Wyoming Healthcare Commission

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October 28, 2003

Senator Curt Meier and Representative Tony Ross: Co-Chairmen, Corporations, Elections, and Political Subdivisions joint interim committee;

Senator Charles Scott and Representative Doug Osborn: Co-Chairmen, Labor, Health and Social Services joint interim committee

Recommendations relating to Enrolled Act No. 90 (Original House Bill 0261)

Enrolled Act No. 90 directed the Wyoming Healthcare Commission (WHC), in concert with the Wyoming Insurance Commissioner, to determine the feasibility of a number of potential alternatives to Wyoming's current medical malpractice insurance market. The attached study represents a true collaboration between the WHC and the Wyoming Insurance Department.

The bill required the inclusion of 8 specific elements within this study:

1. **Determine the feasibility of establishing a joint underwriting association (JUA) comprised of all casualty insurers in Wyoming to provide medical liability insurance on a self-supporting basis**
2. **Determine the impacts of a JUA on the current Wyoming medical liability market**
3. **Calculate the rate and reserve fund requirements for solvency of a JUA**
4. **Calculate the level of policy holder participation needed to sustain a JUA**
5. **Determine the feasibility of revising and using W.S. 26-33-101 through 26-33-111 to create a medical liability compensation fund**
6. **Determine the feasibility of establishing a provider owned medical malpractice mutual insurance company including possible mechanisms for providing start-up assistance by the State of Wyoming**
7. **Determine the feasibility of establishing a provider liability risk retention group**
8. **Assess the ability of the state to respond to a crisis through the establishment of any of the alternatives listed above**

Due to the compressed time frame available, we extend our sincere appreciation to the co-chairmen of both the joint interim corporations, elections and political subdivisions committee and the labor, health and social services committees for allowing us an extension of the original reporting deadline, from October 15, 2003 to October 31, 3002. This additional time was essential

in allowing us to conduct a more thorough investigation and produce higher-quality data upon which to base WHC recommendations.

A large volume of Wyoming-specific data was generated in order to accurately assess current market conditions with respect to the availability and affordability of medical liability insurance in Wyoming. A complete summary of our Wyoming physician survey is included as part of this report, as well as the results of a comparative study of medical malpractice base rates for Wyoming and surrounding states.

Merlinos and Associates, a Georgia-based actuarial consulting firm, was hired to provide specific information about the levels of reserves and premiums which would be required to operate a self-supporting insurance entity in Wyoming, both on a competitive and an insurer-of-last-resort basis. Preliminary draft recommendations were prepared by Kenneth G. Vines, Wyoming Insurance Commissioner; and final recommendations were adopted by the Wyoming Healthcare Commission at their meeting on October 27, 2003.

Thank you for the opportunity to provide this information for the use of the Wyoming Legislature. If you have questions or comments, please do not hesitate to contact WHC Director, Diane Harrop.

Sincerely,

T. Chris Muirhead

T. Chris Muirhead, Chairman
Wyoming Healthcare Commission

Kenneth G. Vines

Kenneth G. Vines,
Wyoming Insurance Commissioner

P.O. Box 2760 (100 West Midwest Ave., Third Floor) · Casper, WY 82602
E-Mail: dharro@state.wy.us · *FAX (307) 235-3266* · *PHONE (307) 235-3227*

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JOINT UNDERWRITING ASSOCIATION STUDY

Wyoming Healthcare Commission
Wyoming Insurance Commissioner

I. INTRODUCTION

During the 2003 Legislative Session, House Bill No. 0261 was enacted as Enrolled Act No. 90. (Chapter 151, Session Laws of Wyoming, 2003) This legislation required the Wyoming Health Care Commission (WHC), with the support of the Wyoming Insurance Commissioner, to conduct a study on the feasibility of establishing a joint underwriting association for the purpose of providing medical liability insurance on a self-supporting basis. The act also requires the study of related subjects.

A. Summary of Enrolled Act No. 90

Enrolled Act No. 90 clearly details the parameters of this study. The central requirement of the study is to investigate the feasibility of establishing a joint underwriting association comprised of all insurers authorized to underwrite casualty insurance in Wyoming for the purposes of providing medical liability insurance on a self supporting basis.

In addition, the law requires the WHC to investigate other related subjects. Those areas related to the joint underwriting association include the impact of such an association on the current Wyoming market for medical liability insurance; the rate and reserve fund requirements necessary for such an association to remain solvent; and the level of necessary policyholder participation in such an association.

The study is also to discuss the feasibility of revising and using the medical liability compensation account provided by W.S. 26-33-101 to 111 as the joint underwriting association; the feasibility of establishing a provider owned mutual insurance company to provide health care liability insurance including mechanisms for providing state assistance to start such a company; and the feasibility of establishing a provider liability risk retention group.

Finally, the study is to explore the ability of the state to act on a stop-gap basis in establishing any of the alternatives mentioned in the law to ensure the availability of health care services to Wyoming residents in the event of an emergency, such as the loss of some or all of the current medical malpractice liability market. Specifically, this portion of the act relates to immediate state action to ensure the availability of health care services to Wyoming residents.

A copy of Enrolled Act No. 90 is attached to this report as *Appendix I*.

B. Wyoming Health Care Commission - Jurisdiction

The Wyoming Legislature enacted W.S. 9-2-2801 et seq. during the 2003 session. A copy of this legislation is attached as *Appendix II*. This law establishes the WHC within the Governor's Office in order to study issues related to the access, cost and quality of health care for Wyoming citizens. The WHC consists of nine members appointed by the Governor. In addition, the Governor has named the Director of the Wyoming Department of Health and the Wyoming Insurance Commissioner as ex-officio members of the WHC.

W.S. 9-2-2803 sets forth the WHC's duties. Subsection (a) provides that the WHC shall develop strategies to improve health care and reduce health care and medical liability insurance costs for Wyoming citizens. The WHC is also to specifically address health care tort and liability insurance reform.

C. HOW THE STUDY WAS COMPLETED

In order to review various issues related to a joint underwriting association, the WHC determined that it would be necessary to employ a consulting actuary. The WHC assigned the Insurance Commissioner the task of locating and recommending an actuary to complete the actuarial work. After conducting a search and speaking with two actuarial firms, the Insurance Commissioner recommended to the WHC that Merlinos and Associates, Inc. (Merlinos) of Norcross, Georgia be employed as the consulting actuary. The WHC agreed and a contract was entered into with Merlinos to provide the actuarial expertise for the medical malpractice study.

Merlinos subsequently conducted research and provided actuarial information and advice to the WHC regarding JUA issues, including rate and reserve recommendations. The section of this report relating to the feasibility of a JUA relies heavily on the information and conclusions supplied by Merlinos.

The WHC also conducted a survey of Wyoming physicians in order to collect Wyoming-specific data relating to the availability and affordability of medical malpractice insurance in Wyoming. A copy of the survey and a summary of the survey results are attached as *Appendix III*.

The initial draft of this study was completed, at the request of the WHC, under the direction of the Wyoming Insurance Commissioner. The draft was reviewed by WHC members and appropriate changes made. A final report was then approved by the WHC for submission to the Wyoming Legislature.

II. CURRENT WYOMING MEDICAL MALPRACTICE INSURANCE MARKET

A Insurers Holding a Wyoming Certificate of Authority Allowing the Sale of Medical Malpractice Insurance

Any insurer that holds a Wyoming Certificate of Authority in the line of casualty is permitted to sell medical malpractice liability insurance. According to Wyoming Insurance Department records, there are currently 619 insurers licensed for casualty insurance in Wyoming. However, most insurers licensed for the casualty line of insurance do not actually sell medical malpractice insurance. There are a relatively limited number of companies that provide medical malpractice insurance in Wyoming. According to information obtained from the data base of the National Association of Insurance Commissioners (NAIC), 44 companies had some activity in the medical malpractice line of insurance in Wyoming during 2002. Of those companies only 23 wrote any direct premiums in Wyoming for 2002; and of those 24 companies, most had only nominal amounts of premium written.

B Insurers Actively Selling Medical Malpractice Insurance in Wyoming - Market Shares

The most recent numbers relating to market shares of insurers selling medical malpractice insurance in Wyoming come from the 2001 Market Share Reports for Property/Casualty Groups and Companies published by the NAIC. The report lists the top ten writers in each property and casualty insurance line in each state, including medical malpractice. For Wyoming those companies and their market share are as follows:

1	MLMIC Group (OHIC Insurance Company)	47.27%
2	Doctors Company Group	36.15%
3.	St. Paul Group*	3.43%
4	CNA Insurance Group	3.06%
5	Zurich Insurance Group (Farmers)*	2.72%

6 through 10: American International Group (2.21%); Allianz Insurance Group (1.08%); NCMIC Group (.75%); Fairfax Financial (.39%); and Markel Corporation Group (.35%).

* Currently withdrawn from the market or intending to withdraw from the market by January 1, 2004, and no longer writing medical malpractice insurance.

OHIC Insurance Company and The Doctors Company dominate the Wyoming medical malpractice insurance market. In 2002, OHIC Insurance Company wrote $7,989,549 in Wyoming medical malpractice insurance premiums and The Doctors Company wrote $4,669,690 in Wyoming medical malpractice insurance premiums. The next company in amount of Wyoming medical malpractice premium written in 2002 was Truck Insurance Exchange (Farmers) which had $422,921 in premiums. It should be noted that Farmers Insurance notified insurance regulators in September, 2003, that it is completely withdrawing from the medical malpractice insurance line on a national basis effective January 1, 2004.

Utah Medical Insurance Association (UMIA) has recently become more active in writing medical malpractice insurance in Wyoming. In 2002, it wrote $224,735 in premiums in Wyoming.

C. Summary of Rate Regulation Pursuant to the Wyoming Insurance Code

The Wyoming Insurance Department does not, in general, regulate the insurance premium rates of insurers operating in Wyoming. Wyoming is considered a "competitive" state with regards to rate regulation. In other words, the market will set and regulate rates in Wyoming. Prior approval of rates by the insurance department is not required as in some states. This has been true since 1983 when the Wyoming Legislature adopted W.S. 26-14-104 which states that a competitive market is presumed to exist except as otherwise provided by law. Rate regulation is dealt with in general in the Wyoming Insurance Code at W.S. 26-14-101 et seq.

The only exception to the competitive market in Wyoming is the situation where a specific market, or line of insurance, is determined to be "non-competitive" under the rate statute. W.S. 26-14-103(a)(vii) defines a non-competitive market. The definition includes any market in which two insurers transact more than eighty percent of the business. The NAIC 2001 market share numbers show that the medical malpractice line in Wyoming meets this definition. That means the Wyoming Insurance Commissioner has the authority to review and approve premium rates before they can be used. The Commissioner has, therefore, reviewed rates for medical malpractice insurance since the early 1990's.

Once a market has been determined to be non-competitive, the Commissioner may review those rates to determine whether they are excessive, inadequate or unfairly discriminatory pursuant to W.S. 26-14-105 to 108. The following list represents rate requests for physicians filed with the Department by the two major carriers over recent years.

<u>The Doctors Company</u>

Requested 11.6% - Granted 7.8%

1998 - Requested 1.0% - Granted 1.0%

Requested -5.3% - Granted -5.3%

2001 - Requested 12.4% - Granted 10.0%

Requested 40.0% - Granted 28.8%

2003 - Requested 18.6% - Granted 18.6%

OHIC Insurance Company

Requested -3.1% - Granted -3.1%

2001 - Requested 23.8% - Granted 23.8%

2002 - Requested 15.0% - Granted 14.6%

2003 - Pending Filing

III. JOINT UNDERWRITING ASSOCIATION

The information and data provided in this section are based upon work done by Merlinos & Associates, Inc., Actuaries and Consultants (Merlinos). A letter and exhibits from Merlinos are attached as *Appendix IV* and reflects the actuarial basis for the data in this section.

The most significant portion of Enrolled Act No. 90 requires an analysis of the feasibility of a joint underwriting association (JUA) for the purpose of providing medical malpractice insurance to Wyoming physicians and hospitals. The actuarial work done in order to determine the rates for such a JUA provide data which allows several conclusions regarding the feasibility of a JUA in Wyoming. It is important to review the material contained in *Appendix IV* in order to understand the conclusions and data presented in this section.

A. Feasibility/Rate and Reserve Requirements

A JUA is typically an unincorporated association of insurance companies formed to provide a certain line of insurance. A JUA is usually funded by the premiums paid by the policyholders and assessments. Assessments are usually only made if premium funding is inadequate to cover claims and expenses. The assessment mechanisms replace the need for the JUA to have surplus. Assessments can be paid by the policyholders or by the insurers who make up the JUA. A JUA also sets its own rates and creates its own policy forms subject to approval by state insurance regulators.

Merlinos based its rate recommendations for a JUA in Wyoming on several data sources. Because rates in a JUA must be actuarially sound, and Enrolled Act No. 90 requires any Wyoming JUA to be self supporting, Merlinos reviewed the rate filings and levels of the two major medical malpractice carriers, The Doctors Company and OHIC Insurance Company. The rate recommendations are expressed as a function of the rate level in effect for these carriers as of October 1, 2003. This "October 2003 market rate level" does not reflect the recently approved increase in rates for the Doctors Company of +18.6% nor does it reflect any rate change that may result from OHIC Insurance Company's pending rate filing. Merlinos also reviewed financial information for the industry as a whole and the relationship of JUA rates to market rates in other states. A complete list of the information used by Merlinos to make a rate recommendation can be found in the material found in *Appendix IV*.

Merlinos makes two separate rate recommendations. One is for the situation where the JUA in Wyoming is to be a competitive entity with no anti-selection. The JUA in this situation would compete with companies already in the market and would accept applications for insurance from all physicians. The physicians in this JUA would not be any more prone to losses than the average risks currently insured by market insurers.

The other recommendation is for a JUA designed as a market of last resort. This JUA would only accept risks rejected by the insurers already in the medical malpractice market in Wyoming. Physicians who seek coverage from this type of JUA would be more prone to losses than the average risks.

For a competitive JUA, Merlinos recommends rates at a level of +30% of the October 2003 market rate level. For a JUA of last resort, Merlinos recommends rates at a level of +75% of the October, 2003 market rate level. These rate recommendations are for policies issued in 2004. In other words, the rates for a competitive JUA should be set at a figure which is at the market level in effect as of October 1, 2003 plus an additional 30%. If the Doctors Company recently implemented rate change is considered and the OHIC Insurance Company implements a similar change, Merlinos recommended competitive JUA rate level is about +10% over these companies' 2004 rates. The rates for a market of

last resort JUA should be set at a figure which is at the October, 2003 market level plus an additional 75%.

