the phase-out would be larger, than under the basic limits phase-out approach. Table 16 uses the Fund's projected claim payments through the year 2000 to illustrate the differences in the unfunded balance under immediate termination and the two phase-out proposals. As the table shows, the unfunded liability after the year 2000 is higher under either phase-out plan than under immediate termination, which means that surcharges after the year 2000 would be higher under the phase-out plans than under immediate termination.

Table 16

Projected Unfunded Liability as of December 31

Year	Fund Estimate of Claim Payments	Termination as of 8/31/96	Basic Limits Phase-Out	Quota Share Phase-Out
1996	$230,000,000	$2,052,000,000	$2,052,000,000	$2,052,000,000
1997	$242,000,000	$1,810,000,000	$2,006,000,000	$2,061,000,000
1998	$250,000,000	$1,560,000,000	$1,874,000,000	$2,006,000,000
1999	$260,000,000	$1,300,000,000	$1,684,000,000	$1,881,000,000
2000	$275,000,000	$1,025,000,000	$1,431,000,000	$1,676,000,000

Source: Developed from *Medical Professional Liability Catastrophe Loss Fund, Estimation of Unfunded Liability as of December 31, 1995,* prepared by Coopers & Lybrand L.L.P., and other information provided by the Fund.

Although a gradual phase-out would make the transition to higher insurance premiums a little easier for providers, it would also draw out the claims problems the Fund now faces. For example, questions of when the alleged malpractice occurred and who had the most responsibility would take on added significance as coverage levels changed from year to year. The apportionment of the providers' responsibility could determine how large the insurer's share would be or whether the Fund would participate at all under a basic limits phase-out.

Changing coverage levels on an annual basis, which would be required under either gradual phase-out option, might also intensify the search for lower premiums as insurers reassessed their marketing strategies year after year in light of the increasing risks imposed on them. If the Fund terminated immediately, only one major adjustment in rates and coverage would be necessary.

Finally, the involvement of the Fund would become increasingly less cost effective during the phase-out. By the fourth year, the maximum amount of Fund participation would drop to $200,000 per claim under either phase-out proposal. Quota share would exacerbate the problem, because the Fund would remain involved in every claim exceeding $200,000 but only as a 20 percent contributor.

Summary of the Features of the Proposed Options

Exhibit 11 provides a summary of the features of the various proposals, including the estimated annual loss costs in future years if the Fund continues to offer its present layer of coverage or if its coverage is reduced as proposed by the Fund.[13]

[13] See Appendix K for additional information about alternative Fund coverage levels which have been proposed and the reductions in fund claims payouts and the number of claims paid if such proposals had been in effect in 1995.

Exhibit 11

Features of Proposed Options

Feature	No Change	Fund Proposal	Senate Bill 1122
Primary Coverage	$200K/$600K (P) $200K/$1.0M (H)	$300K/$900K (P) $300K/$1.5M (H)	$200K/$600K (P) $200K/$1.0M (H)
Fund Coverage	$1.0M/$3.0M	$900K/$3.0M	$1.0M/$3.0M
Unfunded Liability	Pay-as-you-go.	Pay-as-you-go.	Pay-as-you-go.
Est. Annual Loss Cost	$275 million after 4 years.	$224 million after 4 years.	$275 million after 4 years.
Claims Management	Fund	Fund	Private insurers for excess claims; the Fund for Section 605 claims.
Provider Recourse for Bad Faith Handling of Claims Within Fund Coverage	No	No	Yes
Effect on Unfunded Liability	Continues to grow. Will increase more rapidly if claims payments are delayed as in the past.	Unfunded liability continues to grow.	Unfunded liability continues to grow. Growth may be slower if claims are paid more quickly than in the past.

Exhibit 11

Features of Proposed Options (Continued)

Immediate Termination			Gradual Termination	
Pay as You Go	Bond Issue	Insurers	Basic Limits	Quota Share
$1.2M/$3.6M (P) $1.2M/$4.0M (H)	$1.2M/$3.6M (P) $1.2M/$4.0M (H)	$1.2M/$3.6M (P) $1.2M/$4.0M (H)	+$200K/$600K per year	$200K/$600K (P) $200K/$1.0M (H)
None	None	None	-$200K/$600K per year	-20% per claim per year
Pay-as-you-go.	Amortized	Reserved	Pay-as-you-go.	Pay-as-you-go.
$174 million after 5 years.	$124 million for 30 years.[a]	$165 -195 million for 10 years.[b]	$210 million after 5 years.	$232 million after 5 years.
Fund, JUA, or private insurers.	Fund, JUA, or private insurers.	Private insurers if their reserves are at risk.	Fund, JUA, and private insurers at different points in time.	Private insurers if their reserves are at risk.
Yes if managed by JUA or private insurers.	Yes if managed by JUA or private insurer.	Yes	Yes	Yes
Immediately stops growing, but two-thirds of the unfunded liability must be paid off in the first six years.	Immediately stops growing. The costs to retire it are comparable to the average annual surcharge payments between 1989 and 1991.	Immediately stops growing . Some form of financing would be needed in the early years to pay claims and keep surcharge payments at manageable levels.	Starts to be reduced. Unfunded liability is higher after 5 years than under options for immediate termination. Complex to administer.	Starts to be reduced. Unfunded liability is higher after 5 years than under options for immediate termination. Complex to administer.

[a] Based on an assumed $1.9 billion unfunded liability as of December 31, 1995.

[b] Based on the March 1995 estimate of a $1.87 billion unfunded liability as of 12/31/94. All others are based on the April 1996 estimate of a $1.95 billion unfunded liability as of 12/31/95.

Source: Developed by LB&FC staff.

VI. APPENDICES

APPENDIX A

Comparison of Proposed and Approved Annual Fund Surcharges

Year	Actuary's Proposed Surcharge	Fund Recommended Annual Surcharge	Commissioner Approved Annual Surcharge
1987	87.0%	87.0%	87.0%
1988	70.0	70.0	61.0
1989	70.0	70.0	59.5[a]
1990	72.6	54.0	50.0
1991	75.0	75.0	68.0
1992	90.0	90.0	90.0
1993	91.0	91.0	91.0
1994	93.0	93.0	93.0
1995	102.0	102.0	102.0[b]
1996	164.0	164.0	164.0

[a]The Insurance Commissioner originally approved a 66 percent surcharge. The Commonwealth Court in an unpublished decision by one judge in a case brought by the Pennsylvania Medical Society determined that the surcharge should be 55.4 percent because the Fund's balance was greater than the $15 million "buffer" provided for in statute.

[b]In 1995 an additional 68 percent emergency surcharge was approved.

Source: Developed from information provided by the Insurance Department.

APPENDIX B

Beginning Year Fund Balance, Income, and Expenses of the Medical Professional Liability Catastrophe Loss Fund

As of December 31, 1986 Through 1995

Calendar Year	Beginning Year Fund Balance	Income			Expenses	
		Surcharge	Investment	Other	Claims Paid	Other Incurred Expenses
1986	$ 4,977,209	$152,388,063	$ 4,016,415	$374,514	$136,124,199	$3,232,054
1987	22,429,825	181,748,016	8,325,171	435,782	136,050,829	3,956,934
1988	72,940,236	146,207,414	11,476,282	186,051	168,188,485	6,242,655
1989	56,390,956	133,220,596	12,606,064	161,780	143,613,256	6,260,861
1990	52,527,982	105,653,454	9,666,228	173,505	132,109,257	9,364,022
1991	26,577,189	138,217,966	6,575,128	104,689	150,053,687	11,824,089
1992	9,620,452	166,129,218	4,311,115	130,822	153,221,558	14,212,434
1993	12,778,408	170,648,215	3,711,466	19,716	164,495,505	8,047,584
1994	14,632,066	170,841,742	5,360,788	46,867	171,842,345	17,919,397
1995	1,214,254	286,868,074	6,253,114	14,839	279,552,207	7,578,748

Source: Developed from the Fund's *Annual Statement Submitted to the Insurance Commissioner*.

APPENDIX C

Status of Health Care Provider Claims
From September 30, 1979, Through December 31, 1995

Year	Number of New Claims Open During Year	Number of Claims Paid During Year	Number of Claims Closed Without Payment During Year	Cases Remaining Open at Year End[a]	Total Claims Filed Since Inception
1995	3,702	665	3,585	9,333	39,258
1994	6,543	446	2,394	9,881	35,556
1993	2,795	411	1,860	6,178	29,013
1992	3,273	409	2,007	5,655	26,218
1991	2,480	407	1,623	4,798	22,945
1990	1,900	385	1,104	4,348	20,465
1989	4,653	383	3,012	3,936	18,565
1988	2,025	427	1,620	2,678	13,912
1987	1,442	421	1,265	2,699	11,887
1986	2,099	460	1,730	2,942	10,445
1985	3,444	301	1,802	3,033	8,346
1984	1,134	226	510	1,918	4,902
1983	658	183	265	1,477	3,768
1982	913	158	598	1,084	3,110
1981	611	90	412	1,021	2,197
1980	724	64	426	823	1,568
1979	---	8	---	588	862

[a]As of 12/31 for all years except 1979, 1983, 1984, and 1989. Data for 1984 and 1989 are reported as of 3/31. Data for 1983 are reported as of 6/30, and data for 1979 are reported as of 9/30.

Source: Developed from information reported in the Fund's Annual Statistical Reports.

APPENDIX D

Fund Paid Claimants* and Their Average Payments

Payment Year	Claimants	Avg. Claimant Payment
1978	7	$350,102
1979	25	90,600
1980	31	526,898
1981	77	253,967
1982	140	271,972
1983	169	320,528
1984	195	342,497
1985	252	387,797
1986	402	338,468
1987	357	381,095
1988	357	471,505
1989	324	443,252
1990	335	394,207
1991	332	451,969
1992	337	454,663
1993	332	495,468
1994	370	464,439
1995	551	507,956

*One claimant may file claims against multiple health care providers over a single medical injury. These numbers, therefore, represent the number of claimants who had claims paid by the Fund, not the actual number of health care provider claims paid.

Source: Information provided by the Medical Professional Liability Catastrophe Loss Fund.

APPENDIX E

Medical Professional Liability Catastrophe Loss Fund Claim Payments

Payment Year	Payment Total	Number of Health Care Provider Claims Paid	Average Payment Per Claim
1976	$ 0	0	$ 0.00
1977	0	0	0.00
1978	2,450,717	9	272,301.89
1979	2,265,000	8	283,125.00
1980	16,333,839	64	255,216.23
1981	19,555,472	90	217,283.02
1982	38,076,060	158	240,987.72
1983	54,169,175	183	296,006.42
1984	66,786,997	226	295,517.69
1985	97,724,928	301	324,667.53
1986	136,064,199	460	295,791.74
1987	136,050,829	421	323,161.11
1988	168,327,197	427	394,208.89
1989	143,613,571	383	374,970.16
1990	132,059,492	385	343,011.67
1991	150,053,687	407	368,682.28
1992	153,221,558	409	374,624.84
1993	164,495,505	411	400,232.37
1994	171,842,345	446	385,296.74
1995	279,552,207	665	420,379.26

Source: Developed from data in the 1994 Annual Report of the Fund and 1995 paid claims data provided by the Fund.

APPENDIX F

Medical Professional Liability Catastrophe Loss Fund Surcharges

Year	Surcharge Percentage	Surcharge Collection
1976	10% or $100, whichever is greater	$ 9,862,000
1977	10% or $100, whichever is greater	8,938,000
1978	0%	0
1979	0%	429,000
1980	10% or $100, whichever is greater[a]	7,335,000
1981	22%	18,431,000
1982	38%	34,852,000
1983[b]	41%	46,287,000
1984[c]	52%	66,160,929
1985	70%	95,282,144
1986	87%	152,388,063
1987	87%	181,748,016
1988	61%	146,207,414
1989	59.5%	133,220,596
1990	50%	105,653,454
1991	68%	138,217,966
1992	90%	166,129,218
1993	91%	170,648,215
1994	93%	170,841,742
1995	170%[d]	286,868,079
1996	164%	300,000,000 (est.)

[a]Policies written after 10/15/80 -10% no minimum.

[b]Limits of liability increased for health care providers other than hospitals - $150,000/$450,000 - hospitals - $150,000/$1,000,000.

