

**YOUR PROFESSIONAL LIABILITY BROKER,**



**IS PLEASED TO BE SENDING YOU, OUR  
*CORNERSTONE QUARTERLY NEWSLETTER.***

**If any of your colleagues are in need of our assistance,  
please have them give us a call at 800-508-1355.**

**Thank you,  
Chris Zuccarini  
President**

**1500 LIBERTY RIDGE DRIVE . WAYNE, PENNSYLVANIA 19087 .  
610-296-3700 . 800-508-1355 . FAX: 800-508-1354**

# CORNERSTONE

PROFESSIONAL LIABILITY CONSULTANTS

A QUARTERLY NEWSLETTER



## CORNERSTONE'S NEW WEBSITE

is up and running – check it out at [www.cornerstonepic.com](http://www.cornerstonepic.com). Within the website you will find company applications, recent newsletters, informational faxes as well as frequently asked questions. New physicians will also be able to visit the site and complete a short questionnaire. A producer will review the information and give the doctor a call back to discuss the coverage options that are available. *PA physicians – there is a link on our website's home page that will take you directly to the Mcare website.*

## MCARE 2004 – WHAT'S HAPPENING?

Mcare has taken the position to defer the 2004 assessment until April 1, 2004. House Bill 44 was passed and signed in to law on December 23, 2003. This bill establishes the Healthcare Provider Retention Program. This Program will provide for an abatement of the 2003 and 2004 Mcare assessments for healthcare providers who meet the eligibility requirements contained in the law.

Mcare has made public an on-line application form for those seeking to qualify for an abatement of the Mcare assessments at either the 50% or 100% levels for 2003 and 2004. An application will have to be completed for each year. Healthcare providers are required to submit the request for an abatement to the Department using this electronic form no later than February 12, 2004. All supporting documents as indicated on the on-line application form must be postmarked by February 12, 2004. It is encouraged that you submit your application as soon as possible due to the expected volume.

In return for the abatement, healthcare providers are required to sign a “pledge to practice” agreeing to continue to provide healthcare services within the Commonwealth for a full calendar year following the year for which the abatement was granted. Failure to fulfill that pledge means that 100% of the assessment would need to be repaid along with administrative and legal costs, if applicable. If you know you are leaving practice in Pennsylvania anytime in 2004, please notify our office so that we can have the insurance carrier process your Mcare 2003 billing.

Mcare Website - [www.mcare.state.pa.us](http://www.mcare.state.pa.us)

## GE MEDICAL PROTECTIVE IN NEW JERSEY – WHAT'S CHANGING?

With the ever-changing markets Medical Protective has taken even a more stringent position in NJ. The insurance department has yet to approve the requested rate increase but since NJ is a “use and file” state, carriers are able to use the rate increase prior to the filing being approved by the Insurance department.

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**ProMutual, MIIX  
ADVANTAGE AND CONVENTUS  
ARE OPTIONS IN NEW JERSEY...**

Although MIIX Advantage and Conventus have capital contributions, they are an alternative for coverage in an ever-tightening market. Pro Mutual is also available for coverage and is pushing for doctors to purchase claims made policies but will continue to offer occurrence coverage. Conventus offers claims made coverage and MIIX Advantage offers claims made as well as permanent protection policies (pre-funded tail).



**PENNSYLVANIA CASUALTY  
ASSOCIATION (PCA) –  
REDUCES THE SUBSCRIPTION  
FEE.**

PCA has come through again with the reduction of the subscription fee. The management felt it was necessary to seek outside investors in order to reduce the fee associated with binding coverage with the carrier. This will enable the carrier to be more competitive in the market. The fee has been reduced to 25% of the chargeable premium.

***IN OTHER NEWS.....***

***PA doctors launch a Billboard Campaign for Med Mal caps...***

The PA Medical Society started a billboard advertising campaign to spark movement on the stalled measure in the Senate.

**TO IMPROVE THE MED MAL  
CLIMATE PENNSYLVANIA  
ACTS AGAIN...**

The Pennsylvania Patient Safety Authority (PSA) selected ECRI to develop a statewide system to report medical errors and incidents of a serious nature. Pennsylvania created PSA as part of Act 13 Mcare legislation that was passed in 2002. The system is designed to educate healthcare providers of the errors being made and how to prevent them. The intent of this system is to reduce medical malpractice lawsuits in the state, which would in theory, encourage insurers to enter the state and provide affordable rates.



**WHAT'S HAPPENING IN  
CONNECTICUT?**

CMIC has raised rates again..... Pro Mutual has again stepped up to the plate to offer coverage to CMIC doctors as long as they meet the underwriting guidelines. Currently, new business is flooding Pro Mutual and they are eagerly reviewing applications looking for those who meet the guidelines.