With regard to why rates for a JUA are recommended at a higher level than the market rates, Merlinos indicates that such recommendations for the competitive JUA are based on industry loss experience for the past seven years, industry loss cost trends, and industry rate changes implemented during the experience period. For the competitive JUA, it is Merlinos' opinion that the October 1, 2003 market rate level is inadequate, and for this reason he recommends an initial rate level for the competitive JUA at +30% over the October 2003 market rate level. For the JUA market of last resort, Merlinos' recommendations are largely judgmental. Doctors that use this type of JUA are typically higher-than-average risks since the insurers in the market will not insure them because of their claims history. Merlinos' recommendation is based on the relationship of JUA rates to market rates for medical malpractice in other states and in other lines of business in other states. Consideration was also given to the adequacy of the current market rate level which is more adequate than it has been for at least seven years. However, the October, 2003 market rate level is still not adequate according to Merlinos' review of recent rate filings and industry experience.

With regard to initial reserves for a JUA, it is clear that any JUA established in Wyoming would need to initially devote all premiums received to establishing reserves since under the law it would have to be self supporting. It is also likely that some sort of assessment mechanism would need to be established in order to pay any claims which arise prior to the reserves being built up. As noted, such assessments could be levied against the policyholders/providers or the casualty insurance companies which make up the JUA. Some initial assessment would be needed in order to pay for the set up and administrative costs of the JUA.

In order to qualify for a certificate of authority under the Wyoming Insurance Code, specifically W.S. 26-3-108, a stock insurance company offering casualty insurance, which includes medical malpractice insurance, would be required to have minimum capital of $1,000,000 and minimum surplus of $1,000,000. A mutual insurance company from another state would be required to have minimum surplus of

$2,000,000. As noted below in Section V it is not entirely clear how much surplus a Wyoming domestic mutual insurer would be required to have, but the level of surplus would be similar to the figures noted above.

It should be emphasized that the above noted surplus amounts are minimum amounts under the statute. Any given insurance company may need more surplus in order to support the amount of risk to which it is subject.

Any statute creating a JUA probably does not need to include specific rate or reserve levels. Such rates and reserves will change over time and should only be specifically determined at the time a JUA is created. This should be done by a feasibility study provided for in the statute authorizing the JUA.

B Further Issues and Recommendations Related to a Joint Underwriting Association

As part of its review of a JUA for medical malpractice insurance in Wyoming, Merlinos made several general comments and recommendations related to JUAs in general. These items were initially made to the Mississippi Insurance Commissioner when Merlinos did similar work for the Mississippi Department of Insurance in 2002. Merlinos has stated in its letter set forth in *Appendix IV* that these recommendations are also applicable to any proposed Wyoming JUA.

These recommendations are important enough to be restated here:

i. A JUA should be designed as a market of last resort. Generally, a JUA should not compete by offering lower rates, broader coverage or higher limits than the voluntary market. This recommendation is significant to insurance regulators such as the Wyoming Insurance Commissioner because it is important to preserve the current medical malpractice insurance market. Currently, Wyoming has at least three companies actively selling medical malpractice insurance. Should those companies be required to compete against a JUA, which they may be required to support through assessments, it is always possible they will decide to withdraw from the

market. This effect may occur with other casualty insurers since they also would be part of the JUA even if they do not specifically sell medical malpractice insurance. Pursuant to this recommendation, there should be a requirement that those seeking coverage under the JUA show rejection for insurance in the current market.

ii. The legislature should consider setting specific measurable criteria to determine when the JUA starts to provide coverage. In other words, at what point is the current market not providing adequate medical malpractice insurance.

iii. Any period for activation should be limited in duration. If the voluntary market returns to adequate levels, the JUA should not continue.

iv. The eligibility requirements should be broad enough to include those health care providers that can't purchase insurance in the voluntary market. It is also recommended that the JUA be able to reject some risks that do not meet underwriting criteria.

v. The legislature should consider having the JUA governed by a board of governors and the board members include representatives of health care providers and insurers and members with financial expertise. The Wyoming Insurance Commissioner also strongly recommends that any such board be given the ability to hire an administrator with JUA expertise to set up and operate the JUA. The Insurance Department does not have the expertise or staff available to actually operate a JUA. Such operation should be done by those with experience in the JUA field. The Wyoming Health Insurance Pool, a health insurer of last resort, operates in this manner.

vi. The JUA should have a mechanism in place to cover any deficit that might result from its operations. As noted by Merlinos, even with adequate rates, deficits can occur. The most likely mechanism would be an assessment of participating providers or insurers making up the JUA.

vii. The JUA should have the authority to purchase reinsurance protection in order to limit its exposure to adverse claim experience.

viii. The JUA should be regulated by the Insurance Department similar to other insurance entities.

This is another reason why the Insurance Department should not actually operate the JUA. It would be an inherent conflict to both regulate and operate the JUA.

ix. The JUA should be required to file audited financial statements and be subject to financial examination by the Insurance Department.

x. The JUA should be required to have separate actuarial opinions on rates and reserves filed with the Insurance Department.

xi. Rates should be actuarially sound. As Merlinos indicates, an actuarially sound rate is one that would cover all of the expected costs and is reasonable, not excessive, not inadequate, and not unfairly discriminatory. Because the JUA must be self-supporting, this is the most important recommendation made by Merlinos.

xii Rates should be monitored and adjusted annually. Merlinos also indicates that, initially, rates should be set as a function of market rates in anticipation of the anti-selection that is associated with a market of last resort.

xiii. The coverage offered should be no broader than that commonly purchased in the voluntary market. This typically is a claims-made coverage. Merlinos further recommends that the JUA offer mature claims-maid coverage to doctors. This avoids doctors having to purchase tail coverage from their current insurer at a cost of 150% to 200% of their current policy premium.

xiv. The JUA should offer policy limits of no greater amounts than the most common limit purchased in the voluntary market. For doctors this is typically a policy limit of $1,000,000 per occurrence and $3,000,000 annual aggregate.

xv. The JUA policy should include features for coverage termination and cancellation similar to those commonly available in the voluntary market.

Enrolled Act No. 90 also asks for an evaluation of necessary policyholder participation requirements for a JUA. The opinion of the consulting actuary, Merlinos, is that if you can get one of the insurers who currently writes malpractice insurance in Wyoming to administer it that is probably can operate with a small number of doctors, possibly are low as 25. If you can't get an insurer who already has the claim functions etc. in place

to run it, it probably won't be viable unless you get approximately 50 to 100 doctors. A JUA which is a market of last resort will not reach these numbers.

IV. REVISION OF W.S. 26-33-101 TO 111

W.S. 26-33-101 et seq. was enacted by the Wyoming Legislature in 1977. (Chapter 179, Session Laws of Wyoming, 1977) The law creates a medical liability compensation account. To qualify to participate in the account, a physician shall annually purchase health care professional liability insurance coverage of not less than $50,000 per occurrence and shall pay the surcharge provided for in the law. Any award or settlement of a malpractice claim in excess of $50,000 against a qualified physician shall be paid from the account up to a limit of $1,000,000 in any calendar year for one or more awards or settlements regarding the individual physician.

The medical liability compensation account is to be funded by requiring qualified physicians to pay an annual surcharge. The Insurance Commissioner, based upon sound actuarial principles, shall determine the amount of the surcharge, however, the surcharge cannot exceed 150% of the cost to each physician for a basic $50,000 malpractice insurance premium. The surcharge is to be collected by the insurer providing the $50,000 malpractice policy. The insurer then pays the surcharge to the Commissioner.

The Commissioner may use account monies to purchase insurance for the account and its obligations. The Commissioner may participate in a physician's defense and reasonable legal expenses incurred for such defense are payable out of the account. All expenses of administering the account shall be paid from the account. The Commissioner shall also purchase reinsurance, if needed, for the protection of the account. Such reinsurance shall cover each qualified physician from $250,000 to $1,000,000.

The law creates a medical liability compensation account board of six members. Four are appointed by the Governor with the advice and consent of the Senate. The State Treasurer and the Commissioner are the other members of the board. Of the appointed board members, one shall be a physician, one an attorney, one a health care consumer and one a licensed insurance agent.

The legislature appropriated from the general fund $300,000 for the purpose of establishing reserves and for the costs of administration of the medical liability compensation fund account. After five years from the date of the creation of the fund, the State Treasurer and the Commissioner shall adopt an amortization schedule to repay with interest as determined by the State Treasurer the $300,000 to the general fund.

To the best of the knowledge of the Wyoming Insurance Department, the medical liability compensation account was never created or implemented, nor were the appropriated funds used. The Department is not aware that a board was ever appointed. The reasons for this are unknown, although it is assumed that the medical malpractice insurance market was adequate in providing coverage to doctors and, therefore, the compensation account was not attractive to the doctors. It appears that the major disincentive for physicians in participating in a medical liability compensation account is that such participation requires a surcharge that must be paid to the account in addition to the premium already being paid for the doctor's primary coverage.

In order to be used, the current law would have to be updated as the dollar figures reflected in the law are based on circumstances as they existed in 1977. The initial policy that a physician would carry in order to qualify for the account is only $50,000. That is a very small amount as most doctors now carry $1,000,000 per occurrence and $3,000,000 aggregate coverage.

An audit report done by the South Carolina Legislative Audit Council of South Carolina's patients' compensation fund in January 2000, indicates that the seven other states with such funds required primary coverage of anywhere from $100,000 to $1 million/$3 million. (A Review of the Medical Malpractice Patients' Compensation Fund) These funds then pay anywhere from $400,000 to unlimited amounts after the primary policy amount is used depending on the particular state.

It is essentially a public policy decision where the initial policy amount should be set and where the upper limits of the compensation account should be set. This involves a decision as to how large a policy should the doctor carry as opposed to what the fund will pay. The

combination of the primary policy and the fund coverage essentially equal a medical malpractice policy that doctors currently purchase. It appears that the initial policy should provide significant coverage for the physician. It may also be difficult to obtain a low dollar medical malpractice policy from insurers who generally issue policies at the $1 million/$3 million level.

Once a policy decision is made on the level of coverage, an actuarial study would be needed in order to determine the amount of the surcharge and the level of reserves necessary to start the fund. The amount of the surcharge would also depend on the type of coverage that the fund would provide to the physicians. This is also a public policy decision that needs to be made.

A medical compensation fund may suffer some of the same problems as a competitive JUA in that it would have to be actuarially sound and may not be able to offer savings to participating physicians. The physicians would have to pay a surcharge in addition to the premium for the primary insurance coverage. This surcharge can be up to 150% of the premium they pay for their primary coverage. This may be a disincentive to doctor participation. The fund may be no cheaper for doctors than the current market.

The current law also appears to be administratively complex which may add additional costs. For instance, the surcharge payment is made to the insurer providing the primary policy and the insurer in turn pays that amount to the Insurance Commissioner. This seems to add an extra layer of administrative costs that will eventually be reflected in premium costs. The JUA model discussed above may be more efficient in providing administrative services.

Other areas of this law need to be updated. The medical liability compensation account board should be given specific authority to hire an administrator to operate the account. The administrator should make recommendations as to insurance benefits, reinsurance, claims administration, surcharge rates and other related items to the board which should have approval authority. The current law allows the Insurance Commissioner to participate in the defense of cases brought against doctors. The Insurance Commissioner should be given regulatory authority over the account, but the day to day operation of the fund, including the defense of claims,

should be left to the board through an administrator with expertise in the area.

It is questionable whether such an account would work now. It may be no cheaper to the physicians than a JUA or insurers currently in the market. It also appears to be administratively complex which may add to costs. Finally, the fact that physicians must pay both a premium and a surcharge may be a disincentive to participating in the account.

PROVIDER OWNED MUTUAL INSURANCE COMPANY

Laws currently exist which would allow the creation of a provider owned mutual insurance company. In Wyoming, Chapter 24 of the Insurance Code contains provisions which allow the establishment of domestic (Wyoming) stock or mutual insurers. A mutual insurance company is, essentially, a corporation owned by its policyholders or members. A stock company, obviously, is owned by its shareholders. An example of a Wyoming domestic mutual insurance company is Mountain West Farm Bureau Mutual Insurance Company of Laramie. Generally, mutual insurers do not generate profits as any excess income is returned to the policyholder/members as dividends or is retained in the company to support future growth.

W.S. 26-24-109 sets forth the initial requirements for a Wyoming domestic mutual insurance company. These requirements include minimum surplus amounts. The provisions contained in W.S. 26-24-109 appear to be outdated and the amount of surplus required minimal. The section gives two alternative requirements for a new mutual insurer.

Under the first alternative, the company must be otherwise qualified under the Insurance Code, must have received and accepted bona fide applications as to substantial insurable subjects, have collected in cash the full premium therefore at a rate not less than that usually charged by other insurers for comparable coverages, and have surplus funds on hand and deposited as of the date the insurance coverages become effective. This alternative appears to have no specific surplus requirement, although the "otherwise qualified" under the Insurance Code may mean

that surplus and capital requirement found elsewhere in the Code may apply.

Under the second alternative, the company must deposit and maintain surplus in accordance with a schedule listed in the statute. For the casualty line this means $100,000 of minimum surplus funds or $200,000 of surplus in lieu of the $100,000 surplus funds. The schedule in the statute also appears to limit the minimum amount of insurance on each subject to $1,000 and the maximum amount of insurance on each subject to $10,000. The section also requires the insurer electing the second alternative to maintain an additional surplus amount of not less than $50,000 or 50% of the deposited surplus required under the schedule which ever is larger.

Another section of the Insurance Code, W.S. 26-5-110, which applies to all insurers, including mutuals, requires that no insurer shall retain any risk on any one subject of insurance in an amount exceeding 10% of its surplus to policyholders. This would require a company to maintain surplus at a level that would allow coverage for the number of physicians insured. The insurer, once it began operating, would also be subject to risk-based capital requirements found in W.S. 26-48-101 et seq. This law requires the insurer to maintain a certain level of surplus based upon the risks the company is subject to.

The disadvantage of forming a mutual insurer under alternative one is that it requires the company to charge a rate not less than that usually charged by other insurers for comparable coverages. Further, it does not provide for a specific, required surplus amount. Because alternative one is subject to the requirement that insurers shall be otherwise qualified under the Insurance Code, it is likely that the Insurance Department would apply the surplus requirements of W.S. 26-3-108(a) for a foreign (state other than Wyoming) mutual insurer which is $2,000,000.

Alternative two does not appear to be a reasonable option for a medical malpractice insurer. That alternative appears to limit initial coverage to between $1,000 to $10,000 which is not realistic for medical malpractice coverage that is typically $1,000,000 per occurrence and $3,000,000 aggregate. The surplus required under alternative two appears to be $150,000 total which would

probably be insufficient to support the risk assumed by a medical malpractice insurer.

A provider owned mutual insurance company could also be formed in another state as a foreign mutual insurance company which could then become licensed to do business in Wyoming. Other state laws may be more favorable to the formation of a mutual insurance company.