[c]Limits of liability increased for health care providers other than hospitals - $200,000/$600,000 - hospitals - $200,000/$1,000,000.

[d]In 1995, an annual surcharge of 102 percent and a 68 percent emergency surcharge were imposed.

Source: Developed from the Medical Professional Liability Catastrophe Loss Fund Manual, the Pa. Bulletin 9/30/95, and the Hofflander & Nye Malpractice Study for 1976 through 1983 and the Annual Reports of the Fund for 1983 through 1994. 1995 revenues were provided by the Fund. The estimate for 1996 is based on the Fund's 1996 Annual Surcharge Request.

APPENDIX G

Fund Claims Handling Process

LB&FC staff gave Fund staff a copy of *Overview of the Medical Professional Liability Catastrophe Loss Fund*, by Milan K. Mrkobrad (then-Chief Counsel of the Medical Professional Liability Catastrophe Loss Fund). This chapter in *Tough Problems in Medical Malpractice* (©1992 Pennsylvania Bar Institute) included a description of the Fund's claims handling practice. Fund staff updated this document as follows to reflect current practice and procedure:

EXCESS CLAIMS HANDLING

I. Claim Reporting

A. Self-insured providers and primary carriers (hereafter, the term "primary carriers" will also refer to self-insured providers) are required by 40 P.S. §1301.702(c) to ". . . promptly notify the Director of any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage or self-insurance plan or falls under Section

605. Failure to notify the Director shall make the basic coverage insurance carrier or self-insured provider responsible for the payment of the entire award or verdict, provided that the Fund has been prejudiced by the failure of notice."

B. Primary carriers report excess and third party claims by filing Form C-416, pursuant to 31 Pa. Code §242.6 and §242.11.

1. The claim cannot be considered formally reported until the C-416 has been filed by the primary carrier.

C. When a C-416 is received, coverage is verified, the file is opened and assigned to an Examiner.

1. Claims by the same claimant against different health care providers are opened as "companion files" and assigned to the same examiner.

2. Where no Fund coverage exits, a denial of the claim is sent to the primary carrier.

a. Coverage is not provided prior to January 13, 1976, the effective date of the Act (40 P.S. §1301.101 and §1301.1003).

b. Coverage is not provided for health care corporations prior to November 26, 1978, or for certified nurse midwives before November 6, 1985, because, prior to these dates, these

practitioners were not defined health care providers pursuant to §1301.103.

c. Coverage is not provided for claims involving denial or restriction of staff privileges or antitrust actions.

d. Coverage is not provided for corporations and/or partnerships which are not entirely owned by health care providers (40 P.S. §1301.811).

II. Claim Evaluation

A. Primary carriers are notified of the acceptance of the claim and requested to submit to the assigned Examiner the following documents and information:

1. Complaint.

2. Copies of medical reports (history, operative, admission and discharge summaries for hospital patients).

3. All expert reports.

4. Letters from counsel which evaluate the case to date, summarize pleadings and depositions, or are otherwise important to the successful and efficient handling of the claim.

5. Conciliation Conference and Pre-Trial Statements of the parties.

6. Other documents and information necessary to properly evaluate the claim as requested by the

Examiner.

B. The Examiner assigned to the file reviews the materials received and monitors the developing claim. The Fund will generally not take an active role in the development of the claim unless the Examiner feels the claim is likely to require Fund involvement, or the Fund's interests are being compromised.

1. When the Examiner needs more information or would like specific action taken, a request must be made to the primary carrier. In the rare instance the primary carrier denies the request, the Director may exercise his option to join in the defense of the claim, pursuant to 40 P.S. §1301.702(d).

C. In addition to the above materials, the claims examiner also considers the following "intangible" factors in deciding whether a claim should be defended or settled:

1. The attitude of the health care provider towards a trial and/or settlement, including ...

a. Whether the policy provided by the primary carrier contain a "consent to settle" clause. This prohibits the primary carrier from settling the claim unless the health care provider has given consent.

(1) Where the Fund disagrees with a health care provider's refusal to consent to

settlement, he/she will be reminded that any verdict in excess of their primary and Fund coverage will make their personal assets subject to judgment.

(2) There is no requirement for the Fund to obtain the health care provider's consent in Excess claims under Act 111; the Fund is required to obtain the authorization of the health care provider's primary insurer to settle Excess claims. However, as a practical matter consent is always solicited.

2. The geographic location of the incident and the venue of the action.

   a. The geographic breakdown for all reported claims is approximately:

      Philadelphia, Delaware, Montgomery, Bucks and Chester Counties: 59%

      All other counties: 41%

3. The reputation of the health care provider.

4. The relative expertise of both plaintiff and defense counsel.

5. The expertise, reputation and appearance of the expert witness for the plaintiff and the defense.

6. The nature of the injury alleged.

7. The prognosis of the plaintiff.

8. What appearance the health care provider and the plaintiff will make as witnesses.

9. The recommendation of defense counsel and primary carrier.

10. The recommendation of the judge.

D. If the decision is made to defend the claim, then no further action is taken except to monitor new developments until the time of trial.

1. The decision may be made to try a claim where a settlement value could not be agreed upon. In this instance, the Fund may admit liability and try the claim on damages only.

III. Claim Verdicts

A. Defense Verdicts are welcome.

B. Plaintiff's verdicts are not considered final for the purpose of payment under Section 1301.701(e)(2) until all properly perfected appeals have been exhausted. The primary carriers remain responsible for all defense costs, including any appeal bond necessary, and any post-verdict interest.

C. Delay damages which have been awarded pursuant to Rule 238 are added to the compensatory damages of a verdict, decision or award subject to certain limitations and restrictions.

1. Payment of any delay damages cannot cause the Fund to exceed its statutory limit of liability.

2. The Fund reserves its right to review the assessment of delay damages, which review in part is to determine whether the statutory duties owed to the Fund were fulfilled.

IV. Claim Settlements

A. Once the decision is made to settle a claim, the tenders and contributions must be received from the respective defendants' primary carrier.

B. Claims that involve multiple defendants are usually complex and difficult to settle. Although the Fund always attempts to resolve litigation with a full release of all defendants, there are situations in which a joint tortfeasor release is utilized.

1. The suggestion of a joint tortfeasor release is often enough to make the non-contributing carriers reconsider their position.

2. Joint tortfeasor releases are rarely used, because it is the policy of the Fund to secure a release for all defendants in a case.

C. Once the appropriate primary monies have been collected, the Examiner must prepare a formal evaluation of the claim, noting past and future lost wages and medical expenses, and

request authority to settle within a specified amount of money.

1. The primary carriers have the right under 40 P.S. §1301.702(f) to disapprove any settlement.

D. The Fund's Examiners negotiate their own cases with plaintiff's counsel; however, on occasion defense counsel may be permitted to assume this responsibility.

1. The Examiner may attempt to settle the claim with a structured settlement. Annuity brokers are chosen from a list approved by the Fund. All annuities are purchased from A or A+ companies, as rated by A. M. Best. The Fund must pay a "lock-in" fee to guarantee the rate from the date of settlement until the annuity is actually purchased on December 31st.

2. Defense counsel and the primary carriers are kept apprised of negotiations to the extent feasible under the constraints of negotiations.

E. When a settlement is reached, the Fund's Release must be executed. The Release states the statutory payment date for the Fund, the December 31st following the August 31st by which it became final (40 P.S. §1301.701(2)), and has a non-publicity clause.

1. The signing of the above Release is a condition and term of settlement.

2. The non-publicity clause reads as follows: "...neither the undersigned, nor our attorneys or other representatives, will in any way publicize, in any news or communications media, including but not limited to newspapers, magazines, radio or television, the facts or terms and conditions of this settlement. All parties to this agreement expressly agree to decline comment on any aspect of this settlement to any member of the news media. This paragraph is intended to become part of the consideration for settlement of this claim."

V. Claim Payments

A. The claim check may be made payable to the plaintiff and plaintiff's counsel. Checks to purchase annuities are made payable to the insurance company.

B. Claim checks are mailed at the close of business on the last business day of the year. They may be picked-up in the Fund's Rosemont or Harrisburg Office on this day if a written request to do so is received by the Fund before December 10th.

SECTION 605 CLAIMS HANDLING

I. Section 1301.605 of Act 111

A. Section 1301.605 of the Health Care Services Malpractice Act addresses claims filed more

than four years after the alleged breach of contract or tort. It provides as follows:

> All claims for recovery pursuant to this Act must be commenced within the existing applicable statute of limitations. In the event that any claim is made against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred which is filed within the statute of limitations, such claim shall be defended and paid by the Medical Professional Liability Catastrophe Loss Fund established pursuant to Section 701. If such claim is made after four years because of the willful concealment by the health care provider or his insurer, the fund shall have the right of full indemnity including defense costs from such health care provider or his insurer. A filing pursuant to Section 401 shall toll the running of the limitations contained herein.

II. Purpose

A. To provide a remedy for claimants negligently injured by health care providers more than four years before a claim is made.

B. To provide accessible and affordable medical liability insurance for health care providers by shifting the costs and the risk of loss for the long trial of medical liability claims

from the primary carrier to the Fund when the claim is filed more than four years after the breach of contract or tort occurs.

1. One of the reasons for the medical malpractice crisis was the exposure medical liability carriers faced in the mid-seventies (and continue to) by the long "tail" of medical malpractice claims. This "tail" can be attributed to three main sources:

   a. Claimants who know of their injuries and the malpractice at the time it occurred but fail to bring their claims until after the two-year statute of limitations has run. Regardless of its validity, this claim must still be defended.

   b. Claimants who have no reason to know or suspect they have been harmed at the time of the occurrence but who, at some later date, discover they have been harmed from the occurrence and bring suit after that time. (e.g., under the Discovery Rule, this would include a patient who had surgery on April 4, 1978, did not discover a sponge had been left in the area until an x-ray revealed the same on July 31, 1985. This can also include continuing torts, such as failure to diagnose disease X over a period of years, when the health care provider saw the claimant on a

regular basis and may have been checked for disease X).

c. In the future, a large class of these claims will result from minors who now have until their 18th birthday, plus two years, to bring a claim for injuries received during their minority prior to their 18th birthday. (See 42 Pa. C.S.A. § 5533)

III. Medical Cat Fund 605 Claim Reporting and Determination

A. Pursuant to Act 111, the Fund is responsible for the cost of defense, settlement and verdict for all claims filed more than four years after the breach of contract or occurrence, to the extent of the statutory limits of $1,000,000 per occurrence and $3,000,000 per aggregate for each health care provider.

B. The primary carrier reports these claims to the Fund via Form C-416, Claim Reporting Form, with "Section 605" marked clearly on the form. Included with this report is the complaint, if received, and other information pertinent to the claim. (See supra. EXCESS CLAIMS HANDLING - Section I, B)

C. The Fund verifies that the health care provider had the appropriate primary and Fund coverage at the time of the occurrence and/or

the claim. (See supra. EXCESS CLAIMS HANDLING - Section I, C).

D. The Legal Unit or its designee reviews the claim notice to determine if it properly falls under Section 605.

IV. Claims Evaluation

A. Once the claim is accepted as a Section 605, outside defense counsel is assigned.

B. Claims not in litigation may be handled by an Examiner on an "in-house" basis.

C. 605 claims are evaluated to be defended or settled in the same manner as excess claims (See supra. EXCESS CLAIMS HANDLING - Sections II, III and IV) with some slight modifications.

1. Unlike regular excess claims where the Fund's Examiners work with the primary carriers' claims representatives, Section 605 claims require the Fund's Examiner to work in conjunction with the assigned defense counsel to direct discovery.

D. The statute of limitations defense will be vigorously pursued by the Fund for all 605 claims. Defense counsel for the Fund are aware of this policy.

V. Claim Verdicts, Settlement and Payment

A. Should an adverse verdict be returned or the decision be made to settle a 605 claim, the

payment date for the Fund remains December 31st following the August 31st, by which it became final (40 P.S. §1301.701(2)). The standard Fund Release, including the non-publicity clause, must be executed. (See supra. EXCESS CLAIMS HANDLING - Sections III, IV and V)

APPENDIX H

Actuarial Estimates of the Unfunded Liability

Although the Medical Professional Liability Catastrophe Loss Fund does not hold reserve funds for incurred claims that will have to be paid in the future, it has an independent actuary estimate its unfunded liability annually. A pay-as-you-go fund focuses attention on its unfunded liability only if proposals call for changing it to a reserve-based operation or eliminating it altogether. Interested parties want to know the size of the unfunded liability that will have to be paid off if such events occur.