**GE MEDICAL PROTECTIVE: AN  
OVERVIEW  
RETENTION AND DESTRUCTION  
OF PATIENT RECORDS**

For many years, GE Medical Protective (MedPro) has used one word to describe its corporate

recommendations to insured physician and dentists relative to the retention of patients' records; that word is: ***indefinitely***. There is really only one reason for this and it is to protect the legal rights of the doctor.

Most risk management policies are rooted in the commitment to provide health care services that protect patients from harm and that strive to ensure patient satisfaction.

Occasionally, doctors are urged to implement a risk management strategy that focuses on legal rather than on clinical goals. The advice that physicians and dentists should retain their records for as long as possible is one of those legal rather than customer-oriented recommendations.

Generally, patients' records lose their clinical value within a few years. With the possible exception of long-term failure to diagnose/treat a condition, allegations related to medical or dental negligence are usually focused on the provision of recent care. Even when adults bring complaints related to medical or dental care they received as children, the documentation of non-clinical issues, such as parental non-compliance, are often more important than the actual treatment provided-at least from a legal perspective.

However, regardless of the degree of possible exposure, the physician or dentist whose records are available stands a much greater chance of being able to defend himself.

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Analysis of Medical Protective closed claims shows that these potential cases are often abandoned when the documentation contained in the record disputes the patient/plaintiff's recollection of the events. Reputable plaintiffs' attorneys are often reluctant to invest their time and money in pursuing cases when the record clearly highlights the doctors' clinical skills, compassion for the patient, and attempts to ensure patient compliance. Even if a patient is successful in filing a lawsuit beyond the normal time constraints, the existence of the record will keep all parties focused on the standard of care that was in effect at the time the patient received the allegedly problematic care. The availability of records may offer the primary reason for the doctor's successful defense. In many lawsuits, the patient's expert witness and the doctor's expert witness are diametrically opposed in their determination of whether or not the patient was the victim of negligence. When this happens, juries often rely upon the only "neutral" witness that can speak accurately and contemporaneously about the disputed care or treatment. This witness, juries say, is the patient's record. In effect, the experts cancel each other out—and the record speaks for itself. The documentation often existed before any dispute occurred. Along with his clinical observations, the doctor may also have noted

the patient's lack of participations, failure to comply with the accepted treatment, and other factors that may have altered the doctor's ability to ensure a successful outcome of the patient. **Reprinted with the permission from Medical Protective. This is one of the many articles appearing in the risk management publication, Protector, published by Medical Protective. The insightful, timely article are written by GE Medical Protective experts to help customers mitigate risk in their practice.**

## THE GOVERNMENT WEIGHS IN: WHAT'S CAUSING INCREASED MEDICAL MALPRACTICE PREMIUM RATES.

October 2003 – by Charles Kolodkin

The **General Accounting Office (GAO)**, the audit, evaluation, and investigative arm of Congress prepared perhaps the best analysis recently done of the factors influencing medical malpractice insurance. The report issued June 29, 2003, GAO 037702, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," focuses exclusively on physicians medical malpractice insurance; it does not address liability insurance for hospitals and nursing homes.

The report, the result of over a year of research, concludes that multiple factors contribute to the rise in rates, but the chief culprit is increased **LOSSES**. Perhaps because the GAO did not conclude that insurance company mismanagement, malfeasance, or misconduct caused the current medical malpractice insurance problems and the agency did not make significant recommendations for alleviating the problems, the study's sponsors felt it did not merit further attention. Unfortunately, the media has not publicized the GAO finding widely, even as debate about tort reform amplifies and the need for unbiased information increases.

### METHODOLOGY

The GAO selected a sample of seven states, California, Florida, Minnesota, Nevada, Pennsylvania, Mississippi and Texas, for in-depth review. These states represent a valid mix of locations that are considered in "crisis", have had a rapid rise in premium rates and/or have non-economic damage caps.

As part of its research the GAO interviewed insurance regulators, medical malpractice insurers, actuaries, consumer advocates, medical professionals, and trial attorneys. Data provided by insurance companies, state insurance departments, the National Association of Insurance Commissioners (NAIC), and AM Best Co. were also evaluated. In its assessment of premiums, the GAO focused on base rates charged to three medical specialties — internal medicine, general surgery and obstetrics/gynecology. (continued on page 4)

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Rates examined were for one of the most common policies purchased, a mature claims-made policy with coverage limits of \$1m each incident /\$3m aggregate.

As the title indicates, multiple factors have contributed to increased medical malpractice insurance rates for physicians, but the principal contributor has been the rapid growth in insurers' losses from claims. Claim losses include not only the settlements and judgments paid by carriers to the claimants on behalf of their physician-insureds, but also most of the expenses incurred in the defense of a claim.

The swift rise in loss costs has become more pronounced since 1998. After adjusting for inflation, the GAO found paid losses rose approximately 3% annually from 1988 to 1997, but rose 8.2% annually from 1987-2001. The trend for incurred losses was even harsher: from 1988 to 1997, incurred losses rose approximately 3.7% annually, but from 1998-2001 the annual increase was 18.7%.