Some other states have "captive" insurance laws. Wyoming does not currently have a captive law. Captive insurance companies are companies formed and owned by a corporation or firm whose purpose is to use the captive to write its own insurance at rates lower than other insurance company rates. Captives can be single owner captives or multiple owner captives and other variations also exist. Single owner captives insure the risks of their parent while multiple owner captives insure the risks of their several owners. An association of the captive's members can be a type of multiple owner captive.

Captives are formed for several reasons. They may provide benefits to its owner such as tax savings, operating cost savings, program stability and control, and program flexibility among others.

Some states have become well known as domiciles for captive insurance companies. Vermont is an example of a state that has a long history of captive laws and that has developed the regulatory expertise to oversee captives.

Whether a provider owned mutual insurance company is feasible depends on several factors. The laws are currently in place which would allow the formation of such a company. The providers interested in forming such an insurer would have to determine whether it would be feasible. They would need to have a feasibility study done by an actuary in order to determine what rates and reserves would be necessary to form the company. Like any other insurer the company would have to be actuarially sound. The providers would need to estimate how many providers are willing to become members of the insurer and whether and how much each provider would contribute to the surplus of the company. They would have to consider whether there are sufficient numbers of physicians willing to participate in the company in order to make it viable.

All of these determinations would have to be made by the providers forming the company. It is likely that an insurance consultant experienced in these types of companies would need to be employed to assist in setting up the company and running it once it becomes active. In light of the fact that provider owned mutual companies have existed for many years, the fact that none have been formed in Wyoming may lead to a conclusion that they have not been considered viable.

As far as state assistance in creating such a company, such assistance could take several forms. The state could provide initial capitalization, the state could act as a reinsurer for the company, the state could provide for the assessment of casualty insurers in the state to provide initial capitalization and start up costs, or the state could provide a loan for the start up of the company.

It is not clear that a provider owned mutual insurance company could offer medical malpractice insurance at a lower price than the companies currently in the market. As noted, the company must be actuarially sound in order to survive unless the state wants to continually subsidize the company. It is also not clear whether Wyoming providers would be willing to participate in or fund such a company, or whether there are a sufficient number of doctors in Wyoming to make such a company viable.

In summary, the ability to form a mutual insurance company exists and providers can take advantage of that law to create such companies if the providers feel such a company is viable and would save the providers money.

VI PROVIDER LIABILITY RISK RETENTION GROUP

Risk retention groups may be established pursuant to federal law. The Liability Risk Retention Act of 1986 created risk retention groups. That law amended and expanded the Product Liability Risk Retention Act of 1981. Generally, the purpose of these laws was to increase the availability of commercial liability insurance which became severely restricted in the hard market of the 1980s. Congress was attempting to aid high risk groups in securing insurance coverage at an affordable price.

The aw essentially created a category of insurers which may legally transact business in all states without

meeting traditional licensure requirements. The risk retention group is a risk bearing entity that must be chartered and licensed as an insurance company in one state. Once licensed in its domiciliary state it may operate in all states without the necessity of a license and is largely unregulated, except by the domiciliary state. The risk retention group must be owned by its insureds and the insureds must have similar or related liability exposure. Risk retention groups cannot write other types of insurance business such as property insurance.

Some reasons for forming a risk retention group include program control, affordable, tailor-made coverage not available in the conventional market, increased program efficiency, and reduced overall costs.

Non-domiciliary states do have some regulatory authority over risk retention groups. In Wyoming, a non-resident risk retention group must register with the Insurance Department prior to conducting business. Risk retention groups are also subject to examination by non-regulatory states, if the home state refuses to conduct such an exam. All regulators have the authority to apply to a United States District Court for an order enjoining the operation of a risk retention group if such group is in a hazardous financial condition.

It is important to note that a risk retention group is not covered by state guaranty associations which provide a safety net in case of insurer insolvency. If a risk retention group fails financially and becomes insolvent, state insurance insolvency guaranty funds are not available to pay claims.

W.S. 26-36-104 provides that a risk retention group seeking to be a Wyoming chartered group (Wyoming domestic) must become licensed as a liability insurance company under the Wyoming Insurance Code. W.S. 26-36-105 covers non-domiciliary risk retention groups.

As with mutual insurance companies, authority to create risk retention groups, either in Wyoming or other states, already exists and their use has been permitted since 1986. Wyoming has no domestic risk retention groups. Any group wishing to form a Wyoming risk retention group would proceed to form a casualty insurance company, either

as a mutual or stock company. The requirements for forming such an insurer are the same as set forth in Section V relating to provider owned mutual insurance companies. The group would have to meet all requirements in the Wyoming Insurance Code for creating an insurance company.

As with a provider owned mutual insurance company, the fact that no one has formed a risk retention group in Wyoming in order to provide medical malpractice insurance may lead to the conclusion that such a group would not be able to provide insurance at more affordable rates. The Wyoming Insurance Department is aware that two Wyoming hospitals are currently using a non-domiciliary risk retention group, VHA Mountain States, A Risk Retention Group, domiciled in Vermont, to provide medical malpractice insurance. Another group of hospitals from Wyoming and other states is in the process of forming a Vermont risk retention group to provide medical malpractice insurance for those hospitals.

Risk retention groups can be formed as captives although Wyoming has no captive law. Vermont is one of the main domiciles for captive insurers and risk retention groups.

The items discussed in Section V relating to mutual insurance companies also apply to risk retention groups. The rates charged by a risk retention group must be actuarially sound in order for the group to survive. In order to form a risk retention group, it would be necessary to have actuaries and risk retention consultants conduct a feasibility study to determine whether such a risk retention group would be viable. It would need to be determined whether a sufficient number of doctors or hospitals were interested in forming such a group and providing sufficient funds for the group. Risk retention groups do offer the ability to operate across state lines with ease.

The laws allowing the formation of risk retention groups are currently in place and are available for use if any group of providers believes such a group can offer medical malpractice insurance at a cost savings while remaining solvent.

VII. EMERGENCY PROVISION OF MEDICAL MALPRACTICE INSURANCE - JOINT UNDERWRITING ASSOCIATION

The use of a JUA for the emergency provision of medical malpractice insurance has been discussed to some extent in Section III above. It is important to have a prioritized list of possible emergency options available in case the current Wyoming medical malpractice insurance market collapses. With two insurers providing most of the medical malpractice insurance in Wyoming, the loss of even one company could be devastating to the provision of health care in Wyoming. Loss of an insurer can occur because of insolvency or hazardous financial condition, or it can occur because an insurer makes a business decision that it no longer wishes to offer medical malpractice policies in Wyoming. The company may also decide it is withdrawing from the medical malpractice line of business completely on a national basis.

One of the recommendations from Merlinos is that a JUA be designed only as a market of last resort. This recommendation should be extended even further to include the suggestion that legislation to create any state-sponsored medical malpractice insurance mechanism should only be enacted after some sort of dramatic disruption in the current market has already taken place. The legislature certainly could pass initial legislation which outlines a set of conditions upon which an emergency JUA might be created and activated. In the event of an emergency where medical malpractice insurance becomes unavailable through competitive markets, the enacting legislation should also provide for the structure of the JUA and contain details about how the JUA would be funded and operated. Any enacting legislation should also provide for the hiring of an administrator experienced in the creation and operation of a JUA. The funding of such a JUA could be done through some combination of premiums, assessments and state contributions. Some initial money would be needed as start up funding for the JUA.

WYOMING HEALTHCARE COMMISSION RECOMMENDATIONS

BASED ON THE 8 SPECIFIC ELEMENTS REQUIRED BY ENROLLED ACT NO. 90

1. WHC members considered three possible JUA types and ultimately concluded that none of the three are acceptable options for Wyoming, given the legislative requirement that a JUA must be self-supporting and given the over-riding intention of not creating a situation that would have the effect of forcing current medical malpractice insurance providers and/or physicians out of the state. Also, in any of these cases, a separate entity must be created and be responsible for administering these insurance entities, since it would be a clear conflict of interest to ask the Wyoming Insurance Department to both operate and regulate a JUA or any of the other alternatives.
    a. A *competitive JUA* that is self-supporting is certainly a possibility, but is not likely to be attractive to medical providers. Such a JUA would need to be actuarially sound which means it would probably have to set rates at or above the rates charged by current medical malpractice insurers. The Merlinos actuarial study estimates a rate of +30% of the current market rate for a competitive JUA. Further, such a JUA would need to incorporate some type of assessment mechanism in case premiums are not adequate to cover claims. Medical providers may not wish to participate in a JUA which allows the providers themselves to be assessed over and above their premium rates. Finally, a competitive JUA may disrupt the current medical malpractice insurance market in Wyoming. For these reasons, the WHC recommended against the creation of a competitive JUA.
    b. The creation of a *JUA of last resort*, dubbed a *cherry-picking JUA* by members of the WHC, also presents a unique set of problems. All agreed that having such a mechanism in place might, in and of itself, encourage insurers to leave the state—or worse—to drop higher-risk physicians,

and/or discontinue writing policies to cover selected high-risk specialty areas such as OB, emergency medicine, or surgery; thus guaranteeing that the JUA would suffer from adverse selection difficulties from the outset. As a result, premium and assessment rates are likely to be extremely high. Also, with this approach, the likelihood of ever being able to sunset the JUA would be very low, because high-risk medical providers who opted for this coverage would have limited outside options for other sources of insurance. The WHC, therefore, recommends against adoption of a JUA of last resort.

c. An *emergency JUA* which could be activated in the event of a severe disruption of, or loss of, critical facets of the current medical malpractice market would appear to be prudent, but could actually precipitate this kind of crisis if developed in anticipation of an actual crisis. While the WHC recommends against the creation of an emergency JUA at this time; if a crisis were to develop, an emergency JUA is an appropriate option to consider. If an emergency JUA is created, the elements of sections III-A & B of the JUA study narrative should be reviewed and used as guidelines.

2. Dual impacts on current markets must be considered:

a. Obtaining sufficient funding to operate a JUA on a self-supporting basis is problematic. For premiums and assessments charged to participating medical providers to adequately self-fund a JUA, rates would be from 30% to 75% above current market rates. If, as Enrolled Act 90 suggests, all 619 insurance carriers licensed to underwrite casualty insurance in Wyoming were to be assessed additional amounts to provide a wider funding mechanism, these providers—most of whom do not sell medical malpractice insurance—might consider this a strong incentive to cease doing business in Wyoming with other lines in which they are active. There is also the question of whether or not the state could legally assess one group of insurers to cover the risks of another group.

b. WHC research (*Appendix III*) supports the conclusion that Wyoming's current medical malpractice insurance crisis is not one of

availability, but of affordability. Thus, any solution that potentially raises rates would be seen as counter-productive; as would any approach that provides subsidies that would allow a Wyoming JUA to unfairly compete with the major medical malpractice carriers currently writing medical malpractice policies in Wyoming. For these reasons, the WHC recommends great caution when considering any state-sponsored insurance mechanism that affects competitive markets.

3 Rate and reserve fund requirements are addressed in-depth in Section III-A of the study narrative and in *Appendix IV*. The WHC concluded that an actuary should immediately be retained if any crisis measure is adopted, in order to determine exactly what rates and reserves might be required to support the insurance mechanism being created. These numbers will vary significantly depending upon a wide range of factors: the type of insurance mechanism being used, the potential number of participating policy-holders, current market conditions, the level of state subsidies available, etc. For most of the alternatives considered as part of this study, the amount for minimum start-up surplus was estimated to be $2,000,000. Rates for individual medical practitioners ranged from 30%-75% above competitive market rates now being charged by OHIC and The Doctors' Company. Also, additional assessments (or state subsidies) might also be needed to cover losses if premiums are not sufficient.

4 Levels of policy-holder participation necessary to guarantee that a new insurance entity would be self sustaining are dependent upon a variety of factors, including the question of whether or not a company currently operating in the Wyoming market would be willing to administer the state's program. In this case, a JUA could probably operate with as few as 25 policy-holders. If no existing structure is available to administer it, minimum requirements would be 50-100.

5 Revising and using a medical liability compensation account as defined by W.S. 26-33-101 through 111 has some potential, but the WHC concluded that the existing statute would need major revisions and would

be useless in an emergency situation where insurers have left the market.

a. For medical liability compensation accounts to work, there have to be existing insurance companies in the market willing and able to offer the first layer of coverage—usually in limits of $200,000/600,000 or $250,000/750,000—to medical providers, who can then turn to the state compensation account for the remainder in order to reach total $1/$3 million or $2/$6 million levels that are common today. In the case of a crisis where major insurers have left the state or decline to write new policies, voluntary market options for obtaining this first insurance layer may not exist.
b. There are serious questions as to whether or not current major insurers would consider this an incentive or disincentive to continue doing business in Wyoming.
c. More research will be done on this option, since several other states have developed and are successfully using medical compensation accounts; notably Nebraska, Kansas, and Indiana. As part of its on-going research, the WHC will conduct an inquiry to determine whether or not tort reforms in those states are instrumental to the success of medical liability compensation account mechanisms.
d. W.S. 26-33-101 to 111 was passed in 1977 but never implemented. This type of medical liability account may be no cheaper to physicians than a JUA or rates offered by insurers currently in the voluntary (competitive) market.
e. The law is also administratively complex which may add to the costs of providing coverage. The fact that physicians must pay both premiums and a surcharge may be a disincentive to participation in the account.
f. For now, the WHC's consensus opinion is that this does not provide an effective emergency response, but more research will be done to determine its value as an alternative mechanism if all-out crisis does not develop. Any positive recommendations involving this option for use on a non-crisis basis will be forwarded to both joint interim committees after November 17, 2003.

6. Provider-owned medical malpractice mutual insurance companies can be formed now, so the fact that one has not been started leads the WHC to believe that this is not economically feasible.
    a. One especially troubling requirement in the existing statutes is that, under some circumstances, these entities cannot undersell others in the market. There could certainly be opportunities for state assistance in starting one of these, but current regulations would have to be revised.
    b. The state could provide initial surplus amounts, act as a re-insurer, devise and operate an assessment mechanism or provide a loan for start-up costs, however, the WHC does not see enough potential to recommend this approach as a solution to current problems.

7. Provider risk retention groups are currently allowed under federal law, but there is very little regulatory authority by state insurance departments over them.
    a. Since risk retention groups are possible to use now without enacting any additional laws, the WHC determined that this approach would not provide an effective response to a medical malpractice emergency in Wyoming.
    b. Other states have much more experience with risk retention groups than Wyoming does, so it would be logical to look to other states for help with developing and managing one. Ideally, Wyoming could join together with one or two other states to form a risk retention (or physician's mutual insurance) group, where risks could be spread over larger numbers of medical providers. It must be noted, however, that, COPIC in Colorado has already declined to expand into the Wyoming market.
    c. The fact that these entities are not covered by the guarantee association that acts as a safety net if a company were to become insolvent was also cause for concern since that might lead to injured Wyoming people being denied appropriate compensation.