The unfunded liability is the amount by which the projected ultimate losses for claims incurred in the past exceed the claim payments made to date. Ultimate losses in medical malpractice insurance are future payments that can not be precisely determined, because they stem from events that the insurer may not yet know about and the size of the loss will depend on the outcome of negotiation or litigation.

Actuarial Methods for Projecting Ultimate Losses

Actuaries typically use several methods to project the ultimate losses for coverages such as medical malpractice and calculate a weighted average based on the reliability of the available data. Each method has strengths and weaknesses. For example, some methods produce accurate results for occurrence years approaching maturity (i.e., the peak years for claims have already passed) but require subjective estimates for more recent years. Other methods may reflect the historical data less accurately, but they project trends that stabilize within a few years.

The various methods of projecting ultimate losses provide the basis for estimating future payments by determining the most likely combinations of claim frequency (number) and claim severity (average size). The factors for making such determinations may include the following:

- Average size of claims paid to date or in recent years;
- Number of claims paid to date or in recent years;
- Percentage of reported claims closed with payment;
- Trends in claims reported for years approaching maturity;
- Insurance industry trends in malpractice frequency and severity.

Actuaries also project ultimate losses based on the estimated claim values (ECVs) that insurers assign to open cases. The ECV method enables actuaries to project ultimate losses without having to estimate future claim frequencies or adjust historical severities for inflation. However, actuaries have made only limited use of Fund ECVs because it does not have sufficient data that the actuaries can use for determining such values prior to 1988.

APPENDIX H (Continued)

The Fund assigns an arbitrary book value of $125,000 to every claim it opens and does not adjust this amount until settlement negotiations begin. About three-fourths of the reported claims incurred from 1976 through 1980 have closed without payment.

Actuarial Assumptions Regarding the Unfunded Liability

The assumptions underlying a given method may vary and can produce different results. For example, Maher Associates, Inc., substituted Fund experience for industry trends in one method and estimated the unfunded liability at $2.04 billion as of December 31, 1993. A year later, Coopers & Lybrand L. L. P. relied heavily on the same method but used industry data and estimated the unfunded liability at only $1.87 billion as of December 31, 1994.

Six months later, William M. Mercer Incorporated completed an actuarial analysis of the Fund for the new director. Mercer estimated the December 1994 unfunded liability at $2.18 billion, a figure more in line with Maher's 1993 estimate, given the 1994 ultimate losses projected by Coopers.

Mercer attributed the difference between its estimate and Coopers's estimate of the 1994 unfunded liability to assumptions about the number of participating providers and the use of alternative methods for projecting ultimate losses. Specifically, Mercer contended that the apparent decline in the primary premium base for surcharge assessment reflected increasingly competitive conditions in the malpractice market, not a decline in the number of health care providers. Fewer providers would mean fewer exposures to risk, an assumption reflected in Coopers' ultimate loss projections, as cited by Mercer.

Coopers revised its ultimate loss projections for prior years in its analysis as of December 31, 1995. The revisions had to do with the following concerns raised by the Fund:

- A large number of claims in the 1995 data base could have been opened, closed, or both in earlier years and should have been counted in those years.
- Cases involving breast implants or pedicle screws represent a category for which no reliable projections of future losses can be made and should be excluded from the data base.

The foregoing assumptions had the effect of changing the projected ultimate losses for prior years. As a result, Coopers' report showed the ultimate losses continuing to grow instead of leveling off in the mid 1990s, as the previous report had shown. Coopers estimated the unfunded liability at $1.95 billion as of December 31, 1995.

The changes in the prior years' ultimate losses also changed the unfunded liability estimates for those years. For example, the revised estimate for 1994 rose to $1.92 billion and the 1993 estimate came to $1.80 billion, a figure more than 10 percent lower than Maher's estimate for that year.

APPENDIX I

Medical Malpractice Insurance
1994 Direct Premiums Written in Pennsylvania

	Premiums Written	Market Share
PHICO Insurance Company	$ 50,308,000	21.4%
PA Medical Society Liability Insurance Co.	29,158,000	12.4
Physicians Insurance Company	28,384,000	12.1
Medical Protective Company	18,767,000	8.0
Princeton Insurance Company	14,792,000	6.3
Medical Inter-Insurance Exchange of NJ	13,104,000	5.6
Steadfast Insurance Company	12,697,000	5.4
St. Paul Fire & Marine Insurance Company	11,988,000	5.1
P-I-E Mutual Insurance Company	8,316,000	3.5
American Continental Insurance Company	5,223,000	2.2
Chicago Insurance Company	4,782,000	2.0
Continental Casualty Company	3,339,000	1.4
Tri Century Insurance Company	3,153,000	1.3
Continental Insurance Company	3,056,000	1.3
American Casualty Company of Reading	2,745,000	1.2
PA Professional Liability JUA	2,326,000	1.0
AAOMS Mutual Insurance Company RRG	2,236,000	1.0
National Union Fire Ins. Co. of Pittsburgh	2,235,000	1.0
Legion Insurance Company	2,158,000	0.9
St. Paul Mercury Insurance Company	2,124,000	0.9
Frontier Insurance Company	2,098,000	0.9
97 Other Companies	12,176,000	5.2
Total	$235,164,000	100.0%

Source: Developed from information compiled by the National Association of Insurance Commissioners, as provided by the PA Insurance Department.

APPENDIX J

1995 Fund Paid Claims

Total Costs to Resolve Claims Before the Fund on December 31, 1995

In December 1995 the Fund paid more claims and had a higher claims payout than at any time in its history. The Fund paid on average $420,379 for each health care provider claim settled in December 1995. The Fund's overall average payment, however, understates the total cost to resolve claims before the Fund. It also masks other important differences in the Fund's cost to resolve claims.

As seen in Table 17 in 1995 the total settlement costs[1] for cases involving multiple health care providers averaged over $2 million for excess and partial Section 605 claims involving multiple providers. Section 605 claims involving a single hospital had the lowest average total settlement cost.

Table 17

1995 Average (Mean) Total Settlement Cost

	Cases Involving Multiple Health Care Providers	Single Hospital Claims	Single Physician and Other Individual Claims	Single Corporation and Partnership Claims	Single Nursing Home Claims
Excess Claims.....	$2,052,091	$994,818	$615,264	$515,629	$250,000
Section 605 Claims....	704,972	242,500	324,333	293,375	--
Partial Section 605 Claims[a]	2,003,297	--	--	--	--

[a]Partial 605 claims are claims involving multiple providers where the claims against some providers are Section 605 claims and for others they are excess claims.

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

[1]Reported total settlement cost includes payouts by the health care provider's primary insurance carrier, the Fund and other excess payments and contributions reported by the Fund. They include both settled cases and adjudicated cases.

APPENDIX J (Continued)

Fund's Costs to Resolve Claims on December 31, 1995

As shown in Table 18, only 13 percent (74 out of 551) of the cases closed with payment by the Fund in 1995 were resolved with Fund payments of $100,000 or less. Moreover, over 32 percent of the claims in which the Fund paid $100,000 or less were Section 605 claims where the Fund is responsible for first dollar payment.

Cases involving more than one health care provider accounted for the highest Fund payments in 1995. The Fund paid on average $1.58 million for partial Section 605 claims involving multiple health care providers and $1.3 million for excess claims involving multiple providers. (See Table 19.) The average Fund payment for excess claims involving a single hospital ($467,866) and a single physician ($393,432) are closest to the Fund's reported average payment ($420,379) for all types of claims in 1995.

Table 18

Number of 1995 Cases in Which the Fund Paid ≤ $100,000

	Cases Involving Multiple Health Care Providers	Single Hospitals Claims	Single Physicians and Other Individual Claims	Single Corp. and Partnership Professional Claims	Single Nursing Home Claims
Excess Claims.....	0 (N=59)	10 (N=84)	34 (N=286)	2 (N=9)	1 (N=1)
Section 605 Claims	3 (N=27)	1 (N=2)	20 (N=76)	0 (N=2)	--
Partial Section 605 Claims.....	0 (N=5)	--	--	--	--

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

Table 19

1995 Average Fund Payment, by Type of Claim

	Cases Involving Multiple Health Care Providers	Single Hospital Claims	Single Physician and Other Individual Claims	Single Corporation and Partnership Claims	Single Nursing Home Claims
Excess Claims.....	$1,321,017	$467,866	$393,432	$282,296	$50,000
Section 605 Claims....	631,824	242,500	295,912	293,375	--
Partial Section 605 Claims.....	1,580,000	--	--	--	--

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

The Fund's Contribution to Total Settlement Costs Varies According to the Type of Health Care Provider Involved and the Type of Claim to Be Paid

In general, the Fund pays a greater share of the total settlement costs for physicians than for hospitals. As shown in Table 20, the Fund contributed on average 47 percent toward the total settlement cost for excess claims involving a single hospital, compared to 64 percent for similar claims involving physicians. In 1995, the Fund paid on average between 91 and 100 percent of the total costs to resolve Section 605 claims involving only one provider.

Table 20

The Fund's Share of a Provider's Total Settlement Costs

1995 Claims Involving Single Providers

Type of Claim	Single Hospital Claims	Single Physician and Other Individual Claims	Single Corporation and Partnership Claims	Single Nursing Home Claims
Excess Claims.....	47%	64%	55%	20%
Section 605 Claims..	100	91	100	--
Partial Section 605 Claims.....	--	--	--	--

Source: Developed from information provided by the Medical Professional Liability Catastrophe Loss Fund.

A somewhat similar pattern occurs with Fund payments for cases involving multiple health care providers. As shown in Table 21, the Fund paid on average 50 percent of a hospital's contribution toward the total cost to resolve an excess claim involving multiple providers and 72 percent of a physician's share. For Section 605 claims involving multiple providers, the Fund's contribution accounted for 53 percent of a hospital's total contribution toward the settlement, and 100 percent of a physician's contribution.

Table 21

The Fund's Share of a Provider's Total Settlement Costs

1995 Cases Involving Multiple Providers,

Type of Claim	Hospitals	Physicians and Other Individuals	Corporations and Partnerships
Excess Claims	50%	72%	73%
Section 605 Claims ..	53	100	100
Partial Section 605 Claims	59	82	100

Source: Developed from information provided by the Medical Professional Liability Catastrophe Loss Fund.

APPENDIX K

Changes in Fund Coverage and Their Effect on Fund Payouts

Several suggestions to change the Fund's coverage have been proposed. To date, a fiscal analysis of the effect of such changes has not been developed. LB&FC staff, however, considered how such proposals would have changed the Fund's 1995 claim payout if they had been in effect in 1995. When considering such changes, it is important to keep in mind that, in order for their full effect to have been realized in the Fund's 1995 claim payout, they would had to have been implemented in the late 1980s. This is due to the long drawn-out claims maturation period in medical malpractice insurance and because the changes cannot be applied retroactively to polices issued in the past.

1. The Fund's Proposal: Increase the primary or basic coverage requirement from $200,000 to $300,000 per occurrence while reducing the Fund's coverage for excess claims from $1 million to $900,000 per occurrence and make no change in the Fund's coverage for §605 claims.

Table 22 shows that, if the full effect of the Fund's proposed change had been in effect in 1995, the Fund's annual claim payout would have been 18 percent less and it would have paid 10 percent fewer claims.

Table 22

Basic Limits of $300,000 for 1995 Claims Paid

Basic Limits	Losses Paid	Change	Claims Paid	Change
$200,000	$279,552,207	.....	665	.....
$300,000	$227,862,033	-18%	598	-10%

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

As shown in Table 23, in order to have achieved a higher reduction in the Fund's annual claim payout and in the number of claims paid, considerably higher increases in the primary limits would have been needed several years ago. If the primary limits had been increased to $400,000 several years earlier, the Fund's annual claim payout in 1995 would have been reduced by just over one-third and the number of claims paid would have been reduced by just over 20 percent. To reduce the Fund's annual claim payout and the number of paid claims by more than one-half, the primary or basic limits would had to have been increased to over $600,000.

