**JOINT SUBCOMMITTEE STUDYING RISK MANAGEMENT PLANS FOR PHYSICIANS AND HOSPITALS**
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The second meeting of the second year of study of the Joint Subcommittee Studying Risk Management Plans for Physicians and Hospitals featured reports on the disciplinary process for physicians, state-sponsored medical malpractice insurance programs, and the perspective of independent insurance agents.

Dr. William Harp, Executive Director of the Virginia Board of Medicine, outlined the Board's disciplinary procedures for health care practitioners. The Board of Medicine is one of thirteen boards under the Department of Health Professions. The disciplinary process is governed by the Administrative Process Act and is driven by complaints and by reports from persons who are mandated by law to report certain acts. The Board investigates complaints and responses can range from dismissal of a case to revocation of a license. Dr. Harp addressed the Subcommittee's 2005 legislation, which directs the Board of Medicine to require an assessment of the competency of a health care practitioner who has had three medical malpractice claim payments in 10 years. He noted that of the almost 31,000 doctors licensed in Virginia, there are 40 physicians with three paid claims. He also discussed HB 1441/SB 1334 from 2003, which enhanced reporting, changed the disciplinary standard from gross negligence (which had existed since 1934) to simple negligence, and provided for confidential consent agreements. It has resulted in an increase in reporting. In response to questions it was noted that the Department of Health Professions receives no general funds and the entire budget comes from fees paid by regulants.

Patrick Riley, Senior Vice-president with Marsh, U.S.A., manages the Health Care Alternative Risk Solutions unit within Marsh, which helps clients set up and operate medical malpractice insurance facilities. Clients include health care providers, insurance companies and governmental entities. Marsh currently works with six governmental or government-sponsored medical malpractice programs across the country. The medical malpractice liability insurance marketplace is about a $30 billion marketplace with approximately one-third of the premiums and premium-equivalents being paid to insurance companies (mutuals, stock companies) and the remainder being paid to alternative risk solutions (self-insurance programs, captives, risk retention groups and governmental facilities). Governmental facilities constitute about 3 percent (or less than a billion dollars) of the total premium equivalents in the marketplace. Although it is a small percentage, the states in which these facilities operate are big players, especially during hard market cycles. There are basically two types of government-sponsored entities: those that supply first dollar coverage, such as joint underwriting associations; and patient compensation funds that provide excess medical malpractice insurance. Because SB 601 contemplates first dollar coverage, Mr. Riley addressed the two categories of such programs. The first category consists of permanent programs that have

been established as ongoing parts of the medical malpractice liability insurance marketplace. Such programs were established in the 1970s in New Hampshire, Rhode Island, Pennsylvania, South Carolina, Florida, Minnesota and Texas. During their 30 years of existence they have ebbed and flowed with the market cycles, grown extensively during hard markets and shrunk during soft markets. States have kept them in place because they feel they are a useful tool when they need them.

The second category consists of facilities established as short term solutions to cyclical problems. States with such programs include West Virginia, Mississippi, Missouri, Nevada, Kansas, New York and Virginia (because Virginia had a joint underwriting association at one point). The insurance industry as a whole is cyclical and the cycles are amplified within the medical malpractice portion of it. Some of these state plans compete with the open market and some are residual markets with stipulations before a health care provider can obtain coverage. In response to a question about the effect on competition of having open market providers, Mr. Riley stated that it varies by state. Three negatives commonly attributed to government facilities are that: the plans may squeeze out private competitors, the philosophical consideration of whether such involvement is an appropriate role for government, and whether a government-plan enables a health care provider who should not have insurance to have insurance.

Subcommittee members also questioned the effect of state-sponsored plans on rates and whether such plans are exempt from legal requirements imposed on private companies. Mr. Riley stated that government plans do not function like a typical insurance company. Some are regulated by the insurance commissioner and some are not, they are not required to carry reserves or surplus, they are not required to be capitalized at the same level as an insurance company, and they are not held to the same financial standards in general. They can operate at a deficit and may have access to three backstops if there is not enough cash to meet short-term needs: they can ask their participants for more money, they can request a loan from the insurance industry, and they may be backed by full faith and credit of the state. Only West Virginia and Mississippi have had programs backed by the full faith and credit of the state. Public sector facilities address either availability or affordability; consequently their success is measured differently than from that applicable to a private insurance company.