8 Responding to a crisis situation is the main focus for all considerations for each of these alternatives.

a. Considering that Wyoming's current problems are more with affordability than availability *(Appendix III and Appendix V)*, the WHC has a high level of concern that creating and adopting a legislative response before an out-and-out crisis should develop may, in fact, precipitate the very crisis we would all like to avoid.

b The WHC will be prepared to present a prioritized list of potential approaches that could be considered by the Wyoming Legislature if a medical malpractice insurance *access* crisis develops, but we recommend that these not be directly considered until or unless a crisis-level situation produces an urgent and compelling need for immediate legislative action. This list will be produced following further discussions at the November 17 meeting of the WHC.

c. The final observation of the WHC is this: if the goal of the legislature in directing this study was to identify effective mechanisms for providing cost-effective alternatives for medical malpractice insurance premiums for Wyoming physicians, none of the proposed insurance alternatives mentioned have the potential do this *on a self-supporting basis.* However, if the state is willing to provide on-going subsidies, several of these alternatives could be made to work.

APPENDIX I

ORIGINAL HOUSE
BILL NO. 0261

ENGROSSED

ENROLLED ACT NO. 90, HOUSE OF REPRESENTATIVES

FIFTY-SEVENTH LEGISLATURE OF THE STATE OF WYOMING
2003 GENERAL SESSION

AN ACT relating to insurance; requiring the Wyoming health care commission with the support of the insurance commissioner to conduct a study to establish a joint underwriting association for purposes of providing medical malpractice insurance; imposing study and reporting requirements; providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1

(a) The Wyoming health care commission with the support of the Wyoming insurance commissioner shall conduct a study on the feasibility of establishing a joint underwriting association comprised of all insurers authorized to underwrite casualty insurance in Wyoming for purposes of providing medical liability insurance on a self-supporting basis. The study shall investigate the impact of the association upon the current market for medical liability insurance, shall review rate and reserve fund requirements necessary for association solvency and shall evaluate necessary policyholder participation requirements. The study shall also:

(i) Evaluate the feasibility of revising and using the medical liability compensation account provided by W.S. 26-33-101 through 26-33-111;

(ii) Evaluate the feasibility of establishing a provider owned mutual insurance company to provide health care liability insurance including mechanisms for providing state assistance to start such a company;

(iii) Evaluate the feasibility of establishing a provider liability risk retention group; and

(iv) Evaluate the ability of the state to act very rapidly on a stop-gap basis in establishing any of the alternatives considered pursuant to this section in the event a sudden emergency requires immediate state action to ensure the availability of health care services to Wyoming residents.

(b) On or before October 15, 2003, the Wyoming health care commission and the insurance commissioner shall report study findings to the joint corporations, elections and political subdivisions interim committee and the joint labor, health and social services interim committee. The report shall include consideration of all the options set forth in subsection (a) of this section and shall include recommendations on the feasibility of establishing a joint underwriting association in Wyoming for purposes of providing medical liability insurance.

APPENDIX II

ORIGINAL HOUSE
BILL NO. 0046

ENGROSSED

ENROLLED ACT NO. 71, HOUSE OF REPRESENTATIVES

FIFTY-SEVENTH LEGISLATURE OF THE STATE OF WYOMING
2003 GENERAL SESSION

AN ACT relating to health care; establishing a health care commission within the governor's office; providing for membership; authorizing advisory committees as specified; specifying duties; requiring the commission to submit its recommendations to the legislature as specified; authorizing the commission to hire a director and staff; providing an appropriation; providing for the termination of the commission, board and staff positions as specified; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 9-2-2801 through 9-2-2804 are created to read:

9-2-2801. Health care commission created; membership; salary; meetings; advisory committees.

(a) The Wyoming health care commission is established within the governor's office to study issues related to the access, cost and quality of health care for Wyoming citizens.

(b) The commission shall consist of nine (9) members appointed by the governor.

(c) Appointed commission members shall serve until completion of duties delegated to the commission under this article. If a vacancy occurs on the commission, the governor shall appoint a new member to fill the vacancy for the remainder of the term. The governor may remove members as provided in W.S. 9-1-202. Commission members who are not state employees shall receive a salary equal to the per diem paid members of the Wyoming legislature under W.S.

28-5-101 for each day of actual service and when engaged in necessary travel plus necessary expenses.

(d) The governor shall designate one (1 member to serve as chairman.

(e) The commission shall meet at the call of the chairman. Five (5) members shall constitute a quorum.

(f) As used in this article, "commission" means Wyoming health care commission created by this section.

(g) The commission may form advisory committees to assist with its duties imposed under this article. Advisory committee members shall serve until completion of duties delegated by the commission. Services rendered by advisory committee members shall be voluntary and shall not be compensated, except for meal, lodging and travel expenses as provided in W.S. 9-3-102 and 9-3-103. Members of advisory committees shall meet at the call of the chairman of the advisory committees.

9-2-2802. Director; appointment; duties; additional staff; qualifications.

(a) The governor, with the consent of the commission, shall appoint a director who shall serve at the pleasure of the commission. The director shall:

(i) Serve as administrative head of commission;

(ii) Perform duties prescribed by the commission and assist the commission in carrying out the duties imposed under this article; and

(iii) Not be subject to W.S. 9-2-1019, 9-2-1022 and 9-3-101 through 9-3-104 but shall receive compensation and be reimbursed for travel and other necessary expenses as prescribed by the commission and approved by the governor.

(b) Subject to approval by the commission, the director may employ one (1) staff member to assist the commission in performing its duties. The staff member shall possess those administrative, technical, professional and clerical qualifications determined necessary by the commission. All staff to the commission shall serve at the pleasure of the director.

(c) The commission may contract for services with recognized health care systems experts as necessary to assist in the technical aspects of data development, review and analysis.

9-2-2803. Health care commission duties; report; open meetings; attorney general to represent; rulemaking.

(a) The commission shall develop strategies to improve health care and reduce health care and medical liability insurance costs for Wyoming citizens by holding public meetings throughout the state, hearing from experts and other interested parties, studying and researching other states' actions on health care and medical liability insurance reform, studying and utilizing Wyoming data, considering past efforts, including, but not limited to, the report issued by the Wyoming health reform commission on December 1, 1994, and future possibilities that can be useful in decision making by addressing the following:

(i) Access to an affordable, effective and quality health care system for Wyoming, including rural areas of the state;

(ii Access to affordable health insurance;

(iii) Issues of wellness and individual responsibility for personal health;

(iv) Disease prevention and management;

(v) Health care tort and liability insurance reform;

(vi) Workforce shortages among medical provider professions;

(vii) Cost shifting by medical providers that occurs as a result of low reimbursement from public and other programs;

(viii) The aging population in Wyoming and the long term care services that will be needed by that population;

(ix) The implications of any reforms nonhealth care activities;

(x) A system to investigate and reduce health care errors with the provision of compensation for errors due to negligence on a schedule as an exclusive remedy;

(xi) Other issues as deemed appropriate by governor and the commission.

(b) The commission shall consult and coordinate with the state planning grant task force within the department of health on issues relating to health insurance. The governor may make the state planning grant task force subordinate to the commission, assign the commission director as executive secretary of the state planning grant task force or merge the task force into the commission.

(c) The commission shall submit to the legislature, joint labor, health and social services interim committee and the governor a preliminary report on its findings no later than June 30, 2004, and a final report with its recommendations for legislative changes by December 1, 2004.

(d) Every two (2) months the commission shall submit a written progress report to the joint labor, health and social services interim committee. The committee shall create a subcommittee to meet jointly with the commission, as appropriate and subject to the agreement of the chairman of the commission, and prepare legislation necessary to implement commission recommendations. The subcommittee shall submit recommended draft legislation to the joint labor, health and social services interim committee for consideration.

(e) Public hearings of the commission shall be held in accordance with W.S. 16-4-401 et seq. The attorney general shall be the legal adviser of the commission.

9-2-2804. Termination of article

W.S. 9-2-2801 through 9-2-2803 are repealed effective June 30, 2005.

ORIGINAL HOUSE
BILL NO. 0046

ENROLLED ACT NO. 71, HOUSE OF REPRESENTATIVES

FIFTY-SEVENTH LEGISLATURE OF THE STATE OF WYOMING
2003 GENERAL SESSION

Section 2. There is appropriated three hundred fifty thousand dollars ($350,000.00) from the budget reserve account to the governor's office for the period beginning April 1, 2003 through December 30, 2004 to implement the purposes of this act. Notwithstanding W.S. 9-4-207, the appropriation under this section shall not lapse at the end of the biennium ending June 30, 2004.

Section 3. This act is effective immediately upon completion of all acts necessary for a bill to become law as provided by Article 4, Section 8 of the Wyoming Constitution.

(END)

Speaker of the House

President of the Senate

Governor

TIME APPROVED: 5:47 pm
DATE APPROVED: 3/4/03

I hereby certify that this act originated in the House.

Chief Clerk

APPENDIX III

Wyoming Healthcare Commission

T. Chris Muirhead, Chairman

COMMISSIONERS:
George Bryce
Ford Bussart
Stacy J. Childs, M.D.
Carol V. Jenkins
Paul A. Lang
Dixie M. Roberts
John H. Vandel
Robert Volz, M.D.

Diane Harrop, Director
Emily Genoff, Assistant

Affordability and Availability of Medical Malpractice Insurance Survey Summary

In October 2003, the Wyoming Healthcare Commission surveyed the Wyoming Board of Medicine's 907-physician database regarding the affordability and availability of medical malpractice insurance. There were 365 respondents, or 40% of physicians licensed to practice in Wyoming; 97% of the respondents reported being in active practice while 3% of the respondents were locum tenens, or had retired, moved, were on leave.

The respondents' practices are devoted to the following specialties:

Family/general practice	25%
Internal medicine	10%
General surgery	6%
OB/GYN	6%
Pediatrics	6%
Radiology	6%
Orthopedic surgery	4%
Emergency Medicine	3%
Ophthalmology	3%
Urology	3%
Anesthesiology	3%
Orthopedics	3%
Cardiology	2%
Dermatology	2%
Psychiatry	2%
Pathology	2%
Otolaryngology	2%
Other specialties	12%
Total	100%

Only 10% of the respondents reported being non-renewed, cancelled or denied medical malpractice coverage within the past three years.

Of these, 44% were cancelled or non-renewed because their carriers discontinued medical malpractice coverage in Wyoming. Another 21% said they lost coverage because they, or their partners, had a claim filed against them, and 6% said they had been non-renewed but fought successfully to get coverage back. Other reasons cited:

- At the very last minute, insurer decided not to write any new ER policies. Nearly ended up having to close ER!
- New provider in state of Wyoming where few rehab specialists exist. No pool to draw upon. Denied by insurer.
- I was non-renewed by insurer when they assumed I was responsible for a patient's problem. They retracted this after proof that I was out of Wyoming at the time of the event in question.
- When I asked for a quote on a new insurance premium from another company, I was denied OB coverage because my estimate of 100 deliveries during my residency 1980-83 showed a lack of experience. I have delivered babies for 20 years in practice. Can you figure that?
- "High risk" specialty in "high risk" state.

Only 15% reported having any claims in the past three years.

Of those, 56% had one claim, 20% had two claims, and 7% reported three or more claims. More than half -- 53% -- reported *no judgments against them*. Another 22% said litigation is still pending on the claims filed against them, and 11% reported judgment amounts ranging from $15,000 to $500,000.

More than half, 53%, also reported *no settlements in the last three years*, and 22% reported settlement amounts ranging from $20,000 to $600,000 on about a dozen claims. Other comments:

- Carrier "settled" with a patient who did not sue but threatened to. I am not sure how much; I had to sign a letter saying carrier could do whatever they wanted without my permission.
- Carrier spent approximately $100,000 on defense preparation.

In 2002 and 2003, the Doctor's Company and OHIC covered about 85% of physicians in Wyoming, with about a 50/50 split between the two companies.

More than 70% of physicians choose $1 million/$3 million coverage, while 20% chose higher coverage amounts.

Given an opportunity to comment, several physicians noted that premium costs are escalating despite the absence of claims against them or changes in coverage. Some said they fear for their insurance carriers' financial viability. Others said their employers and/or Wyoming hospitals provide coverage:

- Our hospital is forming a group and self-insuring – our present coverage is more expensive for less coverage.
- Premium dropped by a factor of 15! I'm paying 1/15 of my Wyoming rate now (moved out of state)
- I can't lose the feeling that carrier is a "house of cards."
- Too high for ENT; not doing plastic surgery.
- I'm in half-time practice and thus get a lower rate.
- Group rate with physician organization.
- Carrier's mature premium will be $500,000 a year.
  Changed malpractice carriers due to increasing premium and possibility of carrier's bankruptcy and continued downgrading. Changed limits carried due to high premiums.
- Premium 2002: $30,592, 2003: $42,971.
- Carrier considered me to have two losses – even though both cases were dropped. One more suit for any reason and I'm sure they would have dropped me, so I switched to another carrier, who sees me as someone with no cases.
- My insurance cost increased 86% (currently $40,000 per year) over the three years I have practiced in Wyoming, despite no complaints, lawsuits or other actions against me!
- Dropped by carrier in June but reinstated after review. Changed to another carrier voluntarily.
- Rates keep going up due to increasing malpractice claims. We need tort reform!
- Significant concerns over stability and viability of the company in lieu of best rating.
- Premium tripled while limits halved, effectively a 600% increase plus I paid a "tail" to carrier – an additional $34,000.
- The "average" OB malpractice settlement is approaching in some states over $1 million. I can't afford adequate coverage to have to pay $1 million.
- Raised limits due to risk in Wyoming.
- Carrier is discontinuing all medical malpractice coverage in 2004 so we are finding new coverage once again.
- Self insured
- Malpractice more than 200% increase from Colorado to Wyoming
- I think carrier cancelled me due to I am approaching 55 when I could retire and not pay a tail. This way they can cancel me and charge a $60,000 tail.
- Did discuss lowering amount of coverage.
- Was told I would have to pay $2,000 more per year to cover a <u>voluntary</u> job as medical director of drug rehab clinic I have done for almost 20 years.
- I work 20 hours or less weekly. For malpractice coverage, I pay $5,600 <u>with</u> discounts. The base premium is $12,500.
- This level of insurance required by hospital in order to have hospital privileges

- Premium went up 40% in one year
- Rates increased by 300%
- Part time practice – cost of insurance is a problem.
- Carrier went from $10,000 to $50,000 per MD.
- Changed from modified occurrence to claims made and reduced limits.
- Carrier is in financial trouble -- if they go under we are not covered for previous years, since no one would pick up the tail!