Table 23

Basic Limits Higher Than $300,000 for 1995 Claims Paid

Basic Limits	Losses Paid	Change	Claims Paid	Change
$200,000	$279,552,207	.....	665	.....
$400,000	$185,363,404	-34%	518	-22%
$600,000	$123,295,584	-56%	382	-43%
$800,000	$ 85,387,821	-69%	288	-57%
$1,000,000	$ 60,202,821	-78%	237	-64%

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

2. Maintain Fund coverage at $1 million/$3 million and repeal §605 by eliminating the distinction between §605 and excess claims.

Proposals to phase out the Fund have raised questions about how the repeal of §605 would affect Fund claim payments. Under such proposals, those claims which are now referred to as §605 claims would be treated as excess claims. The primary insurer, rather than the Fund, would be responsible for the first $200,000 of the total settlement. The Fund would be responsible for the remainder of the total settlement up to its current coverage limits.

Table 24 shows how the Fund's claim payments would have differed in 1995 if Act 1975-111 had not contained §605 and these claims had been handled in the same way as excess claims. As the table shows, the Fund's annual claim payout would have been 7 percent less and 12 percent fewer claims would have been paid in 1995.

Table 24

Basic Limits of $200,000 With §605 Claims Treated as Excess Claims

§605 Status	Losses Paid	Change	Claims Paid	Change
Current	$279,552,207	.....	665	.....
Excess Only	$258,645,212	-7%	582	-12%

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

3. House Bill 2294: Privatize the Fund's current coverage layer over five years by increasing the primary or basic coverage limits and eliminating the distinction between excess claims and §605 claims.

HB 2294 would repeal §605 as of December 31, 1996. Private carriers and self-insurers would have responsibility for the full mandatory coverage of $1,200,000 by the year 2001.

Table 25 shows how claim payments would have differed in 1995 if each of the incremental stages in the H.B. 2294 phase-out had taken effect in the late 1980s. Again under this proposal, the primary or basic coverage limits would have had to increase to $600,000 per occurrence several years earlier in order for the Fund's annual claim payout to have been reduced by more than 50 percent in 1995 and for its number of paid claims to have been more than cut in half.

Table 25

Basic Limits Higher than $200,000
With §605 Claims Treated as Excess Claims

Basic Limits	§605	Losses Paid	Change	Claims Paid	Change
$200,000	Yes	$279,552,207	.....	665	.....
$400,000	No	$161,629,425	-42%	408	-39%
$600,000	No	$ 94,086,605	-66%	255	-62%
$800,000	No	$ 53,553,842	-81%	156	-77%
$1,000,000	No	$ 16,302,500	-94%	89	-87%

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

4. The Pennsylvania Podiatric Medical Association's five-year Fund phase-out through increasing quota share and eliminating the distinction between excess and §605 claims.

This proposal is an alternative to privatizing the Fund's coverage through increasing primary or basic coverage requirements, as proposed in H.B. 2294. Under this proposal private carriers and self-insurers assume incrementally larger shares of the Fund's paid losses. The basic limits of $200,000 would not change during the phase-out. However, insurers would pay 20 percent of the Fund-covered losses in 1997 and would pay an additional 20 percent each year until they had responsibility for the full mandatory coverage in 2001.

Table 26 shows how claim payments would have differed in 1995 if each of the incremental stages of a quota share phase-out had taken effect in the late 1980s. The illustration assumes the repeal of §605 and treats these claims in the same manner as excess claims to facilitate comparison with the basic limits phase-out. The actual number of paid claims during the proposed phase-out would remain near the 1995 level. As shown in Table 26, private insurers would have had to pay 60 percent of the Fund's loss costs in order for the Fund's claims payout in 1995 to have been reduced by more than 50 percent.

Table 26

1995 Paid Claims Under Quota Share With §605 Claims Treated as Excess Claims

Quota Share	§605	Losses Paid	Change	Claims Paid	Change
None	Yes	$279,552,207	.....	665	.....
20%	No	$206,916,170	-26%	582	-12%
40%	No	$155,187,127	-44%	582	-12%
60%	No	$103,458,085	-63%	582	-12%
80%	No	$ 51,729,042	-81%	582	-12%

Source: Developed from data provided by the Medical Professional Liability Catastrophe Loss Fund.

Source: Developed by LB&FC staff from the Fund's 1995 paid claims.

APPENDIX L

The Fund's Response to This Report

COMMONWEALTH OF PENNSYLVANIA
MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

JOHN H. REED
DIRECTOR

10TH FLOOR, SUITE 1000
30 NORTH THIRD STREET
P.O. BOX 12030
HARRISBURG, PA 17108
717-783-3770

June 13, 1996

Philip R. Durgin, Executive Director
Legislative Budget and Finance Committee
400 Finance Building
Harrisburg, PA 17105-8737

Dear Mr. Durgin:

Please accept this letter, with enclosures, as the Fund's response to the Committee's request for written comments regarding your study of the Medical Professional Liability Catastrophe Loss Fund. It is my understanding that these comments will be included as an appendix to the final version of your report.

I would like to point out, however, that the Fund's comments for the Committee are highlights only and do not provide an in-depth discussion of every issue raised in the report. The Fund's somewhat abbreviated response was necessitated by the limited time we had to respond to the report and by a number of constraining factors such as the Fund's recent move into new office space, appearances before the House Insurance Committee and Senate Banking and Insurance Committee, and the day-to-day operational duties of running the Fund. To provide the Committee with further clarification regarding some of the Fund's positions I have also enclosed a copy of the Fund's April 1996 newsletter.

I also welcome the Committee's invitation to participate in the meeting scheduled for 9:00 a.m. on Wednesday, June 19, 1996. I will be available at that time to answer any questions the Committee might have regarding the issues raised in your report, the comments enclosed with this letter or any other issues related to the Fund.

Thank you for these opportunities for the Fund to present its position on many of the important matters relating to the Fund currently being reviewed by your and other legislative committees.

If I can be of further assistance to the Committee, please do not hesitate to call.

Sincerely,

John H. Reed, Esq.
Director

JHR:dam
Enclosures

Medical Professional Liability Catastrophe Loss Fund Response to Legislative Budget and Finance Committee Report

The Fund appreciates the effort made by the Legislative Budget and Finance Committee in its study of the Medical Professional Liability Catastrophe Loss Fund. The Committee has commented on a number of complex issues that have a significant impact on the health care providers and health care consumers of the Commonwealth of Pennsylvania.

However, the Committee's report discusses but does not adequately emphasize the fact that most of the problems currently facing the Fund and health care providers in the Commonwealth are the direct result of the following factors.

Premium Discounting

Aggressive discounting of primary premiums by certain large carriers has decimated the premium base upon which the Fund surcharge is assessed. These significant discounts are mainly being offered to large, integrated health care systems and provider networks at the expense of smaller, independent hospitals and physicians. By way of example, recently the Fund learned that a large, self-insured hospital system entered into an agreement to purchase a first-year claims made policy from a large writer of hospitals at an effective discount of 82%. The result of this arrangement is a $5.7 million decrease in surcharge collections from an institution for which the Fund expects to pay out an estimated $8-11 million in claims this year alone. This is in the face of a 62% increase in the annual surcharge percentage, and a loss history which was described by a representative of the hospital system as, "On average, one lawsuit per week."

Such discounting practices have necessitated a higher percentage surcharge, unfairly shifted the surcharge burden to health care providers paying fair premiums, and created uncertainty about the amount of revenue that will be collected from this year's surcharge. In addition, it has already been observed that market share will be concentrated in the hands of fewer insurers and, over time, such anti-competitive pricing practices may force smaller health care providers out of business and limit the health care choices available to consumers.

Late Reporting and Late Tenders

The Fund begins to monitor cases when they are reported by the primary carriers and can only enter into active negotiations following receipt of a tender from the primary carrier. Thus, if either of those communications from the primary carrier are delayed, intentionally or otherwise, the Fund's ability to dispose of cases in a fair and reasonable manner is severely hampered.

Late Surcharge Remittances

The Fund is dependent upon the timely remittance of surcharges collected by primary carriers from health care providers. Delays and failures to remit surcharge receipts decrease the interest income which the Fund relies upon to support a large portion of its operations. The failure of certain carriers to make timely remittances means that the surcharge burden is unfairly shifted to others in the system.

Absence of Tort Reform

As the Committee touches upon in its report, the absence of meaningful tort reform in Pennsylvania has resulted in strong upward pressures on the settlement and jury value of cases and the associated costs of defense and claims administration. These costs are passed along directly to health care providers and indirectly to health care consumers.

In addition to the general comments above, the following bullet points address specific issues raised in the Committee's report.

- In Section V of the report, entitled Possible Options for the General Assembly to Consider, numerous legislative proposals are presented as originating from the Fund and/or the Fund's director. In fact, almost every legislative proposal that has been made during the debate over the role of the Fund in the medical malpractice insurance market has been set forth by representatives of physicians, hospitals, podiatrists, trial attorneys and other interest groups that have a direct financial stake in the proposed legislation. A particular example can be found on page 60, wherein the report states that "The Fund's proposal, however, has several significant drawbacks. First, it would increase the cost to providers for their primary insurance." This specific proposal to raise the primary limits has mainly been advocated by the Hospital Association of Pennsylvania, not the Fund or the Administration. (ref. pp. 58-65)

- The report repeatedly states that, "Confidence in the ability of state government to manage the Fund has been eroding." Such comments are misleading since the criticisms of the Fund's claims management practices and policies refer to occurrences under the prior Administration and Fund directors. In fact, the current Fund director has engaged in a thorough process redesign initiative and technology upgrade program that will improve every area of the Fund's operations. Accolades have come from virtually every corner of the industry in recognition of these improvements. (ref. pp. vii, xi-xii, 18-30)

- Many of the Fund's claims management "practices" and "policies" criticized in the report, particularly the payment of delay damages and post-judgment interest, are actually governed by current law. Indeed, it should be noted that a Commonwealth Court judge has determined that the Fund has correctly determined that it is not responsible for payment of these items in excess of its statutory limits. Thus, because the Fund does not have any flexibility regarding these areas, certain phrases used in the report, such as "refusing to pay," are inaccurate. (ref. pp. vii, 22, 26, 29, 61-62, 70-71)

- The increase of claims from 370 cases in 1994 to 551 cases in 1995 is attributed solely to the present Fund director's "new claims settlement philosophy." However, the two most important factors underlying this dramatic increase in claims were: 1) a statewide effort, particularly in Philadelphia, by the common pleas courts to clear out a six-year backlog of cases; and 2) the prior Administration's policy of delaying settlements to avoid an emergency surcharge. Director Reed's policy is to settle claims for a reasonable amount early in the litigation process to limit the costs incurred by all parties. (ref. p. 24)

- The Executive summary of the report makes reference to "delaying the assignment of legal counsel for section 605 cases, changing attorneys assigned to defense of cases when changes occur in the Administration, assigning inexperienced attorneys, and contracting with law firms that have a conflict of interest." The only other reference contained in the balance of the 114 page report is two paragraphs found inconspicuously on page 30. These paragraphs flatly admit that there was no investigation of such charges. Indeed, the charges were levied by unidentified health care providers. Furthermore, the allegations regard continuity of defense counsel in the prior Administration, and, in fact, the current Administration has not chosen to take the same course of action in this regard as was taken by the prior Administration. Therefore, it is inappropriate to report such allegations in this fashion and to inaccurately levy these charges against this Administration. (ref. pp. vii, 22, 29-30)

- The Fund's budget request for the 1996-1997 fiscal year is $25.6 million, not $25.8 million as stated in the report. (ref. pp. vii, 16)

- The report contains numerous inaccurate statements such as, "Commercial carriers can provide the Fund's level of coverage to their current insureds at less cost." Nothing could be further from the truth. Numerous parties representing the medical malpractice insurance market have testified before the Senate Banking and Insurance Committee and the House Insurance Committee and responded to the Insurance Commissioner's data call that privatization of the Fund's layer of coverage and payment of the unfunded liability would result in higher total premiums for

health care providers. Tables 1, 10 and 15 should be viewed together since the total cost of coverage in a privatized system would include the figures found in both tables. Further, the responses of all eight insurers who responded to the Insurance Commissioner should be included rather than the first six insurers who responded. The complete data is presented in a table found on page 6 of these comments. Finally, these insurers have made no long-term commitment to provide the Fund's layer of coverage at these rates. (ref. pp. ix-x, xiii-xv, 42, 73-75)