Mr. Riley discussed the West Virginia plan in detail. In 1995, medical malpractice was the most profitable line of coverage in property and casualty in West Virginia; by 1999, it was the least. In 1999, medical malpractice liability insurance went into crisis mode and private industry began to withdraw from market. States that fared the best had indigenous insurance companies that specialized in medical malpractice liability domiciled in their states or they had a very strong joint underwriting association. Companies began to stress and contract their surplus to focus on their core constituency--either geographic domicile or specialty lines. Virginia didn't have a core constituency but benefited from the fact that it is viewed as a good venue. West Virginia faced the same situation as Virginia but was viewed as being an unfavorable venue (plaintiff friendly, insurance unfriendly, and a rural state that has trouble attracting physicians) and is a small state with a small market. Two insurers went into bankruptcy and physicians faced

a serious crisis. Formation of a mutual company was discussed but the requisite money and leadership were not available. When the crisis worsened, the West Virginia legislature called a special session in the fall of 2001 and passed HB 601 (with a sunset clause) creating a medical malpractice insurance company backed by the full faith and credit of the state. The program was overseen by the state's Board of Risk and Insurance Management (BRIM), named BRIM II and outsourced to Marsh. The state made a half-million dollar loan for initial expenses and there were no reserves. BRIM II, which was not a carrier of last resort, opened for business on January 1, 2002. Physicians in the excess and surplus marketplace were picked up first. Later, as other insurers exited or withdrew the marketplace 75% of the physicians could not get insurance through the standard marketplace and turned to BRIM II.

By the end of 2004, BRIM II was a $40 million company insuring over 1400 physicians and 10 hospitals. West Virginia did not want to stay in the insurance business, and in the 2003 General Assembly Session, the state agreed to convert BRIM II into a mutual insurance company. On the day of conversion, July 1, 2004, the program had $80 million in cash and $15 million in paid and reserved losses and liabilities. Because insurance companies must have surplus, the state took $24 million out of the tobacco settlement fund and assessed every physician (whether insured by the state or not) $1,000 and every insurance company $2,500. This amassed $30 million which served as surplus. Rates in West Virginia are extremely high, but the West Virginia Physicians' Mutual Insurance Company recently filed for a 5% rate decrease and is reportedly financially sound at this time.

Bob Bradshaw, representing Independent Insurance Agents of Virginia (IIAV), which is composed of about 7,000 agents and insurance industry employees in the Commonwealth, stated that IIAV continues to be opposed to a state sponsored plan that would compete with the open market. He noted that Virginia is not in the situation in which West Virginia found itself and that the private sector is best able to respond to the insurance needs of consumers. The Subcommittee's 2005 legislation should be given time to take effect and will make Virginia a more attractive state in which to write insurance. Companies will think twice about entering Virginia if they have to compete with a state-run program. Bureau of Insurance reports have indicated that there is not a problem obtaining medical malpractice insurance in the voluntary market, affordability is a greater problem than availability. He noted that the Division of Risk Management's presentation at the August 30th meeting did not indicate that premiums would be substantially lower with a state-sponsored plan and stated that there is no reason to put the state's funds at risk. He urged the Subcommittee to continue to explore initiatives that might have a more positive impact on physician exposure, including the recommendations that the Subcommittee considered last year. He distributed a copy of the June 2003 United States General Accounting Office Report on Medical Malpractice Insurance and noted that it states in its conclusions that "Multiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term." (Page 43) He noted that losses would not be impacted by the establishment of a state- run program.