60% of respondents indicated that their medical malpractice premiums increased by over 25% from the previous year; 40% reported that their premiums increased 25% or less from the previous year.
11% said their increases were from 51% to 100%, 6% said their increases were from 101% to 200%, and 4% said they were paying an increase of more than 200%. In the comment section, physicians detailed their insurance premium costs and anticipated that the situation will only get worse:

- Tripled upon my move here from Colorado to practice full time (had been part time).
- We renewed before the large increase. It will hit us hard next year
- I am paying a $30,000 "surcharge" per year. Have been told by carrier that OB/GYN rates are rising another 15% in 2004.
- It would have been about 50% if we were to continue OB. We dropped it.
- It went down based on changes in practice.

More than half of the respondents (56%) are insured as individuals, while one third (33%) are insured with a group/clinic – and some have coverage in both categories.

Only 9% reported they are covered as employees of a hospital or medical facility. Some said they attach themselves to a facility for the protection afforded:

- Forced to become employee – had less than 36 hours before we closed the ER completely
- OB coverage is on our hospital policy (2)
- I am attached to hospital pathology group for purpose of insurance coverage (premium costs). Am not associated with their hospital practice.

Most (73%) said their insurance coverage had not changed since 2001, other than in price.

19% of those responding said they restricted the type of procedures performed in order to obtain their current medical malpractice coverage. However, the most commonly dropped procedures were OB (particularly VBACs, c-sections, tubal ligation), sigmoidoscopy, surgery, ER coverage, high-risk procedures, and vasectomies. Reasons cited for limitations in practice ranged from lowering the risk of litigation and the price of insurance to being forced to change their practices by their insurance carriers:

- Because of the predation by vicious amoral predators and unreasonable tort law.
- No potentially litigious patients.
- Generally free care with enormous liability downside potential.
- If I can't find affordable insurance, less than $100,00 per year, it will be necessary to leave practice.
  Costs too much. Will leave late 2004 from Wyoming with practice and move to a "capped" state where coverage will not cost 1/10th of current. Higher cost of living at new job, but total still markedly less than current or future in this state.
- Statement from insurance company represented that they may not cover a claim if it happened during an office procedure. The company will not officially say they will or won't.
- Insurance mandate.
- Our coverage would have cost three times what it does now.
- To try to keep insurance and keep costs down. Would have been $50,000 year higher if still in OB.
- If I do any surgical procedure I have to pay double the amount.
- Am part-time and don't want the hassle.
- Cost of liability insurance in relation to number of deliveries per year.
- Lots of reasons, but insurance was definitely paramount.

The physicians responding to the survey were invited to list any other ways that increases in medical malpractice insurance rates have caused them to change, add, or eliminate parts of their medical practices.

Major themes that unfolded were: There is now a pervasive defensive medicine element built into many practices. Medicaid, Medicare and the uninsured are the first to be dropped as patients because physicians see those consumers as being the most litigious. Many procedures that are high risk no longer will be available locally; those cases are referred quickly to regional centers or out of state. OB and higher-risk procedures are the most threatened, along with Emergency Room coverage. Economic development is impacted as physicians explore leaving the state. Many physicians have curtailed plans to go into private practice, expand their practices or develop new services. Communities without adequate medical care – and particularly OB and ER -- are less attractive to non-healthcare industries seeking relocation or expansion sites. Several physicians said they see tort reform as being a solution.

Several hospitals are currently subsidizing OB coverage to maintain the availability of that care which is not economically feasible as many see a downward trend in reimbursements and the number of deliveries. Physicians' comments follow:

- I am probably going to stop accepting Wyoming Medicaid because they have just cut rates down over 60% for procedures and these patients are most likely to sue me!

- The increase was expected. Last year's premium was based on first year of practice in Wyoming (I purchased a tail from prior carrier). The problem in Wyoming for non-surgical specialties is not the affordability/accessibility of malpractice insurance, but rather, it will be hard to recruit new doctors to this state without meaningful tort reforms. Everyone is considering this nowadays when a doctor wants to relocate.

- I'm leaving the state before the new proposed rate of 15% increase occurs on Jan. 1, 2004.

- Continued inability to afford or obtain insurance will force decreases in medical care, quality and most importantly, availability – especially in smaller communities. This will lead to jeopardizing health care for Wyoming citizens and probably affect all aspects of Wyoming's economy.

  We have been working hard to decrease overhead in our practice – reimbursement from Medicare, Medicaid, Worker's Comp has decreased so we've had to work at decreasing overhead to stay even. Our successful decrease in overhead was more than wiped out by the increase in medical malpractice premiums – so we increased fees – but the only ones who can pay increased fees are the uninsured (!!!) and those with private insurance. I work easily 12 to 14 hours in a day – I'm in the hospital at 7:30 a.m. and get home usually after 8 p.m. I'm 57 years old, and I'm not particularly inclined to continue this rat race existence for many more years. My family has always come second to my responsibilities to my medical practice, which is a particular sore point for me personally. I am devoted to my profession and to helping others, but am not expecting to do this much longer. The malpractice mess in our society is just one more large burr under my saddle that is driving me away from clinical work. I often think it would be nice to go home at 5 o'clock and cut the grass – like the "Joe six-packs" of the world.

- When doctors' malpractice rates increase, where does that money come from? The doctors need more patients. The other thing is that a lot of doctors frequently are threatened by patients who say they are going to sue them or may sue if they don't do what they ask them to.

- I am trying to support the gynecological surgical needs of my county. I am here to also help the urologists who do procedures here by doing the pre- and post-op care for our surgical patients. This allows our patients to stay home (our hospital) for their procedures. To do this requires major surgery coverage, which is very costly. I am thinking seriously of quitting – the number of procedures is so few that the cost outweighs the risk generated.

- Because of malpractice risks, it has become necessary to increase use of consultation, increasing testing to minimize risk. This substantially increases costs to patients directly. It makes recruitment to Wyoming more difficult as overhead increases, reducing what we can pay new physicians.

- Almost left the state after 24 years of practice here. I hopefully will retire here if we can get insurance. Tort reform is necessary and caps on non-economic damages. Better control of the insurance companies. Gave me six weeks notice to find new insurance.

- I previously worked in various emergency rooms across the state. My premiums were costly but I also feared loss of personal assets if jury awarded sum over policy limits.

- I certainly over-test my patients and rely less on physical exam findings now to "cover my ass" because of the malpractice crisis in our state. I am not sure this is all directly related to malpractice insurance rates but the lack of tort reform is directly related to rates and escalation of rates.

- I looked into getting my own malpractice to continue doing locums/temporary coverage within Wyoming, but was told that even though I'd worked as part of a group under a major Wyoming carrier for 10 years, they were not taking any new policies on individuals.

- We all do more tests, spend more time on documentation and suffer the constant stress of having a malpractice suit brought against us.

- High premiums forced me to move out of state. The problem is not so much with insurance companies but attorneys and the lack of tort reform! I'm much happier in my current situation. Many more will leave if tort reform doesn't happen. Good luck.

- Many years ago when my then carrier left the state I was helped by some local citizens and was supposedly covered by Lloyds, but for a year I really wasn't. Any payments had to be repaid by me! When I found out the real situation I had to cancel surgeries, send patients home. A real mess.

- At age 55, I want to quit medicine as soon as possible. The liability, increased demands by attorneys for depositions on patients I have seen make any line of work more attractive than risking everything you have worked for in a lawsuit.

- Many more tests ordered because of malpractice concerns; I actually worry about doing or saying something that could trigger a case – one case even if found innocent and I will have to quit medicine.

- Dermatology historically has been one of the lowest malpractice premium specialties. Despite this, my premiums have increased over 300% in the last several years.

- Even though I have not had problems with malpractice claims or coverage, I do feel there is a coming crisis in Wyoming. There are few carriers and lawsuits are increasing while reimbursement is decreasing. With Medicare and Medicaid patients, the increased cost of malpractice can't be passed on to consumer.

- If rates increase another 20%, I will end my practice of medicine in Wyoming. Answer: Either tort reform now or physician strike to cause crisis to enact tort reform. No more talk. Do something ASAP. To recruit quality physicians into this state is impossible.

- We think twice before performing procedures now – it is on our minds daily – will a family not like your tie, sue you without cause and ruin your career? (Rates increasing or dropping your coverage) – will the carrier try to force you to settle a claim that is unwarranted, and then drop you?

- Cannot receive individual insurance policy in Wyoming as a rehab medicine specialist – forced to be hospital employee. This is true despite having no previous malpractice claims.

- We are having difficulty recruiting physicians because of our high rates. The dermatologists in Colorado make more money and pay less in malpractice.

- We are practicing more defensive medicine; trying to reduce rises by limiting higher risk patients or referring them to sub-specialists.

- Will retire early. I avoid high-risk patients. Will have difficulty recruiting new docs to our 15-provider group. Increased expense forces less time with each patient – have to cover costs – it just is not as enjoyable anymore.

- Afraid to take on medical directorships; afraid to take on "high risk" patients – i.e. patients who frequently change doctors, are noncompliant.

- With the overall increase in overhead expense I find it necessary to not see new Medicare or Medicaid patients because they leave the greatest write off to begin with.

- The cost of added diagnostic tests for prevention of lawsuits is very large. I expect about $10,000/month – this will not improve without tort reform. Our legal system is not able to provide compensation for patients who do have injury but provides very well for lawyers. If tort reform is not accomplished we will soon be non-competing in the world market place.

- I only practice two days a week, so my medical malpractice rates are lower. I am worried what will happen Jan. 1 with renewal. If I leave – and I will if insurance reaches $6,000 to $8,000 – this location will be in dire straits without me. There's only one other primary care MD in the area.

- Over the years, my patients have grown "old" with me and as a result, I have predominantly Medicare patients. What I can charge is dictated by Medicare/federal guidelines. Those fees have not kept up with my costs of doing business and I no longer can afford to see new Medicare patients. My costs, overhead, and insurance premiums have "skyrocketed" as my creditors are under no such restrictions of what they can charge. I have, therefore, decided to retire early (next year) as I see no relief coming.

- Lots of extra tests ordered on routine basis. More patients admitted to hospital for chest pain for safety reasons than medical reasons. Considerably more referrals to specialists for safety (risk management) reasons. Hence, patients end up having more tests by specialists. Refusing certain high-risk behavior, noncompliant patients on more regular basis.

- I have limited the type of surgical procedures I perform and I am much more selective on both accepting new patients and performing surgery on certain patients.

- I may go without coverage at all if rates continue to rise!

- I have not changed the scope of my practice but operating expenses have increased due to increases in malpractice premiums. Since I am essentially a rural ophthalmology practice, about 80% of my patients are Medicare (which have drastically lowered surgical reimbursements) and I cannot pass on my increased practice expenses. This has made it difficult to keep my doors open.

- More likely to refer difficult cases out of state.

- I'm in a low risk specialty so my increases have been less. If I had the misfortune of being sued and my rates climbed significantly or if they continue to climb, I would limit the number of Title XIX people I would see to make up the difference. Right now I don't put restrictions on it.

- I doubt anything will be accomplished in time to save my practice by your commission. If you wish to discuss some suggestions I have I would be more than willing to do so. We need immediate temporary help until this issue can be resolved.

- Information from the carrier suggests my premiums will increase another 40% or better next year. If this occurs, the cost of malpractice to practice in this state will be a deterrent to remaining in the state.

- The increasing rates of the harsh consequences of even frivolous suits causes one to be cautious of helping fellow physicians by phone consults (from across the state). When my specialty is not prevalent, I find that the increasing concern on my part to help colleagues to be very unpleasant.

- Approximately 39% increase in premium plus unanticipated "tail" coverage for previously held locum slot resulted in major adverse impact on yearly revenues. We simply can't afford another year like this. This practice has had zero claims in more than 50 years in Wyoming. We will clearly limit health insurance, capital expenditures and expansion plans without some relief or at least stability.

- We are considering leaving Wyoming (not by choice) especially now that the adoption of the "loss of chance" doctrine is in effect. We are experiencing great difficulty in recruiting doctors to come to this state.

- Continuing to practice more "defensively." Although I find it objectionable, a portion of the increase in premiums is passed on directly to the patients. The idea of retirement looms larger!

- It has caused us to raise our own professional rates. So far nothing we do here has been specially targeted in causing increased insurances in specific, only in general.

- Very concerned about V-BAC (vaginal birth after c-section) liability and ability to provide care.

- We have a hard time recruiting MDs to Cheyenne, when in Colorado the rates are lower.

- Not doing big cases when I can refer; less chance of a suit.

- The damage to your insurability is caused by the claim, not the judgments. I am pretty quick to refer situations that might not go well. This is hard on the patients since that (referral site) is 100 miles away, particularly old folk. We just lost our senior ob/gyn because his policy increased $65,000. We need a cap.

- I have started to hate medicine.

- In a community practice that covers much of our state we really have no one else to send patients to for any treatment we are capable of rendering. The closest places we can refer patients to with more in-depth expertise in our field would be Denver, Salt Lake City or further so we have not felt we can restrict our practices for care we can deliver.

- For almost 20 years, I was the "go to" guy for high-risk patients. I now refuse any consults/referrals for high-risk patients.

- I have had broad training to include pediatric and complex biliary procedures, brain, etc. However, there are problems well within my realm of expertise that I will not even consider touching – these patients are automatically shipped out of state because Wyoming is now the medical malpractice capital of the Rocky Mountain Region. Patients who saw a physician in this state at any time during their illness come back here to sue because we have no tort reform and no restriction on frivolous or malicious suits.

- I am very fearful of doing anything that has high risk associated with it due to the high risk of lawsuit, frivolous or not. Any type of lawsuit now whether it even goes to court or not can imply loss of coverage or ultimately me having to move to another state.

- We raised our rates 10% this year to help offset the dramatic increase in liability cost. We will probably raise them the same amount next year, presuming we are still in practice.

- Essentially the money that I am currently compensated for taking trauma call goes to cover the malpractice insurance. If I did not take trauma call, which involved "24/7," 15-minute availability to the hospital 2/5 days, I do not know that I could continue to practice in Wyoming.

- More aware of capturing paying clients.

- I'm contemplating not taking trauma call as it represents higher risk and the reimbursement is less than that paid for elective "sports medicine" surgery. Every insurance increase is passed on to the consumer, who is being told our rates are "beyond the usual and customary." How else can I practice in Wyoming?

- Partner was forced to buy tail coverage for $90,000 as a result of insurance switch. I haven't restricted procedures yet, but I'm more prone to getting second opinions for difficult cases.

- Because of malpractice issues, one partner has requested that he be removed from call responsibilities. Another is concerned that he will have an increase in premiums that will force him to quit practice because of a single lawsuit. The fear of loss of availability of insurance and the loss of tail coverage is constant.