- The Fund was created in 1975 because malpractice insurers left the state and health care providers were unable to obtain medical malpractice insurance. During the past two decades, the presence of the Fund has made Pennsylvania an attractive market for private carriers and has played a central role in guaranteeing the availability and affordability of coverage for all health care providers in the Commonwealth. It is nearsighted for the Committee to assume that carriers currently willing to provide coverage in Pennsylvania under the umbrella of protection provided by the Fund will, over the long term, remain willing to provide such coverage at affordable prices in the absence of a Fund. (ref. pp. viii, 39-41)

- In comparing the average medical malpractice claim payouts for physicians, the Committee's report compares Pennsylvania with seven other states, five of which have tort reform in place and none of which has a major urban center, such as Philadelphia, that play such a dominant role in the malpractice system. (ref. p. 57)

- The Fund's estimate that the 1996 surcharge of 164% would generate approximately $300 million was based on an assumption that the primary premium base would remain stable at 1995 levels. However, due to continued premium discounting and, possibly, fraudulent premium hiding activity by certain carriers, the primary premium base has experienced a dramatic decline in 1996. As your report correctly states, the Fund's funding mechanism cannot continue to be tied to such an unstable funding source. The adoption of the Joint Underwriting Association's manual rates as the basis of the Fund's surcharge would correct this problem and provide a more stable, fair and predictable funding base. (ref. pp. vi-vii, 89)

- Throughout the report, the term "claim" is used when discussing Fund settlements, activity and inventory. The term "claim" as used in the report refers to an action brought against an individual health care provider. In most instances, however, plaintiffs bring suit against multiple health care providers in one "case." By using "claim" instead of "case," the report will cause inflated perceptions of the magnitude of the Fund's involvement in the medical malpractice insurance market. Such mistaken perceptions could incite undue concern among readers of

the report who may not be familiar with the details of the Fund's operations. This is particularly true regarding the breast implant and pedicle screw cases, of which the Fund expects no significant number of new cases to be reported. (ref. pp. xi, xiii, 11-12, 32-33, 35, 38, 52, 86, 88, 107-114)

- The report contains references to the inability of the Committee to accurately determine the amount of the Fund's unfunded liability and to differences between various actuarial reports. The Fund's consulting actuary estimated the unfunded liability as of December 31, 1995 and is confident in the accuracy and reasonableness of the contents of his report. The actuary has included a response to the inaccuracies and misinterpretations regarding his report contained in this Committee's report. [see enclosed letter] (ref. pp. 38-39, 104-106)

- The Fund's consulting actuary, Coopers & Lybrand, is responsible for calculating the unfunded liability. As part of this year's report, the actuary was made aware of the reserving practices of several primary coverage insurance carriers and self-insured hospitals who are involved in breast implant and pedicle screw cases. Although the report indicates that two insurers contacted by the Committee set reserves for breast implant and pedicle screw cases, all of the parties contacted by the Fund indicated that they do not have a sound estimate of the potential cost of such cases and their reserves are set at nominal levels. Given the fact that the industry does not have significant reserves set aside at the primary level and that there is almost no adjudicative history for these cases in Pennsylvania, it is not possible to make a reasonable estimate of the potential future claims payments for these cases. [see enclosed letter] (ref. pp. iv-v, 38)

- The Committee does not accurately interpret the actuarial report submitted by Coopers & Lybrand in which it estimates the unfunded liability as of December 31, 1995. Throughout the report references are made to "increases" in the size of the unfunded liability. Claims payment and reporting information in the unfunded liability report is broken down into accident years. For any given accident year, the Fund has closed or paid off a number of claims with an estimated number of unpaid claims remaining. Thus, for accident year 1976, the Fund has paid essentially all claims and the corresponding portion of the unfunded liability attributed to 1976 will be small. For accident year 1995, by contrast, the Fund has paid only a small percentage of the total claims that will eventually be paid. This example demonstrates that each successive accident year will have more of the unfunded liability attributed to it, but it does not mean that the unfunded liability increases every year. In fact, in 1990 an independent auditor calculated the unfunded liability at $1.8 billion. From 1991 to 1994, it ranged from $1.9 billion to $2.1 billion. And in 1995, the unfunded

liability remained relatively constant at $1.95 billion. The report also makes projections based on the relationship between claims reporting and claims payments to "changes" in the size of the unfunded liability. The date contained in the actuarial report is presented in accident years, while the Fund's claims reporting and payment data is recorded in calendar years. Thus, a hypothetical claim might occur in 1989, be reported to the Fund in 1993, and be paid by the Fund in 1995. To compare accident years to calendar years is, at a minimum, confusing and potentially misleading. (ref. pp. v-vi, x, xii-xv, 14-15, 33-36, 38-39, 72-79, 104-105)

Estimated Total Additional Cost of Fund-Level Coverage and 20-Year Unfunded Liability Payoff

Company	Provider Category	Coverage Including §605 Claims	Coverage Excluding §605 Claims	Unfunded Liability Payoff**	Total Coverage Inc. §605 Claims & Unfunded Payoff
A	Physician	126.5% - 153.3%	82.5% - 100.0%	62.8%	189.3% - 216.1%
	Surgeon	155.9% - 182.1%	101.7% - 118.4%	62.8%	218.7% - 244.9%
B***	Physician/Surgeon	100.0% - 125.0%	75.0% - 90.0%	39.0%	139.0% - 164.0%
C	Physician/Surgeon	125.0% - 140.0%	*	*	*
D	Physician/Surgeon	130.0%	*	53.6%	183.6%
E	Physician/Surgeon	175.0% - 180.0%	*	*	*
	Hospital	146.0%	*	*	*
	Nursing Home	119.0%	*	*	*
	Health Care Facility	150.0%	*	*	*
F	Physician/Surgeon	90.0%	*	69.2%	169.2%
	Hospital	80.0%	*	69.2%	159.2%
G	Physician/Surgeon	140.0% - 160.0%	*	45.5%	185.5% - 205.5%
H	*	*	*	*	*

* No real response/too many questions to estimate
** Insurers were asked to assume a $1.87 billion unfunded liability as of December 31, 1994
*** Carrier has indicated it will not write new medical malpractice policies in Pennsylvania

Source: Developed from survey responses received by the PA Department of Insurance

Coopers &Lybrand

Coopers & Lybrand L.L.P.
a professional services firm

Casualty Actuarial &
Risk Management Consulting

2400 Eleven Penn Center
Philadelphia, PA 19103-2962

telephone (215) 963-8000

facsimile (215) 963-8822

June 11, 1996

Mr. Arthur F. McNulty
Chief Counsel
Commonwealth of Pennsylvania
Medical Professional Liability
Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
Harrisburg, Pennsylvania 17108

Dear Mr. McNulty:

This letter will respond to some of the issues raised in the Legislative Budget and Finance Committee's (the Committee) draft study of the Medical Professional Liability Catastrophe Loss Fund (the Fund), issued May 30, 1996.

The second bullet within the Report Findings and Conclusions section of the study states that the Fund's estimated unfunded liability may be understated. There is discussion regarding the exclusion of breast implant and pedicle screw claims from the unfunded liability analysis, ending with the statement that two major medical malpractice insurers that the Committee contacted indicated, however, that they did reserve for these two types of claims. The current wording may lead readers of the study to make inferences that, we believe, would be misleading.

We have excluded breast implant and pedicle screw claims from our unfunded liability analysis because, based upon discussions with the Fund and our review of the data, we do not believe the breast implant or pedicle screw exposure to the Fund can be reasonably estimated at this time. The fact that some insurers have established reserves for their own exposure for certain of these claims has little, if any, bearing on the ability to estimate the Fund's overall exposure to these types of claims. An insurer's exposure is limited to the primary layer and, even then, is limited further only to claims reported within four years from the date of occurrence. The Fund's coverage begins where the insurer's coverage ends. That is, the Fund provides coverage for the excess layer, and for all claims reported four or more years after the date of occurrence. Therefore, the claims covered by the Fund will likely have significantly different reporting and settlement patterns than those entities providing the primary coverage for these exposures. Moreover, the Fund does not set case reserves per se and we are not aware of any Fund settlements on these claims. The appendix to our unfunded liability analysis displays the Fund's reporting patterns to date for these claims, and we do not believe they are sufficiently stable to reasonably estimate the Fund's ultimate loss for these exposures.

The Committee's report correctly notes that if the observed reduction in the percentage of reported claims that have closed with a payment by the Fund is not a true indication of underlying experience, then the unfunded liability may be higher than what is estimated in our report. However, it should be noted that we have used several methods in arriving at the unfunded liability estimate of $1.95 billion, and each of these methods has its own attendant assumptions. Some of these methods indicate a higher unfunded liability and others indicate a lower liability, and the $1.95 billion should be viewed as a point estimate within a wide range of reasonably possible estimates.

The Committee properly points out that different actuarial assumptions and the lack of sufficient historical claims data can lead to different actuarial estimates of the unfunded liability. We would further point out that comparing estimates of the unfunded liability at different points in time will add to the variation because the estimates will be based on different historical data. Despite all these sources of variation, we believe the recent actuarial estimates of the unfunded liability cited in the Committee's report are within a fairly close range, especially considering the volatility inherent in the underlying exposure.

Appendix H of the Committee's report states that an analysis performed by William M. Mercer, Incorporated, has apparently indicated that our unfunded liability estimate as of December 31, 1994, had assumed a reduction in the number of health care providers covered by the Fund. While we have not had the opportunity to review any analysis performed by Mercer, we wish to make clear that our unfunded liability estimate did not assume a decline in the number of health care providers.

Finally, we note that the Committee has used our unfunded liability analysis to make projections regarding the consequences of Fund actions, and to illustrate the relative difference among the various options for changing the Fund. We caution that this was not the intended use of our analysis and it may not be appropriate for that purpose. We have not reviewed the Committee's projections for reasonableness, nor without doing so can we confirm that our report provides the proper basis from making such projections.

We hope you find this letter helpful in clarifying some of the issues addressed by the Committee's report. Please call me should you have any questions on these items.

Sincerely,

Mark R. Proska

Mark R. Proska
Senior Consultant
Fellow of the Casualty Actuarial Society
Member of the American Academy of Actuaries

CAT FUND UPDATE

Commonwealth of Pennsylvania
Medical Professional Liability Catastrophe Loss Fund
P.O. Box 12030, Harrisburg, PA 17108

Vol. I, No. 1 **April 1996**

LETTER FROM THE DIRECTOR

JOHN H. REED, ESQ.
DIRECTOR

Since Governor Ridge appointed me Director of the Cat Fund in July 1995, it has been our intention to make certain that the Fund carries out its mission in an ethical, cost-effective, and professional manner consistent with the public interest and the best of modern business practices.

Over the past eight months, we have had the opportunity to assess the Fund's strengths and evaluate its weaknesses. As a result of this review, we have implemented managerial reforms which have dramatically reduced our administrative costs and legal fees. Such improvements will ensure that the Fund continues to aggressively defend Pennsylvania's health care providers and deliver professional liability insurance at the lowest possible cost. At the same time, the Fund will provide prompt and fair compensation to deserving individuals truly injured as the result of medical malpractice.

While there are other internal and legislative reforms needed, the Cat Fund stands ready, as always, to insure the availability of insurance to all medical providers in all market conditions so that the crisis of 1975 is not repeated. Additionally, the Fund plays its important statutory role by providing excess malpractice insurance coverage to Pennsylvania's physicians and hospitals.

The Ridge Administration, with the support of the Pennsylvania Medical Society, has proposed serious legislative reforms which will ensure that there will be no emergency surcharges in the future. In addition, the Ridge Administration and current Cat Fund management are committed to reviewing all responsible alternatives for providing the least expensive coverage possible to Pennsylvania's health care providers while ensuring that deserving claimants are adequately compensated for their losses.

The Fund spends just four percent of the surcharge collected on its operating and general expenses, including fees paid to attorneys to defend health care providers in Section 605 cases. As a result of the Fund's efficiencies, more money is available to compensate deserving claimants at the lowest possible cost to Pennsylvania's physicians and hospitals. The Fund's low expense-to-claims paid ratio is starkly contrasted by the private sector's. According to some industry estimates, private carriers would have to spend as much as forty percent of their premiums collected on operating expenses if they absorbed the Fund's level of coverage.