Mr. Bradshaw introduced Tom Cox, Vice-president of PhillipsCox Insurance and Financial Services, who presented an IIAV Position Paper on Tort Reform Related to Medical Malpractice. The IIAV believes that access to health care continues to be threatened in the Commonwealth due to a combination of the high costs associated with running a medical practice and low reimbursements to physicians. As presented last year, it is the position of the IIAV that the introduction of a state-run medical malpractice insurance program, operated by the Commonwealth to compete with the private market, does not address any of the challenges confronting the delivery of health care in the Commonwealth as it promises to do nothing to lower costs or increase reimbursement. To decrease the possibility of access to care challenges occurring, the IIAV believes that the General Assembly should strive to either reduce costs to the malpractice insurance companies (with a resulting decrease in premiums to physicians), find other ways to decrease costs to physicians, or increase physician reimbursement. Four proposals were presented:

- Pass legislation which mandates that health care providers in the Commonwealth carry malpractice insurance with minimum limits of $1 million/$3 million, but prohibit any entity from mandating that physicians carry limits equal to or greater than the current malpractice cap.

- Change the dynamic of the current tort system by spreading the risk incurred by each entity involved in a claim by mandating that all malpractice cases be heard by a Malpractice Review Panel prior to litigation being filed or prior to litigation proceeding and if the panel finds in favor of the defense and the plaintiff proceeds with the suit regardless, and the plaintiff loses at trial, the plaintiff's attorney (*not the plaintiff*) must pay all defense costs.

- In order to assist physicians with paying for medical malpractice insurance, pass legislation that prevents any third party from prohibiting providers charging any additional fees above that which they will be reimbursed by a health insurance company.

- Allow medical practices to collect money at the time of the visit from those people with Health Savings Accounts and Health Reimbursement Arrangements (this would be a small step towards allowing medical practices to operate more like all other businesses in this country).

As a result of questions and issues raised at the August 30, 2005, meeting of the Subcommittee regarding insurance company positions and industry methods, the IIAV gathered information from member companies. The IIAV's responses are summarized here and available in their entirety on the Subcommittee's website.

Are Virginia premiums based on Virginia experience?

> Yes. There are two components to the rates a company files in each state. The first is the "cost of doing business," general operating expenses that tend to vary little from state-to-state and risk, which varies greatly from state-to-state because each

has its own laws of civil procedure, various limits on damages, different strengths and weaknesses of the plaintiff and defense bars, and the like.

Is Virginia money used to pay claims in other states?

Virginia rates are established based on a company's loss experience in Virginia, as noted above. Rates are calculated to anticipate the risk of loss in Virginia in an attempt to ensure adequate premium is collected for each policy written in the state. Due to the strong competition in Virginia it would be foolish for one company to charge excessive rates to supplement lower rates in another state.

Could doctors get lower rates if there was a Virginia-only mutual company?

The answer to this question would not be known for at least five to seven years.

For a single-state mutual to truly be successful, it usually has to dominate the market in order to generate the premium necessary to maintain operations. To do this it must attempt to drive out competition by charging lower premiums and encouraging the physicians to support "their" company. This discourages competition and results, to some degree, in a monopoly. If the mutual is well run and successful, this may work over the long term. If not, the lack of competition fostered by the resultant monopoly leaves doctors with few options.

Therefore, it would seem that the better course for Virginia physicians would be to encourage a strong market with intense competition, rather than encouraging a single carrier to control the market.

Is it true that there is no correlation between the medical malpractice insurance rates in Virginia and claims in Virginia?

If one company were to have a monopoly or some sort of competitive advantage, such as state protection, it might be able to charge rates in excess of expected losses. This is not the case in Virginia.

A larger concern in a competitive market is not that carriers will charge too much but that a carrier will intentionally use inadequate rates to buy market share.

In a competitive market no carrier can have rates that are too high, for fear of losing market share. Responsible carriers also cannot have rates that are too low, for fear of having insufficient funds to cover losses, being downgraded, and perhaps going out of business.

Following the presentations, the Subcommittee discussed the complexity of the practice of medicine, the fact that many errors are systemic errors, and the development of risk management plans that reflect current practice.

The Subcommittee's next meeting will be held in late October at which time the Subcommittee will have an internal discussion of issues that have been brought before the Subcommittee, will hear from the defense bar, receive reports from the Bureau of Insurance on the items mentioned in the study resolutions, and receive information from the State Corporation Commission on insurance company capitalization and financing requirements, including what would be involved in establishing and maintaining Virginia-only mutual medical malpractice companies.

Copies of the presentations are available on the Subcommittee's website under materials for the September 20 meeting.