- I will strongly consider retirement, non-surgical practice or relocation if rates increase any higher. I simply cannot justify the annual expense while reimbursement and total compensation continue to decrease every year.

- No longer take time off, go to less meetings. Will not hire any new employees and lower raises for staff. Go to more outlying clinics to generate more income. Decreased number of days covering hospital ER. Will not accept high-risk complicated procedures. Transfer to other groups in/out state.

- I have been trying to add a non-operative clinic orthopedist for two and a half years but his malpractice rates have been quoted at $40,000 per year (for no surgery). I cannot afford this! He has not started to work and I am unable to meet patient demand and they are going out of state to receive care as a consequence.

- The current PLI (Physician liability insurance) situation is making it harder to recruit an additional needed surgeon to our group. I am seriously considering restricting some high-risk procedure or patient profile due to the PLI crisis. These patients will have to go out of state. Coverage availability is just as big of an issue as the cost of PLI. If Wyoming is such a good place for the PLI carriers, why aren't more here? MICRA reforms needed – look at what was just done in Texas!!

- I don't do spine surgery – never sued for that but high risk. I refer any case that has "potential" liability.

- I am considering retirement.

  I have considered resigning my nursery privileges at Sweetwater County Memorial Hospital. I am obligated to attend c-sections and high-risk deliveries. I have had no special instruction in NICCE other than a week refresher course at LDS Hospital in July 2000.

- Increase in tests that may not be necessary to cover self in eventuality of poor outcome. Certain procedures I can do I will not do now. I will transfer the patient out of state to have same procedure done. Not risking it here in Wyoming. I have increased my charges to my patients to cover my increased malpractice rates. I am currently looking at other job options in more physician friendly states. Likely will leave soon.

- The result of the increase in malpractice is: we pass the expense on to patients. THEY pay the increase either by dropping service (i.e. I no longer splint simple fractures due to increased malpractice so patients pay to have orthopedics do it) or patients pay more for office visits.

- We were told the rate may increase up to 50% more last year on this. It went up only about 10% so we are "waiting" for the increase this year. We are given no other warning so it limits our recruiting efforts as we don't have a clue how much liability insurance will cost us so how much we can afford to pay a new doctor. (Welfare and Medicare did not increase their reimbursement and Kid Care decreased theirs. We pay higher liability insurance and lose more on caring for a majority of our patients.

- Work harder to pay premiums.

- Thinking of leaving Wyoming for a friendlier state!

- I am planning an earlier retirement. I am reconsidering whether to accept all patients (elective patients) regardless of their healthcare benefits. Current malpractice insurance rates make Medicaid a money-losing endeavor. I must limit my losses, in order to continue practice, by filling more visits with full pay patients. Medicaid reimbursements must increase as malpractice premiums increase, or patients will go without care.

- Under the current liability environment, every time I attend a delivery I have the potential to expose myself to a liability suit that could exceed the limits of my policy, and ruin me financially. Given the choice, under the circumstances I would gladly not attend high-risk deliveries, not take care of premature infants, and say no thank you when an obstetrician wants me to attend an emergency delivery, where there is the potential to have a baby with problems. Unfortunately, I have no choice, and have to see any high-risk problem that occurs when I am on call, whether it is an established patient of mine or my call partners, or not. We do not have the luxury of deciding whom we will and will not see. While the cost of malpractice insurance is one issue, and we are fortunate in my specialty that it has not become prohibitive in terms of purchasing coverage that is available, to me there is a second and even larger issue. The fact that I really cannot buy insurance to cover my true liability is a significant problem, and constant source of worry. I currently carry the maximum amount available for purchase but could be subject to a damage award far in excess of the limits on my policy. This situation makes it uncomfortable to practice medicine, knowing one's financial security is always at risk. I can assure you that I will retire as soon as I feel it is financially feasible, even if I have potentially productive years of practicing medicine left, and still have the desire to continue working.

- It may come to a point where we will need to stop providing OB coverage due to escalating cost and the constant threat of malicious lawsuit.

- Had to eliminate services that include high-risk obstetrics i.e. VBAC at hospital. Rising costs to patients to continue to afford to practice.

- Have to increase fees to afford to practice. Places greater difficulty for our non-insurance patients to pay.

- Extreme increases in malpractice rates or possibility of even one claim and risk of non-renewal could cause dropping obstetrical services in next one to three years. High rates and companies not writing new policies for incoming physicians made recent recruitment of new physician very difficult.

- Have increased prenatal testing to include testing for illegal drug usage.

- My partner plans to leave Wyoming within two months. I am considering leaving Wyoming with six months. The five claims "settled" contrary to my judgment. Insurance carrier decided it was less expensive to settle than to prove lack of responsibility. District Judge ordered my defense of five cases to take no more than 12 ½ hours in court, which was clearly contrary to my best interests.

- I practice defensive medicine! I order extra, probably unnecessary tests to try and reduce my liability exposure. A single lawsuit, with or without merit, could result in my losing my liability coverage, and probably having to leave the state. Two, and it's a done deal, I'll be out of business.

- Most practice with a CYA mentality – ordering additional tests, procedures and referrals.

- I have to stop going to hospital June 2003 for fear of litigation and because I am overworked.

- OB coverage is in question but no change in practice yet.

- We have always been a "full service" family practice clinic and now are experiencing referrals based on pressures placed on us by malpractice insurance companies to curtail services we have traditionally provided. We were taught procedures in medical school and residency and have refined the skills over 20+ years of practice only to have an insurance company independently declare that those skills cannot continue to be provided. Malpractice premiums for us in 1990 for four family physicians doing OB were about $80,416. In 2003, the malpractice premium for three family physicians doing OB was quoted to us as $82,400. Coupling that with decreasing numbers of deliveries, the insurance cost for delivering babies went from $632 per delivery to $1,743 per delivery. In spite of efforts to negotiate favorable rates, we chose to discontinue OB services.

- Gave up part-time Emergency Medicine practice.

- We are a single source provider. There are no OB care providers except for my partner and myself in the northern part of our county. We are family practitioners – with our low volume of deliveries, if I was paying my own premiums (the hospital pays my premium) it would cost me $1,000 out of pocket to deliver a baby here. This is rapidly becoming a real problem. The failure of the Legislature to deal with this last term is placing a real burden on my colleagues and me.

- Maybe drug testing doctors, nurses, etc., would cut down on mistakes and insurance claims.

- I am unwilling to consider private practice anymore due to the ridiculously high cost of malpractice. I would quit before starting over again in the private sector.

- I will take on less Title XIX and Medicare patients next year to help limit my exposure to litigation. These entitlement programs don't pay enough of my bill to cover increased expenses.

- I went through hell on earth when my insurance carrier dumped me. I had to seek insurance in the tertiary market via PULIC in California. My next premium would have been $42,0000 up front in January 03. UMIA saved my practice – less than $9,000 per year. My first premium in St. Paul was $50 (yes, $50) per annum in 1967 in Montgomery, Alabama for $100k/$300k – all you needed then. Not "claims made," but occurrence. Coverage: OBs, surgery, MD, peds, ER, moonlighting, orthopedics, nursing home care, hospital, office, ANYTHING!/everything. I don't need to comment on how much progress has been made in medical care or how much <u>better</u> I am as a physician with modern skills, board certified three times. Tell me; am I $600,000 <u>worse</u> now than 37 years ago? No, we do not have a <u>lawyer problem</u> in this country. Spin me some more! Get rid of the tort system contingency fees. Handle injury like worker's comp.

- Insurance carrier placed $20,000+ surcharge and would not give time period. Also increased coverage premium across board. Insurance would have jumped from $12,000 per year up to $40,000 per year. Utah medical gave same coverage for $12,000 per year. Believe plaintiffs and defense attorneys are in bed together – doctor and patient suffer – treated like criminals.

- I am doing tests and procedures that I believe have a low probability of improving care to hopefully reduce the risk of being sued. This increases the cost to the patient and third party carrier.

- It is not possible for me to make any changes at this time without hurting my patients.

- Have limited office procedures to stay in a lower coverage level to save premium costs.

- My medical malpractice costs $2 per patient visit.

- We are receiving financial assistance from the hospital to offset the increasing cost for providing OB services. This is a very tenuous situation; if the assistance stops, so will the OB services in our community, since none of the physicians could possibly afford it independently.

- Increased costs of referral care no longer accessible to PHS patients due to insufficient federal funding to keep up with rising referral costs.

- Currently practicing obstetrics with obstetrical policy covered by the hospital. The hospital has been notified that their insurance company is leaving the medical malpractice field. I will probably drop obstetrics in 2004 because the coverage as an individual will be too expensive.

- Between poor Medicare and insurance reimbursement, increased overall health insurance rates to cover employees' health insurance, malpractice insurance, etc., I am thinking about quitting medicine in the near future. I don't do any OB now. I'm thinking about not taking any new nursing home patients (the internists stopped seeing nursing home patients, already, supposedly because of malpractice issues).

- I have cut back staff, services (fewer call backs). I offer tests and order them if patients wish to get them done, even when there is no clinical reason to do the tests. I spend way more time documenting for liability protection, and for protection from the Board of Medicine. This time comes from patient care. I am making plans to seek an out, i.e. move out of the state if things get worse. I am putting on hold plans to build a medical building because the climate practice seems too risky.

- Very conscious of potentially litigious patients and try to get rid of them quickly.

- Do not recommend trial of labor for previous c-section. Do not ripen cervix for previous c-section.

- I am practicing part-time by my choice. My malpractice insurance cost for six months was one-half the cost of all other equipment, supplies, furnishings, for my (admittedly small) office. Six months cost $7,300 (for part time, no surgery, no ob). Total set up costs, including malpractice: $22,000.

- Because the state and federal governments are not addressing the issues of unaffordable health and malpractice insurance, we are moving towards a nationalized health care system in the form of federally funded clinics. Example: Patients lose or can't afford health insurance, can only be seen at public clinics. Physicians can't afford malpractice insurance, leave private practice and choose employment at clinics where malpractice is covered by state or federal statute. Tort reform is in place at the federal level because of the great difficulty in suing the federal government, keeping the number of suits and the settlement amounts low. In addition, the federal government funds these clinics in a way that virtually guarantees that they can't go bankrupt. If we stay on this path, we are

steadily choking out primary care private practice, and substituting a federally funded, nationalized health plan. This is being done without a significant planning process and without public debate. It happens only by default. Whether or not one agrees with nationalized health care, we all agree that if it happens, it should be done with planning. Not addressing the health and malpractice insurance crises has a cost that goes beyond dollars. It will not be 'business as usual' ever again, no matter how this is settled.

- I stopped covering the emergency room call, as did others in our community, forcing the hospital to employ its own ER physician. We have stopped higher risk obstetric services, forcing patients to either travel 70 to 100 miles or have c-sections instead of vaginal deliveries. With another large increase, we will STOP all OB. Our community covers patients in a 70+mile radius for obstetric services. When will somebody WAKE UP? We need help out here in rural Wyoming and are in danger of losing services, physicians and any economic development. I am so close to leaving Wyoming. I am only here because I have two kids in school. We cannot recruit another physician to our community because of concerns of Wyoming now being labeled a 'crisis' state by AMA.

- I have delivered babies in Wyoming for 11 years. My malpractice premium went up to $30,000 in 1991. I stopped delivering babies. I used to do minor surgical procedures in the hospital. My malpractice premium is going to rise up to $20,000 in year 2000. I have to restrict my practice to office and hospital admissions.

- I practice defensive medicine and am constantly aware that some people are just plain evil.

- The hospital is paying the OB portion of my malpractice coverage. If they were to change their minds, I would have to drop OB services. The cost of coverage exceeds the revenue for this service.

- If it goes up again, we will have to limit deliveries. Currently we are limiting Medicare/Medicaid because we cannot afford to treat them anymore with higher malpractice.

- I was in independent practice for 17 years in Wyoming until this January when I became employed. One of the major reasons was that my carrier intended to raise my malpractice by more than 100% in 2003 and 2004, despite NO claims ever in Wyoming (17 years). My dad was forced to retire in July 2003 because his malpractice was to double – he had four months' notice. My community is now without a gynecologist.

- Consider dropping coverage here or move to another state.

The cost of insurance is only one part of this crisis. The near <u>certainty</u> of being sued if you practice for any length of time in this state was the deciding factor for me to discontinue OB services in the past.

- My coverage costs approximately $13,000 per year at present. I am seeing more patients than ever and paying more for employees and benefits. Also medical supplies. Medicare pays less all the time and Title 19 is a joke. With all of the increasing HIPAA rules etc. etc., medicine is much less rewarding and certainly much less "personable" than ever. I cannot wait to retire.

- I work part time (and have since 1998) due to having three small children. A full time practitioner may work an unlimited number of hours for approximately double my premium. Assuming this full time practice is doing similar office procedures and has similar patient bases, he/she will NOT have two to three times my office overhead and will be able to get theoretically better value out of the money spent on malpractice premiums. I do not have obstetrics; I do minimal office procedures and have never had a malpractice claim. This is "as good as it gets." Should I not be employed by the hospital, I could NOT afford to pay anything remotely close to other physicians' malpractice premiums. But it is only one part of the office overhead I pay. Add staff, continuing education, phone, heat, water and supply bills, etc. etc., and it makes being a family practice practitioner a very marginal revenue generator. Add to this the education I have, responsibility I have agreed to, the worry of lawsuit and I wonder some days if another career would have suited me better. Higher premiums without greater reimbursement will make it impossible to practice.

- It impacts my plans of opening my own practice, i.e. tends to keep me as an employee with umbrella coverage.

Notes:

Physicians' comments were revised to eliminate specific insurance carriers' names, practice information and community names to protect physician anonymity. All respondents were assured that the survey would be confidential.

This study was not designed to be an exact scientific assessment; however, we believe that the ratios reported accurately represent the Wyoming physician community.

Wyoming Healthcare Commission

AFFORDABILITY AND AVAILABILITY OF MEDICAL MALPRACTICE INSURANCE QUESTIONNAIRE

1 Are you actively practicing medicine in the state of Wyoming? Yes No

If yes, specialty: _____

If no, reason (i.e. moved, retired): _____

2. Have you been non-renewed, cancelled or denied medical malpractice coverage within the past three years? Yes No

If yes, reason given: _____

3. Have you had any claims in the past three years: Yes No

If yes, number of claims: _____

Please list the amount of any medical malpractice judgment against you within the past three years, if known: _____

Please list the amount of any medical malpractice settlement on your behalf within the past three years, if known: _____

4. Who was/is your medical malpractice insurance carrier:

In 2002 _____

Limits carried _____

Current year _____

Limits carried _____

Comments:

5. If you do not currently have medical malpractice insurance, how long have you been without coverage? (Please feel free to include comments, using the back of this page if necessary.)