As a result of concerns stemming from prior problems with the Fund, some groups have proposed privatizing the Fund. However, such a change should be considered carefully since privatization of the Fund, even if phased-in over a period of time, would certainly result in higher total malpractice insurance premiums for Pennsylvania's health care providers. Because of the impact on rates, the Pennsylvania Medical Society also opposes privatization of the Fund.

The fact that the Fund has stabilized the cost of medical malpractice liability coverage in Pennsylvania must also be considered. Even with the 1995 emergency surcharge, the average actual premium paid by most physicians is competitive with or lower than what they paid ten years ago. Furthermore, the average total cost for medical malpractice insurance in Pennsylvania is significantly less than comparable coverage in other states.

At the same time, as someone who came to the Fund from a health care facility, I am well aware of the strong downward pressures on physician and hospital incomes due to the impact of managed care and declining Medicare/Medicaid dollars. We must act now to address all of the rising costs of practicing medicine, for, if we wait, the problem will only grow worse.

Therefore, the Ridge Administration and the Fund have presented legislative proposals to the Senate Banking & Insurance Committee and the House Insurance Committee. Our initial proposals focus on improving the current legislation under which authority the Fund operates and Governor Ridge believes that these changes will protect the interests of Pennsylvania's health care providers. Meanwhile, the Pennsylvania Medical Society continues to press forward with the call for Tort Reform.

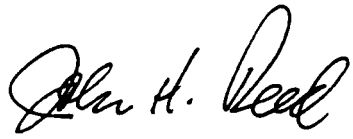
In addition to making legislative efforts on behalf of health care providers, the Fund and the Ridge Administration are committed to developing a strategic plan to reduce the overall cost of medical malpractice insurance in Pennsylvania and sta-

bilize the unfunded liability. We are also committed to increasing the communication between the Fund and members of the health care community so that we can be more responsive to their concerns.

To that end, the Fund will issue a mid-summer report regarding the number and value of cases settled in the current claims year as of that date. The Fund will also publish an estimate of the anticipated surcharge percentage for 1997. We hope that publishing this information earlier than in past years will be of interest and assistance to health care providers as they prepare their budgets for next year.

As the Fund works to accomplish these goals, we are also firmly committed to protecting the right of all health care providers to defend their professional reputations in court. We are mindful of the concerns of hospitals and insurers that they not be unnecessarily exposed to the risk of potential run-away jury verdicts. Therefore, it has been the general policy of the Fund's present management to only settle cases with prior consent from the defendant health care providers. This policy, along with the ability of hospitals and primary carriers to determine the timing of reporting cases and tendering their limits to the Fund, creates a true partnership between the Cat Fund and the health care community in today's legal system.

The Ridge Administration and the Cat Fund hope to work closely with all members of the health care community during this important legislative debate. And while the road ahead is a long and difficult one, together we can achieve success.



THE REAL STORY ABOUT THE CAT FUND AND THE CURRENT DEBATE IN HARRISBURG

There has been a heated debate over the role of the Cat Fund in Pennsylvania's medical malpractice insurance system since the announcement in October 1995 of a 68% emergency surcharge for 1995. During this debate, a significant amount of misinformation has been circulated.

Certain interest groups have outlined a number of proposals which they argue would enable health care providers to purchase cheaper malpractice insurance coverage from commercial insurance carriers. Unfortunately, the recent focus of the Cat Fund debate has diverted attention from the fact that these same proposals would actually result in higher total malpractice insurance premiums for Pennsylvania's physicians and hospitals.

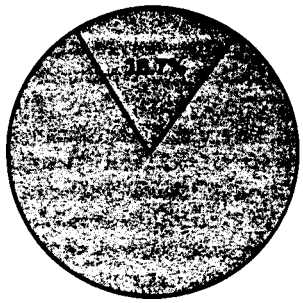
The following are some of the claims that have been made.

Claim: Private insurance carriers can provide the Cat Fund's layer of coverage for less. **Reality: Private insurance companies cannot provide the $1,000,000/ $3,000,000 level of coverage currently provided by the Fund for less money.** This is due to the simple fact that insurance companies are inherently different from the Fund. Private carriers make profits. Private carriers have high administrative costs, salaries and overhead. Private carriers maintain huge financial reserves. Private carriers have expensive marketing and sales budgets. Private carriers pay commissions to brokers and agents. The result: the average insurance company's operating expenses are some fourteen times higher than the Fund's. In the private sector, the costs associated with these expenses are passed on to insured physicians and hospitals in the form of higher premiums. Furthermore, certain high-risk specialties would not be able to obtain coverage at affordable rates from commercial carriers without participating in the Fund's risk pool. (See Chart #1)

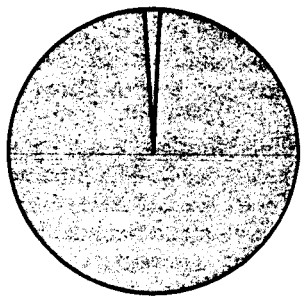
CHART #1

AVERAGE TOTAL OPERATING & GENERAL EXPENSES

MEDICAL MALPRACTICE INSURANCE INDUSTRY



CAT FUND
1.14%



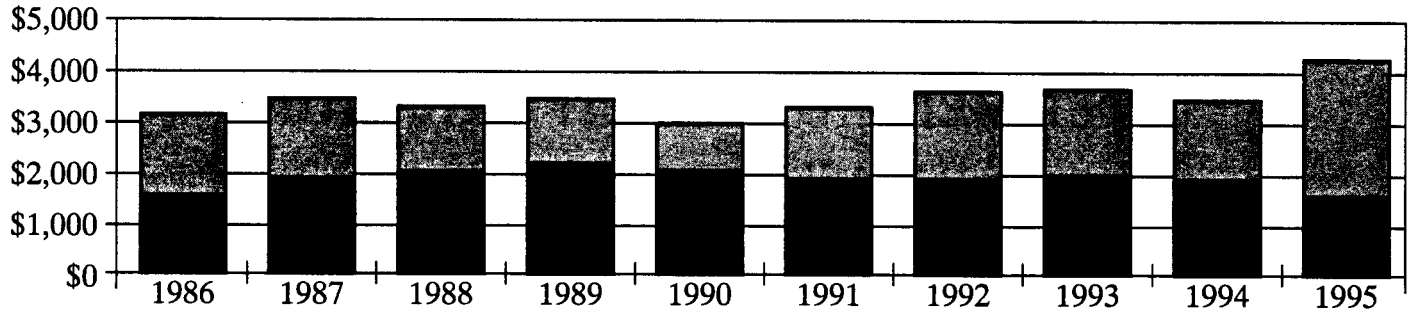
Industry Average figures from Best's 1994 Averages and Aggregates
(Excluding Losses & Loss Adjustment Expenses)
MPLCLF figures represent 1992/1993/1994 average
(Excluding 1994 Reinsurance Cost)

Claim: Pennsylvania physicians are faced with higher malpractice insurance premiums. **Reality: Over the past decade, the average Pennsylvania physician has paid relatively stable total premiums in real dollars.** In fact, many physician specialties pay less today than they did ten years ago, even without indexing for inflation and despite the lack of Tort Reform in Pennsylvania. However, in an era in which physicians' and hospitals' incomes are being squeezed while their costs are rising, the current levels of medical malpractice premiums, in combination with other costs of practicing medicine, are, indeed, proportionately higher than in years past. To help ease this burden, the Fund's leadership is committed to reducing the surcharge from its present level. (See Chart #2)

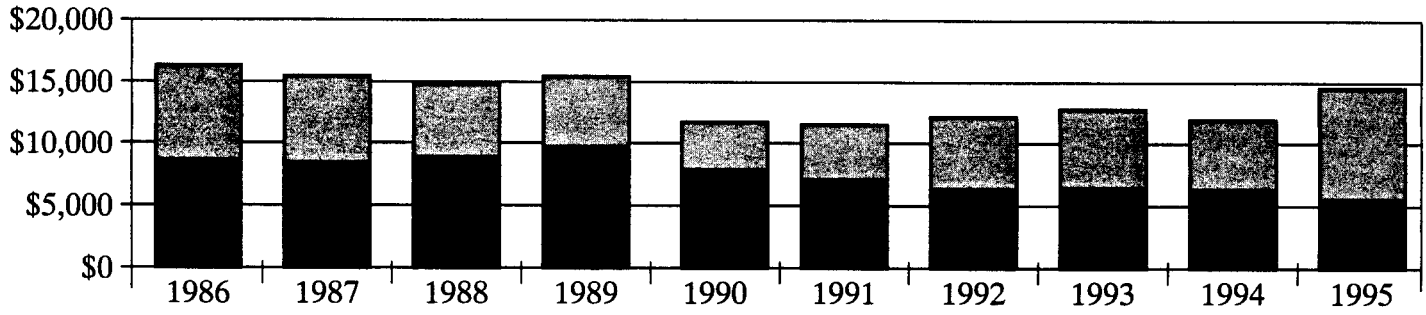
CHART #2

PA AVERAGE ACTUAL PREMIUM PAID

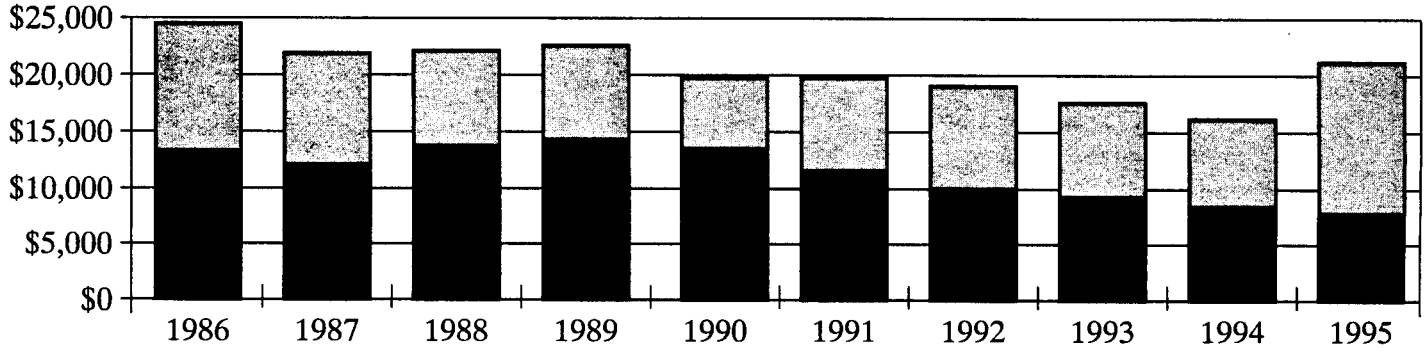
FAMILY PHYSICIANS



GENERAL SURGEONS



OBSTETRICIANS/GYNECOLOGISTS



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Surcharge	87%	87%	61%	60%	50%	68%	90%	91%	93%	170%

$200,000/$600,000 (Primary)