Interestingly, the GAO found wide disparities in rates of increases among the seven states, with some states experiencing significantly higher increases in losses than others. For example, during the period 1998-2001, paid losses in Pennsylvania and Mississippi rose approximately 76.9% and 142.1% percent, respectively, while paid losses during the same period in California and Minnesota increased only 38.7% and 8.7%, respectively. Thus, it is not really surprising that Pennsylvania and Mississippi physicians are having more difficulty finding affordable insurance coverage than are their peers in Minnesota and California.

Incurred losses are the largest cost component for medical malpractice insurers. The GAO examined the 15 largest insurers of medical malpractice coverage for 2001 and found incurred losses, including payments to claimants and the expense associated with defending claims, comprised around 78% of the insurers' total costs. Since insurance companies calculate their premium rates based on their expected costs, anticipated losses are the key determinant of premium rates.

#### **INVESTMENT INCOME**

Another factor that has created an upward spiral in pricing is the decrease in investment income experience by medical malpractice insurers. Generally, insurers are required by state insurance regulators to reflect expected investment income in their premium rate calculations, so bad investment performance will put upward pressure on rates. The fall in investment returns suffered by insurance companies over the past 3 to 4 years is a circumstance that has been poorly understood and explained. A number of commentators attribute the decline in insurance company investment income to equities, mention the stock market bust, and then point to the Dow Jones Index as evidence.

In actuality, state laws restrict medical malpractice insurers to conservative investments, primarily bonds. On average, the 15 largest writers of this insurance had about 79% of their assets invested in bonds, usually a combination of U.S. Treasury, municipal and corporate bonds. Yields on bonds have certainly dropped over the past couple of years, but according to the GAO, declines in investment returns have probably caused premium rates to increase just 7.2% from 2000 to 2002. Thus, the decline in investment income has had only a modest influence on premium rates, far less than the adverse claim payment trend.

#### **PROFITABILITY**

The GAO report confirms that since 1999, the profitability of the medical malpractice insurance market as a whole had declined. This had occurred even in an environment of rising premium rates. Profitability declines have caused a number of insurance companies to exit the marketplace, which in turn reduces the competition and minimizes any downward pressure on premium rates. The negative trend in profitability has occurred in all of the states studied by the GAO, however, it is less evident in California, which helps explain why California premium rates have not been as volatile as other states. *(continued on page 5)*

## REINSURANCE

Almost all medical malpractice insurers purchase reinsurance to protect themselves against large, unpredictable losses. This is particularly true of the smaller physician-controlled insurers who are typically members of the Physician Insurers Associations of America (PIAA), and sometimes warmly referred to as “bedpan mutuals.” The GAO found physicians-owned insurers now cover about 60% of the marketplace. These insurers depend significantly on reinsurance to help stabilize their income statements and cash flow since a few large claims will have a measurable impact on their surplus.

Reinsurance costs incurred by medical malpractice insurers have noticeably risen the past couple of years. The GAO identifies two reasons: (1) overall reinsurance rates have increased as a result of reinsurers’ losses from the September 11, 2001, terrorist attacks, and (2) reinsurers have seen higher losses from medical malpractice than other lines of insurance and are raising their rates to compensate for the increased risk associated with medical malpractice. Accordingly, medical malpractice insurers are passing along these higher reinsurance costs to their physicians-insureds.

## SCARCITY OF DATA

A continuing source of frustration to anyone wishing to do an in-depth analysis of medical malpractice claims frequency and claims severity patterns is the lack of comprehensive claims data. The GAO experienced this during its research. Data submitted by insurers to the NAIC regarding number of claims is not broken out by state, and the NAIC only began collecting data measuring case severity in 2000.

Furthermore, assuming insurers actually track their losses to identify the amount of payments attributable to settlements versus judgments, and non-economic damages versus economic damages, this data is not provided to the NAIC or state insurance departments. The GAO fittingly observed that comprehensive information is vital to effectively study losses and for a better understanding of the causes of increased premium rates.

In fact, the only recommendation made in the GAO report is to have Congress consider encouraging the NAIC and state insurance regulators to identify and collect additional data necessary to evaluate to frequency, severity, and causes of losses on medical malpractice claims.

## CONCLUSION

The General Accounting Office (GAO) recently completed an extensive study of medical malpractice insurance industry and the factors that have caused premium rates to increase. The study found this business line to be unprofitable mainly on account of a persistent upward trend in claims costs. Due to its thoroughness and the lack of bias of its authors, the GAO report should be the basis for discussion on issues effecting medical malpractice insurance, including tort reform. The only action the GAO recommends is implementing a better process for gathering data necessary to evaluate the medical malpractice market.