6. Please estimate the increase in your medical malpractice premium from the previous year, if applicable (circle one):

   25% or less 26% to 50% 51% to 100% 101% to 200%

   Over 200%

7. Type of current medical malpractice coverage (circle one):

   a) Individual b) Group/Clinic c) Covered as an employee of hospital/medical facility

   d) Other (please describe)

8. Did the current coverage shown above change from 2001? Yes No

   Reason:

9. Have you restricted the type of procedures performed in order to obtain the current medical malpractice coverage? Yes No

   If yes, how: _____

   Why: _____

Please list any other ways that increases in your medical malpractice insurance rates have caused you to change, add, or eliminate parts of your medical practice:

Please fax completed survey to: (307) 235-3266; or e-mail to: whcc@state.wy.us

APPENDIX IV

MERLINOS & ASSOCIATES, INC.

ACTUARIES AND CONSULTANTS

WY. INSURANCE DEPT

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MATTHEW P. MERLINO, FCAS, MAAA, FCA
PAUL M. MERLINO, ACAS, MAAA, CFA
MARK L. BRANNON, FCAS, MAAA, CPCU
DAVID M. SHEPHERD, FCAS, MAAA
PETER A. SCOURTIS, ACAS, MAAA
ROSEMARY G. WICKHAM, ACAS, MAAA

October 23, 2003

Commissioner Ken Vines
Department of Insurance
State of Wyoming
Herschler Building, Third Floor East
122 West 25th Street
Cheyenne, Wyoming 82002-0440

Re: Physicians and Surgeons Medical Malpractice
Joint Underwriting Association ("JUA") Rate Study

Dear Commissioner Vines:

At your direction, we have completed studies sufficient to provide recommendations for an initial rate level for a medical malpractice JUA in Wyoming. This letter presents our rate recommendations and discusses the work performed in reaching our conclusions. In addition, we have included as an attachment (See Appendix C) a copy of a letter we sent to the Mississippi Commissioner of Insurance that included our recommendations regarding a medical malpractice JUA. In our opinion, these recommendations are applicable to Wyoming.

Rate Level Recommendations

Our rate recommendations are expressed as a function of the October 2003 market rate level. When referring to the October 2003 market rate level we mean the rates and rating plans in effect as of October 1, 2003. The recently approved rate level increase for The Doctors Company (TDC) that has not yet gone into effect and any pending proposed rate level changes that have not yet been approved are not reflected in what we refer to as the October 2003 market rate level. As you are aware, the rates for doctors vary considerably by specialty, coverage limits, policy form, claims-made step, etc. When referring to the market rate level we mean the entire rate structure as applied by the major insurers in Wyoming. This would include their use of discretionary rate credits and surcharges.

3274-B MEDLOCK BRIDGE ROAD, NORCROSS, GEORGIA 30092
PHONE: (770) 453-9771 FAX: (770) 453-9776 EMAIL: MERLINOS@MERLINOSINC.COM

Rate level recommendations under two scenarios are presented: 1) assuming the JUA is a competitive entity with no anti-selection; and 2) the JUA is a market of last resort with the expectation that only risks rejected by the insurance market will be insured by the JUA. When we are assuming no anti-selection under the first scenario, we are assuming that the JUA will underwrite risks similar to the way they are underwritten by the major insurers and that those doctors that seek coverage from the JUA will not be any more prone to losses than the average risks currently insured by the major insurers. Under the second scenario, we are assuming that the doctors who seek and obtain coverage from the JUA will be those that are rejected for coverage by the major insurers and on average are more prone to losses than the average risks.

Our recommended JUA rate levels under the two scenarios are set forth in the table below.

	Recommended Rate Level for 2004 as a function of October 2003 Market Rate Level
Scenario 1: No anti-selection	+30%
Scenario 2: Market of Last Resort	+75%

We believe that rate structure targeted at 130% of October 2003 market rate level under Scenario 1 and 175% of this rate level under Scenario 2 would produce a reasonable rate level under each Scenario. As discussed earlier, the October 2003 market rate level does not reflect TDC's recently approved increase in rates of +18.6%, nor does it reflect any rate change that may result from OHIC's pending rate filing. If TDC's recently approved rate change is considered and OHIC implements a similar change, our recommended rate level is about +10% over these companies' rates under Scenario 1, and about +48% under Scenario 2.

Discussion of Analysis and Review

In forming our rate recommendations presented above, we reviewed rate filings for the two major medical malpractice insurers in Wyoming and financial information for the industry. We also prepared rate indications using financial information for the industry and reviewed the relationship of residual market rates to market rates in other states. Among other things, our work included:

A review of Ohio Hospital Insurance Company's (OHIC) last four physicians and surgeons approved rate filings and related correspondence

A review of TDC's last four approved physicians and surgeons rate filings and related correspondence

- A review of TDC's pending and now approved physicians and surgeons rate filing
- A review of Statutory Page 14 Wyoming and Countrywide medical malpractice data for the industry aggregate, OHIC, and TDC

- Rate indications using Statutory Page 14 data and assuming rate level changes for the industry consistent with OHIC's and TDC's rate level changes
- A compilation and review of Supplemental Schedule T data (five years) segregating medical malpractice data into hospital and doctors
- A review of the relationships of JUA to Market rates in other states
- Review of residual market to market rates for workers compensation in many states

We have previously provided you with information documenting our review of the OHIC and TDC rate filings. Our review of these rate filings, as well as the rate indication using financial information (Appendix A attached), in large part forms the basis for our Scenario 1 recommended rate level. The industry Statutory Page 14 data, the experience used in the rate level indications, is included in Appendix B attached. The industry experience for both Wyoming and Countrywide suggests that medical malpractice has not been profitable during the past decade. The combined ratio, that is total losses and insurer expenses divided by premiums have exceeded 125% in Wyoming and 120% Countrywide. In other words, for the 1993 to 2002 period, insurers' estimated payout for claims and expenses is more than $1.25 for every dollar of premium collected in Wyoming and more than $1.20 countrywide.

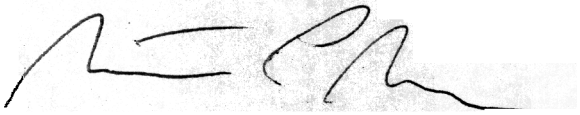
Our Scenario 2 recommended rate level assumes that the market of last resort requires a rate level at about 35% higher than the rate level needed if no anti-selection exists (1.35 x 1.30 = 1.755). The 35% assumption is largely judgmental. Consideration was given to the relationship of JUA rates to market rates in other states and residual market rates to market rates in other lines of business. Consideration was also given to the adequacy of the current market rate level. While the October 2003 market rate level is more adequate than it has been for at least seven years, it is our opinion that this rate level is still not adequate.

Other Issues

As mentioned earlier in this letter, we have attached a letter that we wrote to Commissioner Dale of Mississippi late last year. At that time, the Mississippi legislature was considering the formation of a medical malpractice JUA. We believe that these recommendations are applicable to Wyoming.

We have enjoyed working with you on this project and look forward to discussing our work with you and others at your direction.

Sincerely,



Matthew P. Merlino, FCAS, MAAA, FCA

Wyoming Rate Level Indication
Based on Statutory Page 14 Data
Table of Contents

	# of Pages
Memorandum Discussing Methodologies and Key Assumptions	2
Index to Exhibits	1
Exhibits	4

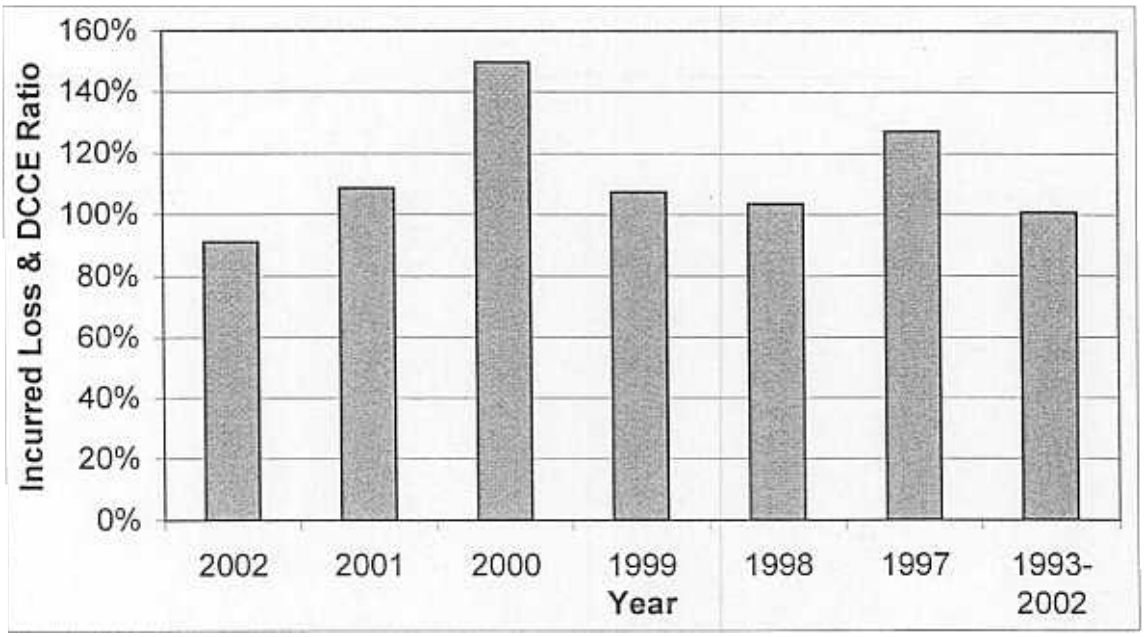
Rate Indications Based on Statutory Page 14 Data
Actuarial Memorandum

The purpose of this memorandum is to document the methods and assumptions used in the rate indications that are contained in the attached exhibits.

Experience

The rate indications are based on financial data reported in the annual statements of insurance companies that write Medical Malpractice insurance in Wyoming. The source data is Statutory Page 14 data for six years, 1997 through 2002. Page 14 data is on a direct basis and includes premiums both earned and written, losses and defense and cost containment expenses (paid and incurred), commissions and taxes, licenses and fees. The data is on a calendar year basis. The use of calendar period data assumes that incurred amounts for the calendar period accurately reflect the ultimate loss and loss expense amounts for the experience period.

Appendix E, Sheet 2 attached shows the Wyoming Medical Malpractice experience for all companies in the NAIC database from 1993 to 2002. This experience includes doctors, hospitals, and other healthcare providers. The sum of 1997 through 2002 earned premiums, incurred losses and incurred defense and cost containment expenses are the amounts used in the rate indications. The incurred loss and defense costs as a percentage of premiums by year and in total for the 1997 to 2002 period are shown in the chart below:



Underwriting Expenses and Other Adjusting Expenses

The Statutory Page 14 data includes two components of underwriting expenses: commissions and taxes, licenses & fees (taxes). Commissions and taxes have averaged 11.3% of premiums in Wyoming over the past six years and we have assumed a 12% loading for these expenses in our rate indication. The Statutory Page 14 data must be supplemented with other data to appropriately reflect all underwriting expenses in the rate indications. Specifically, general expenses and other acquisition expenses that aren't reported on Statutory Page 14 need to be included. For our rate indication, we have assumed that general and other acquisition expenses vary with premium. We have budgeted 9.5% of premium for these expenses. Our selected loadings for these underwriting expenses are consistent with industry data.

Other adjusting expenses, sometimes referred to as unallocated loss adjustment expenses, are not included on Page 14 so an additional loading for these expenses is also required. We have budgeted 6% of loss and defense and cost containment expenses (DCCE) for other adjusting expenses. This provision is consistent with industry countrywide data.

Adjustment for Loss Trend

For the purposes of our rate indication, we have calculated the rate indication using an assumed annual loss trend of 5%. We have assumed the midpoint of the experience period, 1/1/2000, as a beginning point for the trend period and 1/1/2005 as the end point. This trend period assumes that the rate indication is for policies effective in 2004 with an average effective date of 7/1/2004 and an average loss date of 1/1/2005.

Underwriting Profit Provision after Recognition of Investment Income

In our rate indications, we have assumed a target-combined ratio of 107.5% of premium. This implies a target underwriting profit of –7.5% after recognition of investment income.

Adjustment of Premium to Current Level

Earned premiums for the experience period are at collected levels. Most of the premiums do not reflect the recent rate level increases implemented by the industry in the last few years. To adjust premiums to current level, we have calculated premium adjustment factors assuming that the rate level changes implemented for Doctors by the two largest writers of Medical Malpractice in Wyoming are representative of the industry's total rate level changes.

Index to Exhibits

	Exhibit	Sheet
Indicated Rate Level Change		1
List of Key Assumptions		2
Calculation of Rate Level Adjustment Factors	II	1
Calculation of On-Level Earned Premium	II	2

Wyoming Medical Malpractice
Indicated Rate Level Change
Based on Financial Statutory Page 14 Data 1997-2002

Appendix A
Exhibit 1
Sheet 1

Earned Premium for Latest 6 Calendar Years ($000)	$ 68,884
Current Rate Level Adj Factor (Excluding TDC Pending)	
On-Level Earned Premium ($000)	$ 93,214
Loss and ALAE for same period ($000)	$ 77,651
Trend Factor from 1/1/2000 to 1/1/2005 at 5%	1.276
Trended Loss and ALAE ($000)	$ 99,105
Indicated On-Level Loss and ALAE ratio	106.3%
Load for ULAE	
Indicated On-Level Loss and LAE Ratio	112.7%
Assumed PLR (21.5% U/W Expense with -7.5% Profit)	86.0%
Indicated Market Rate Change	**31.0%**

List of Key Assumptions:

- The aggregate statutory Page 15 data is representative of the market
- Calendar Year Loss and ALAE Data for 1997 to 2002 accurately reflects the experience for the six-year period*
- TDC and OHIC rate level changes are representative of the entire market
- Target Underwriting expenses of 21.5 % (Comm. + TLF of 12% plus 9.5% General and Other Acq.)
- Profit including investment income is budgeted at -7.5% (107.5% combined ratio target)
- Assumed effective date is 1/1/2004 and rates are assumed to be in effect for one year
- Assumed trend rate is 5% per year
- Assumed AO loading of 6% of loss and ALAE

* Doctors Company data missing for 1998 and is not included

Wyoming Medical Malpractice
Indicated Rate Level Change
Calculation of Rate Level Adjustment Factors

Appendix A
Exhibit II
Sheet 1

Assuming uniform distribution of writings throughout the year

Assumed Rate Changes by Company

OHIC
+14.6% late 2002 or early 2003. Assuming 1/1/03 effective date.
+23.8% late 2001 or early 2002. Approved December 6, 2001. Assuming 1/1/02 effective date.
+0% for all prior periods in the experience period

TDC
+28.8% effective 4/1/02
+10.0% effective 4/1/01
-5.3% effective 4/1/00
+1.0% effective 10/1/98
+0% for all prior periods in the experience period