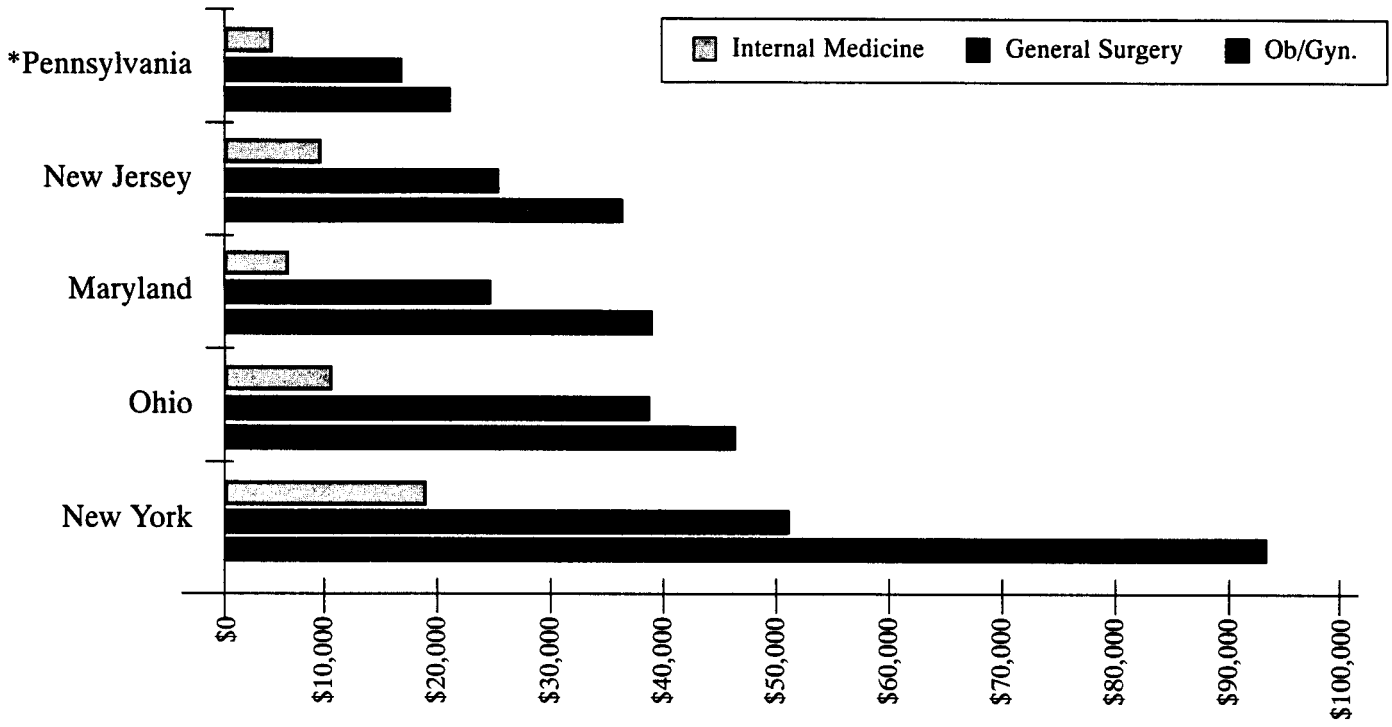
$1,000,000/$3,000,000 (MPLCLF)

Claim: The Cat Fund's unfunded liability is skyrocketing out of control. **Reality: The Fund's unfunded liability has remained relatively stable for the past six years.** In 1990, an independent auditor calculated the unfunded liability at $1.8 billion. From 1991 to 1993, it ranged from $2.0 to $2.1 billion. And in 1994 and 1995, the unfunded liability was $1.9 billion. Industry experts forecast no significant growth in the unfunded liability this year and the Fund's management is firmly committed to preventing any future growth. Clearly, such numbers do not indicate a run-away unfunded liability that is costing health care providers in Pennsylvania more money in the form of higher premiums. In fact, because of the costs associated with carrying reserves, Pennsylvania's physicians and hospitals would have paid higher surcharges for the past twenty years if the Fund followed the insurance industry's normal reserving practices. If the Fund's constituents decide, nonetheless, that they would like to make provisions today to pay for tomorrow's claims, they should keep in mind that the Fund easily remains the least expensive mechanism available to do so. One must also realize that setting aside current dollars to pay for future claims will cost medical providers more money than the Fund's current pay-as-you-go method of operation.

CHART #3

MEDICAL SPECIALTY 1995 RATE SURVEY (PER MEDICAL LIABILITY MONITOR)

AVERAGE RATE COMPARISON FOR $1,000,000/$3,000,000 Limits*

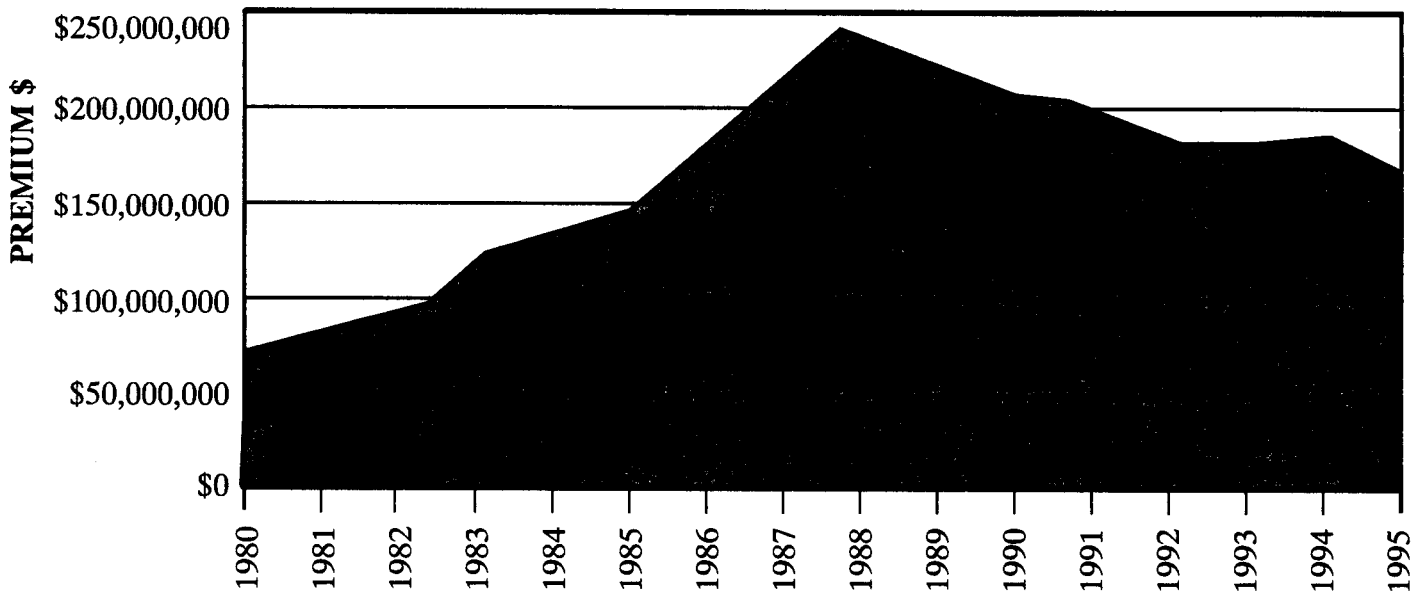


**For Pennsylvania: $1,200,000/$3,600,000 Limits*

Claim: Pennsylvania physicians pay higher premiums than they would in other states. **Reality: The actual premiums paid by Pennsylvania physicians for their total coverage limits of $1,200,000/ $3,600,000 are cheaper than those in neighboring states.** Physicians in some specialties pay even less than they would in neighboring states, in large part due to the cost effectiveness of the Fund's coverage. One must be careful to note when analyzing premium comparisons with other states, that filed premium rates bear little resemblance to the actual premiums paid in today's Pennsylvania marketplace. Premium discounts of 65% or more are not unheard of and, therefore, a comparison of *actual* rates is more valid than one which uses *filed* rates. (See Chart #3)

CHART #4

PA PREVAILING PREMIUM BASE



Claim: The Cat Fund surcharge method is unfairly applied to certain physicians. **Reality: Responding to competitive pressures in today's market, some private insurers offer discounts, as a marketing tool, to some physicians but not to others.** Under current law, the Fund assesses its surcharge as a flat percentage on the actual premiums paid by health care providers. Presently, the Fund is unable to adjust its surcharge calculation to counterbalance some of the insurance carriers' inequitable discounting practices. This has resulted in a declining premium base upon which the Fund assesses its surcharge. The Fund must have the flexibility to modify its surcharge based on the specific claims histories of different classes of health care providers. This would result in more equitable distribution of premiums. (See Chart #4)

The issues behind these and other claims are extremely complex and merit more in-depth discussion and debate. This issue of the *Cat Fund Update* does not attempt to explore the issues in great detail. However, it is important for the Fund, as the last line of defense for physicians and hospitals being sued in Pennsylvania, to make known some of the more salient facts upon which everyone's decisions must be made.

The dialogue currently being engaged in across the Commonwealth and in Harrisburg is an important one, with major implications for all parties involved. Therefore, it is important that all sides have an opportunity to present their opinions and back them up with facts. The Fund welcomes all comments and questions about the issues raised in this newsletter.

COUNSEL'S CORNER: HOW THE CAT FUND WORKS FOR PHYSICIANS WHEN THEY ARE SUED

Being named in a medical malpractice lawsuit is a frightening and often lonely experience. However, you are not alone. Your primary professional liability insurer, your defense attorney and the Cat Fund are all prepared to help you.

When you are named in a lawsuit, and served with a Complaint or Writ of Summons, the clock begins to run for your attorney to file responsive papers. Therefore, it is critical that you immediately notify your primary insurer and attorney so they can begin your defense in a timely fashion.

If the lawsuit concerns care you rendered to a patient *more than* four years before the date the claim was made, your primary carrier will report the claim to the Fund. Such a case is handled by the Fund according to Section 605 of Act 111, the Healthcare Services Malpractice Act of 1975. In Section 605 cases, the Fund retains an outside attorney to represent you and provides you with $1 million in coverage.

If the lawsuit is brought *within* four years of the medical care you provided, the suit is treated as an Excess case by the Fund. If the value of the claim is likely to exceed $200,000 (your primary liability coverage), your primary insurer will report the case to the Fund and you will be entitled to an additional $1 million in Fund coverage.

PROFILES OF CAT FUND MANAGEMENT

John H. Reed, Esquire, Director—Governor Ridge appointed John Reed as Director of the Medical Professional Liability Catastrophe Loss Fund in July 1995. Since then, Mr. Reed has worked to make the Cat Fund operate more efficiently and act more responsively to the concerns of its insured health care providers. Prior to his appointment to the Fund, Mr. Reed served as in-house litigation counsel for the Geisinger Health Care System. In addition to handling various risk management and self-insurance matters, Mr. Reed defended the Geisinger System's hospitals, corporations and physicians in professional and product liability lawsuits. Mr. Reed spent four years as the Assistant United States Attorney in charge of President Bush's Organized Crime Drug Enforcement Task Force in West Virginia. Mr. Reed has also represented the citizens of the Commonwealth as a Senior Deputy Attorney General of Pennsylvania, Assistant District Attorney of Chester County and an attorney in private practice.

Robert W. Waeger, Esquire, Deputy Director—Bob Waeger has served as the Fund's Deputy Director since October 1995. Mr. Waeger brings to the Fund his two decades of experience in the legal and insurance areas of medical malpractice. Mr. Waeger has been House Counsel and East Coast Regional Claims Attorney for Nationwide Insurance and Vice President of Claims for the PHICO Group, Inc. Mr. Waeger also has a long history of trial and appellate success as a partner in two private law firms.

Arthur F. McNulty, Esquire, Chief Counsel—Since December 1993, Art McNulty has acted as the Fund's Chief Counsel. Immediately prior to joining the Fund, Mr. McNulty handled a wide variety of legal and insurance matters for the Pennsylvania Insurance Department. In all, Mr. McNulty has served the citizens of the Commonwealth for more than fifteen years as an attorney for a number of legislative and executive agencies.

Carole Z. Strickland, Claims Manager—After working for more than fifteen years as a Claims Examiner and Supervisor at the Fund, Carole Strickland was promoted to Claims Manager in September 1995. In addition to her long history at the Fund, Ms. Strickland draws on her background in the private sector of the medical malpractice industry. Ms. Strickland manages the claims operation in the Fund's Rosemont office which is responsible for handling Excess cases against health care providers in Southeastern Pennsylvania, processing Claim Reports and claims payments for the entire state.

John W. Cameron, Claims Manager—In October 1995, John Cameron was appointed Claims Manager at the Fund, bringing with him more than twenty-five years of experience in the medical malpractice insurance industry. Most recently, Mr. Cameron served as Vice President of the PHICO Group, Inc., where he managed PHICO's national claims operation. Mr. Cameron manages the claims operation in the Harrisburg office of the Fund which will handle Section 605 cases in the entire state and Excess cases in Western and Central Pennsylvania.

CONGRATULATIONS!

All too often, the health care community is faced with headlines about huge jury verdicts. Meanwhile, cases in which physicians and hospitals successfully defend themselves in court do not make the news. The Cat Fund, therefore, would like to share the good news we have received about favorable outcomes reached in some recent cases.

Plaintiff: Darby. This case was brought by a 61 year-old woman admitted to the defendant hospital for treatment of a myocardial infarction. Plaintiff alleged that performance of a t-PA protocol by the defendant physician was contraindicted because of her recent cerebrovascular incident. Plaintiff went into a coma brought on by a large subdural hematoma. Plaintiff subsequently improved and was released from the hospital, but claimed to suffer from speech and mobility problems. After a one week trial in Monroe County, the jury returned a defense verdict. Plaintiff's settlement demand in this case was $1,500,000.

Plaintiff: Ethier. Plaintiff alleged negligence in prenatal care, failure to perform a timely Caesarean section and negligent postnatal care, resulting in brain damage and spastic quadriplegia in an infant. The three Ob/Gyn defendants and the professional corporation refused to meet Plaintiff's $4,000,000 demand to settle the case on their behalf. After an eleven day trial in Lehigh County, a jury returned a verdict in favor of all defendants, including the second-year resident and hospital who were also sued.

Plaintiff: Fantini. After a four day trial in Camden County, NJ Superior Court, the Judge issued a directed verdict in favor of the defendant physician. Plaintiff's demand for settlement was $400,000 in a case alleging damage to the ureter during surgery which caused the loss of a kidney.

Plaintiff: Gadagno. Plaintiff alleged the defendant physician negligently performed a fixation of a displaced femur in his right leg resulting in rod failure and infection and necessitating a repeat fixation surgery. The defense's motion for Non Suit was granted on the fourth day of a jury trial in Westmoreland County, in a case in which the primary carrier had earlier established a $150,000 reserve.

Plaintiff: Goldenberg. In a case filed in Philadelphia, a 29 year-old female alleged that an improper catheterization in her lower abdomen caused a perforated cecum leading to peritonitis. Plaintiff further alleged that her antibiotic treatment was excessive, given that her immune system was compromised by lupus and anemia, and caused hearing loss and Erb's palsy. The defendants waived their right to a jury trial in this case. Therefore, Judge Moss predicted over this case in a bench trial. Prior to the start of trial, Judge Moss placed a $1,500,000 value on the case. Nonetheless, she returned a defense verdict at the conclusion of the trial.

Plaintiff: Lee. Plaintiff alleged that a physical examination of a mother in her 32nd to 33rd week of gestation, and three days prior to the onset of labor, by the defendant obstetrician revealed that the infant was in a breech position. Plaintiff also alleged that the actions of the defendant hospital's staff prevented a timely Caesarean section delivery when the mother presented in the ER. Plaintiff claimed that the failure to reposition the child and perform a timely Caesarean section resulted in minor brain damage to the infant. Plaintiff's settlement demand was $750,000, but after a one week jury trial in Philadelphia, a verdict was returned in favor of all defendants.

Plaintiff: Tarver. A woman in her late thirties underwent a posterior lumbar fusion with insertion of VSP plate and screws

in early 1991 at one defendant hospital. Later in 1991, Plaintiff underwent a re-exploration, bilateral foraminotomy at L4-5 and removal of VSP plates. She also had a left iliac crest bone graft with posterolateral fusion and reapplication of VSP plates at L4-5. In a suit filed in Philadelphia, plaintiff alleged negligence and lack of informed consent against the defendant physicians and corporate negligence against the hospitals for failing to monitor the physician's use of "investigational" devices. Judge Moss granted a motion for Non Suit on behalf of the defendant hospitals, stating that plaintiff's primary theory was that no instrumentation should have been used in the back and, therefore, was irrelevant as to the "investigational" status of the materials used. Judge Moss clarified that this ruling was not an "across the board" judgment that the hospitals were not liable for allowing the use of "investigational" devices, but rather was specific to this case only. Following a nine day jury trial, a defense verdict was returned for the defendant physicians. No settlement demand was issued in this case.

PREVIEW OF FUTURE COLUMNS

In future issues, the Cat Fund will feature discussions on topics such as the following:

- Risk Management
- Professional Liability Insurance Coverage
- Pennsylvania Legislative News
- Pennsylvania Legal News
- National Trends in Medical Malpractice with Local Implications

The Fund welcomes any suggestions on other topics which might be of interest to Pennsylvania's health care community.

APPENDIX M

LB&FC Comments on the Fund's Response

First Bullet, Page 2: The Fund disagrees with our characterization in Chapter V of the report that it has advocated various proposals to reform the Fund, in particular raising the primary limits (page 2 of their response). This section of the report was based on amendments presented to the House Insurance Committee on House Bill 2294, Printer's No. 2963 by the Fund's director on March 6, 1996 and again on April 2, 1996. In his testimony, he characterized the proposed amendments (A 1665), which included increasing the primary limits from $200,000 to $300,000, as the Administration's proposal "for reforming the medical malpractice marketplace and enabling the CAT Fund to fulfill the role originally envisioned for it by the General Assembly."

Concerning the position of the Hospital Association of Pennsylvania, we understand that it is willing to compromise with the Fund and, therefore, has agreed to support the proposal to increase the primary limits. This, however, is not the Association's preferred option for addressing the problems before the Fund.

Second Bullet, Page 2: The Fund believes that the statement "confidence in the ability of state government of manage the Fund has been eroding" is misleading and does not reflect the new practices put in place under the new Fund director. The statement made here and elsewhere in the report was intended to encompass at least the past five-year period, not just the past 12-month period. Also, the efforts of the Fund director to make improvements are noted in several places in the report, including, for example, pages 18, 20, 22, 23, 24, and 30. We note, however, the Fund has no way of institutionalizing these policies and the problems of the past could reoccur under a new manager. We also believe some of the Fund's claims management problems are structural and will continue to be of concern regardless of who manages the Fund (see page viii).

First Bullet, Page 3: The Fund believes our statements that it is "refusing to pay" delay damages and post-judgment interest above the Fund's coverage limits are inaccurate because due to court decisions it has no flexibility in this regard. On page 29 of the report, we describe the history and current status of the Fund concerning the payment of delay damages and post-judgment interest. As we note on page 29, because the Fund has refused to pay delay damages and post-judgment interest above its coverage limits these issues are now before the courts for resolution. Because the courts have not made a final ruling on these cases, we have modified the report to say simply that the Fund does not pay delay damages and post-judgment interest above its coverage limits.

Second Bullet, Page 3: We added the words "In part" to the sentence on page 24 to clarify that the increase in claims from 1994 to 1995 was not due solely to the present Fund director's new claims settlement philosophy.

Third Bullet, Page 3: The Fund believes our discussion of the assignment of legal counsel to Section 605 claims to be inappropriate and inaccurate with regard to the current Administration. We include the discussion with regard to assignment of legal counsel

because it was a factor several providers cited when we asked them to tell us problems they have experienced with the Fund. Moreover, we do not believe the report "levies charges" against the current Administration. On the two pages on which problems related to the assignment of legal counsel are listed (p.vii and 22) we note that the Fund's current director has taken steps to address many of these problems. On page 30, where we discuss the legal assignment issue in more detail, we include a full paragraph on what has been done under the current Administration to address these concerns.

Fourth Bullet, Page 3: The report has been changed to reflect the Fund's updated FY 1996-97 budget request.

Fifth Bullet, Page 3: The Fund believes the statement that "commercial carriers can provide the Fund's level of coverage to their current insureds at less cost" to be inaccurate. We disagree. The statement is based on the responses of six major insurers who write medical malpractice insurance in Pennsylvania (page ix). We also make the point several times in the report that if the Fund's layer of coverage were provided through the private sector, providers would still be responsible to pay unfunded claims as they become due (pages ix, xiii-xv, and 73-82). For example, on page xiv we state that "provider payments for malpractice insurance and to pay off the unfunded liability would be approximately 1.5 times their 1996 payments" for at least three years.

The Fund's summary of the insurers' responses to the Insurance Commissioner differs from the LB&FC report for the following reasons.

- The Fund shows a 39% premium as Company B's response for the 20-year payoff of the unfunded liability. We did not include this insurer in Table 15 because it reported only the present values of the various scenarios, not the annual premiums. The Fund apparently tried to calculate the premium by dividing 20 into the 780% present value for the combined excess and unfunded liability charge in the 20-year scenario. In addition, in its letter to the Insurance Commissioner this company did not indicate it had stopped writing new medical malpractice policies in Pennsylvania; the company stated its possible intention not to write new coverage in a letter to the Fund.

- The LB&FC report does not include the Fund's Company E response because this company writes very little basic limits coverage in Pennsylvania. In Pennsylvania, it sells mostly excess coverage above the Fund's coverage layer. Moreover, in developing its response, this insurer simply multiplied its filed rates by its filed increase limits factor and noted that it "does not calculate increased limits factors based on loss data from any single state due to the lack of credibility in the higher layers."

- The Fund shows Company G (the report's Company E) reporting a 140%--160% premium, a range that the insurer's actuary describes as an estimate of the industry-wide charge for such coverage. However, the company's actuary goes on to say the insurer's policyholders would probably pay only 99%--114% because of their favorable claims

experience and suggests 125% as an appropriately conservative premium for its client. Accordingly, we report the 125% estimate.

- We did not include the Fund's Company H because, as the Fund shows, the company did not submit a quantitative response.

First Bullet, Page 4: The Fund believes it "nearsighted" to assume that carriers will remain in the medical malpractice market in the absence of the Fund. Although we agree that the Fund has made Pennsylvania an attractive market for private carriers, we disagree with the Fund's contention that there are serious questions as to whether insurers will be willing to continue to provide coverage over the long term. As we explain on pages viii and 39-40, two of Pennsylvania's largest insurers, PMSLIC and PHICO, are affiliated with the Pennsylvania Medical Society and the Hospital Association of Pennsylvania, respectively, and therefore have long-term commitments to Pennsylvania providers. Additionally, the Joint Underwriting Association, a statutorily created body to provide insurance to providers who cannot otherwise obtain it through private carriers, and other alternatives, such as self-insurance and risk retention groups, are available that did not exist when the Fund was created in 1975. Finally, as noted in the report, Pennsylvania is one of only 3 states that mandate that providers participate in a state-administered fund, so the vast majority of states have found that insurers are willing to provide insurance without the "umbrella of protection provided by the Fund."

Second Bullet, Page 4: We agree with the Fund that states differ in terms of tort reform and have highlighted some key differences on page 44. As we explain on page 57 of the report, the states included in Table 13 were selected because they are the only states with state-administered funds.

Fourth Bullet, Page 4: The Fund contends that "in most instances, . . . plaintiffs bring suit against multiple health care providers in one 'case'." While it is true that cases often involve multiple providers, as Appendix J on pages 107-110 shows, only 91 of the 551 cases closed with payment in 1995 involved multiple providers. The remaining 460 involved single providers. We discuss the significance of cases involving multiple providers on pages 24, 26-28. Moreover, a claim (not a case) is the unit that actuaries use in analyzing an insurer's loss experience and estimating its potential liabilities.

First Bullet, Page 5: The Fund contends that the report contains "inaccuracies and misinterpretations" regarding the most recent actuarial analysis and directs attention to the actuary's response. The actuary, Mark R. Proska, reiterates his argument for excluding breast implant and pedicle screw claims from his most recent analysis and believes our statement that insurance companies hold reserves for such claims could potentially be misleading. Mr. Proska suggests that such claims have little impact on the reserving practices of insurers because they need only concern themselves with the primary coverage on claims filed within four years. However, based on this reasoning, one can conclude that these claims are no different than other claims that go to the Fund.

Mr. Proska also states that their actuarial analysis was not intended to be used for illustrating the possible consequences of Fund actions or the differences in options for changing the Fund and expresses concern that it might not be appropriate for such purposes. He does not, however, identify any specific reasons which would bring into question the reasonableness of this approach. Moreover, our report includes cautionary statements about the use of actuarial data on pages 2 and 72.

Third Bullet, Page 5: The Fund contends that we did not accurately interpret the actuarial report submitted by Coopers & Lybrand, citing specifically that the unfunded liability has not increased every year. We disagree. To make the argument, the Fund cites three different actuarial reports by three different actuaries. To compare the unfunded liability estimates in these reports is misleading because they use different actuarial assumptions and cover different time periods. As shown in Table 8 on page 36 of our report, which was developed using Coopers & Lybrand's "hindsight" methodology from its most recent actuarial report, the unfunded liability has increased every year since at least 1984.

The Fund also states that it is "confusing and potentially misleading" to compare accident year to calendar year claim payment data. We disagree. The sum of all claims paid from January 1, 1976, through December 31 of any year will be the same, regardless of whether the accident year payments or the calendar year payments are added. The difference between the sum of the paid claims and the sum of the ultimate projected losses will be the estimated unfunded liability as of that date. (See our discussion of how the unfunded liability has grown on pages v-vi, 14-15 and 33-36.)