OHIC On-Level Factors

1/1/03 and later written premiums	1.000
1/1/02 to 1/1/03 written premiums	1.146
Pre 1/1/02 written premiums	1.419

TDC On-Level Factors

4/1/02 and later written premiums	1.000
4/1/01 to 4/1/02	1.288
4/1/00 to 4/1/01	1.417
10/1/98 to 4/1/00	1.342
Pre 10/1/98	1.355

Earned Factors (Using Parallelogram Method)

	OHIC	TDC
1997	1.419	1.355
1998	1.419	1.355
1999	1.419	1.342
2000	1.419	1.363
2001	1.419	1.378
2002	1.282	1.211

Wyoming Medical Malpractice
Indicated Rate Level Change
Calculation of On-Level Earned Premium

Appendix A
Exhibit II
Sheet 2

	Earned Premiums		On-Level Factors		On-Level Earned Premiums		
Year	TDC	OHIC	TDC	OHIC	TDC	OHIC	Combined
1997	5,993	2,326	1.355	1.419	8,121	3,300	11,421
1998	-	2,993	1.355	1.419	-	4,246	4,246
1999	4,173	3,676	1.342	1.419	5,601	5,215	10,816
2000	3,919	4,194	1.363	1.419	5,341	5,950	11,291
2001	3,931	4,736	1.378	1.419	5,418	6,719	12,137
2002	5,662	6,657	1.211	1.282	6,857	8,537	15,394
Total	23,678	24,582			31,338	33,968	65,305

Countrywide Medical Malpractice
(Amounts in $000)

	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1993-2002
Direct WP	9,547,370	7,591,200	6,423,686	6,149,406	6,168,235	5,951,140	6,088,096	6,174,373	6,136,171	5,457,197	65,686,874
Direct EP	8,887,865	7,051,478	6,371,744	6,150,947	6,171,319	5,953,893	6,035,348	6,140,603	5,996,314	5,257,710	64,017,221
Paid Dividends	133,795	193,350	208,574	205,805	209,462	219,071	158,752	168,255	148,175	177,360	1,822,599
Direct Unearned Premium	3,984,709	3,283,763	2,822,847	2,751,164	2,753,377	2,747,582	2,830,769	2,783,516	2,752,375	2,541,873	
Direct Paid Losses	6,179,545	5,738,517	5,114,809	4,462,045	4,029,349	3,605,388	3,591,766	3,344,017	3,348,231	2,973,285	42,386,952
Direct Incurred Losses	8,302,476	7,096,623	5,132,346	4,600,868	4,608,057	3,231,159	3,610,909	3,262,665	3,172,765	3,440,625	46,458,493
Direct Unpaid Losses	22,549,238	20,973,608	20,204,696	20,208,961	20,085,410	20,202,889	21,027,719	21,031,639	21,119,072	20,345,971	
Direct Paid DCCE	1,962,427	1,829,002	1,747,447	1,625,444	1,462,615	1,387,790	1,350,455	1,254,653	1,187,871	1,087,995	14,895,699
Direct Incurred DCCE	2,447,344	2,017,285	1,687,172	1,699,650	1,558,594	1,441,707	1,406,933	1,519,859	1,287,927	1,167,923	16,234,394
Direct Unpaid DCCE	5,698,485	5,434,913	5,356,956	5,498,920	5,452,654	5,545,788	5,562,990	5,537,560	5,289,603	4,941,346	
Commissions & Brokerage	579,505	488,827	393,741	363,962	375,454	339,182	314,733	318,999	278,121	283,429	3,735,953
Taxes, Licenses, & Fees	211,913	158,812	136,661	129,157	146,876	121,476	125,097	126,898	125,816	117,792	1,400,498
Paid Loss & DCCE Ratio	91.6%	107.3%	107.7%	99.0%	89.0%	83.9%	81.9%	74.9%	75.6%	77.2%	89.5%
Inc. Loss & DCCE Ratio	120.9%	129.2%	107.0%	102.4%	99.9%	78.5%	83.1%	77.9%	74.4%	87.7%	97.9%
Expense Ratio	8.3%	8.5%	8.3%	8.0%	8.5%	7.7%	7.2%	7.2%	6.6%	7.4%	7.8%
Assumed General, Other Acquisition, and Other Adjusting Expense Ratio	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Combined Ratio	144.2%	152.8%	130.3%	125.5%	23.4%	101.2%	105.4%	100.1%	96.0%	110.0%	120.8%

MERLINOS & ASSOCIATES, INC. ACTUARIES AND CONSULTANTS

Wyoming Medical Malpractice - Statewide
(Amounts in $000)

	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1993-2002
Direct WP	18,306	11,625	10,472	10,080	2,601	1,115	11,429	10,742	8,866	8,926	114,162
Direct EP	15,671	10,594	10,355	10,305	1,101	0,858	11,047	10,582	9,059	8,958	108,530
Paid Dividends	17	19	18	16	30	405	4	18	13	90	630
Direct Unearned Premium	8,813	6,672	5,862	5,747	5,971	4,473	4,223	3,853	3,696	3,796	
Direct Paid Losses	10,315	4,274	10,299	6,598	3,126	5,260	8,305	2,898	6,511	3,398	70,984
Direct Incurred Losses	9,139	9,907	12,512	6,222	0,881	9,880	3,738	6,786	4,974	4,753	78,792
Direct Unpaid Losses	15,231	16,571	14,542	12,402	2,782	5,707	10,654	15,235	11,358	12,176	
Direct Paid DCCE	3,226	2,466	2,737	4,158	3,122	2,540	2,230	1,629	2,266	2,458	26,832
Direct Incurred DCCE	5,133	1,603	2,992	4,849	609	3,924	(426)	3,548	2,659	5,653	30,544
Direct Unpaid DCCE	5,813	6,049	7,235	7,005	6,317	8,832	7,426	10,102	7,817	7,179	
Commissions & Brokerage	2,078	1,040	996	1,006	901	789	749	821	613	635	9,628
Taxes, Licenses, & Fees	494	227	282	207	265	257	268	260	212	219	2,691
Paid Loss & DCCE Ratio	86.4%	63.6%	125.9%	104.4%	46.4%	71.8%	95.4%	42.8%	96.9%	65.4%	90.1%
Inc. Loss & DCCE Ratio	91.1%	108.6%	149.7%	107.4%	03.5%	127.1%	30.0%	97.7%	84.3%	116.2%	100.7%
Expense Ratio	14.1%	10.9%	12.2%	12.0%	9.3%	9.4%	8.9%	10.1%	9.3%	9.6%	10.8%
Assumed General, Other Acquisition, and Other Adjusting Expense Ratio	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%
Combined Ratio	120.1%	134.5%	176.9%	134.5%	127.8%	151.5%	53.9%	122.7%	108.6%	140.7%	126.5%

MERLINOS & ASSOCIATES, INC. ACTUARIES AND CONSULTANTS

Wyoming Medical Malpractice - Total of Top 2 Carriers
(Amounts in $000)

	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1993-2002
Direct WP	13,776	9,696	8,168	7,542	3,397	8,756	6,979	6,719	5,853	-	70,886
Direct EP	12,319	8,667	8,113	7,849	2,993	8,319	6,964	6,803	5,848		67,875
Paid Dividends	-	-	-	-	-	391	-	12	13		416
Direct Unearned Premium	6,750	5,783	4,754	4,699	1,762	3,511	2,243	2,228	2,311		
Direct Paid Losses	8,877	3,371	9,746	4,369	4,571	4,597	5,749	2,039	3,206		46,525
Direct Incurred Losses	8,652	8,695	11,591	4,337	2,550	8,058	2,841	3,385	4,058		54,167
Direct Unpaid Losses	11,690	11,915	9,593	7,747	351	9,406	4,455	7,363	6,017		
Direct Paid DCCE	2,810	2,011	2,410	3,498	1,021	2,021	1,359	1,283	1,274		17,687
Direct Incurred DCCE	4,829	1,274	2,897	4,053	345	3,796	(1,554)	3,348	2,297		21,285
Direct Unpaid DCCE	4,744	4,726	5,463	4,976	(58)	6,855	4,832	7,745	5,680		
Commissions & Brokerage	1,573	761	679	687	328	553	361	440	383		5,765
Taxes, Licenses, & Fees	278	163	202	134	69	212	166	168	144		1,536
Paid Loss & DCCE Ratio	94.9%	62.1%	149.8%	100.2%	186.8%	79.6%	102.1%	48.8%	76.6%		94.6%
Inc. Loss & DCCE Ratio	109.4%	115.0%	178.6%	106.9%	96.7%	142.5%	18.5%	99.0%	108.7%		111.2%
Expense Ratio	13.4%	9.5%	10.8%	10.9%	11.7%	8.7%	7.6%	9.0%	9.0%		10.3%
Assumed General, Other Acquisition, and Other Adjusting Expense Ratio	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%		15.0%
Combined Ratio	137.9%	139.6%	204.4%	132.8%	123.4%	166.2%	41.0%	123.0%	132.7%		136.5%

MLMIC Group

Wyoming Medical Malpractice
(Amounts in $000)

	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1993-2002
Direct WP	7,990	5,494	4,379	3,730	3,397	2,853					27,843
Direct EP	6,657	4,736	4,194	3,676	2,993	2,326					24,582
Paid Dividends	-	-	-	-	-	-					-
Direct Unearned Premium	3,602	2,759	2,001	1,816	1,762	1,358					
Direct Paid Losses	2,709	1,080	2,693	1,181	4,571	745					12,979
Direct Incurred Losses	2,664	7,945	7,437	8	2,550	1,627					22,231
Direct Unpaid Losses	7,742	7,787	3,923	(821)	351	2,372					21,354
Direct Paid DCCE	1,311	731	827	1,366	1,021	478					5,734
Direct Incurred DCCE	4,109	2,165	1,913	907	345	846					10,285
Direct Unpaid DCCE	2,798	2,002	568	(518)	(58)	617					5,409
Commissions & Brokerage	764	498	490	366	328	247					2,693
Taxes, Licenses, & Fees	132	64	108	50	69	74					497
Paid Loss & DCCE Ratio	60.4%	38.2%	83.9%	69.3%	186.8%	52.6%					76.1%
Inc. Loss & DCCE Ratio	101.7%	213.5%	222.9%	24.9%	96.7%	106.3%					132.3%
Expense Ratio	11.2%	10.2%	13.7%	11.2%	11.7%	11.3%					11.5%
Assumed General, Other Acquisition, and Other Adjusting Expense Ratio	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%					15.0%
Combined Ratio	128.0%	238.7%	251.6%	51.0%	123.4%	132.6%					158.7%

MERLINOS & ASSOCIATES, INC. ACTUARIES AND CONSULTANTS

Doctors Company Group

Wyoming Medical Malpractice
(Amounts in $000)

	2002	2001	2000	1999	1998	1997	1996	1995	1994	1993	1993-2002
Direct WP	5,786	4,202	3,789	3,812		5,903	6,979	6,719	5,853		43,043
Direct EP	5,662	3,931	3,919	4,173		5,993	6,964	6,803	5,848		43,293
Paid Dividends	-			-		391	-	12	13		416
Direct Unearned Premium	3,148	3,024	2,753	2,883		2,153	2,243	2,228	2,311		
Direct Paid Losses	6,168	2,291	7,053	3,188		3,852	5,749	2,039	3,206		33,546
Direct Incurred Losses	5,988	750	4,154	4,329		6,431	2,841	3,385	4,058		31,936
Direct Unpaid Losses	3,948	4,128	5,670	8,568		7,034	4,455	7,363	6,017		
Direct Paid DCCE	1,499	1,280	1,583	2,132		1,543	1,359	1,283	1,274		11,953
Direct Incurred DCCE	720	(891)	984	3,146		2,950	(1,554)	3,348	2,297		11,000
Direct Unpaid DCCE	1,946	2,724	4,895	5,494		6,238	4,832	7,745	5,680		
Commissions & Brokerage	809	263	189	321		306	361	440	383		3,072
Taxes, Licenses, & Fees	146	99	94	84		138	166	168	144		1,039
Paid Loss & DCCE Ratio	135.4%	90.8%	220.4%	127.5%		90.0%	102.1%	48.8%	76.6%		105.1%
Inc. Loss & DCCE Ratio	118.5%	-3.6%	131.1%	179.1%		156.5%	18.5%	99.0%	108.7%		99.2%
Expense Ratio	16.5%	8.6%	7.5%	10.6%		7.5%	7.6%	9.0%	9.0%		9.6%
Assumed General, Other Acquisition, and Other Adjusting Expense Ratio	15.0%	15.0%	15.0%	15.0%		0.0%	0.0%	0.0%	0.0%		15.0%
Combined Ratio	150.0%	20.0%	153.6%	204.8%		164.1%	26.0%	108.0%	117.7%		123.7%

MERLINOS & ASSOCIATES, INC. ACTUARIES AND CONSULTANTS

MERLINOS & ASSOCIATES, INC.

ACTUARIES AND CONSULTANTS

MATTHEW P. MERLINO, FCAS, MAAA, FCA
PAUL M. MERLINO, ACAS, MAAA, CFA
MARK L. BRANNON, FCAS, MAAA, CPCU
DAVID M. SHEPHERD, FCAS, MAAA
PETER A. SCOURTIS, ACAS, MAAA
ROSEMARY G. WICKHAM, ACAS, MAAA

December 20, 2002

Commissioner George Dale
Mississippi Insurance Department
501 N. West Street
Woolfolk State Building 10th Floor
Jackson, Mississippi 39201

Re: Recommendations related to Medical Malpractice Joint Underwriting Association

Dear Commissioner Dale:

Per the recently enacted Medical Malpractice Act, the commissioner of insurance is required to make recommendations to the legislature concerning the establishment of an actuarially sound medical malpractice joint underwriting association ("JUA"). Per the act, the need and funding for such association shall be determined by the legislature. The Department of Insurance has requested that Merlinos & Associates, Inc. provide suggested recommendations concerning the establishment of a JUA. This letter presents our recommendations.

The recent survey of Mississippi doctors confirms that there are significant changes taking place in the market for physicians and surgeons medical malpractice insurance in Mississippi. Several admitted companies have pulled out of the market or are reducing exposure (St. Paul, Reciprocal of America, ProAssurance). In addition, doctors are paying substantially more for insurance in 2002 compared to 2001.

The largest increases in costs for malpractice are likely due to the movement of some doctors from the admitted market to the surplus lines market. As you are aware, the admitted market has rates that must be filed with and approved by the insurance department. The surplus lines market has rates that are not regulated. It would not be unusual for doctors moving from an admitted market to the surplus lines market to see premium increases of over 100%. Significant premium increases are also due to rate increases by most companies and the reduced use of rate credits.

3060 HOLCOMB BRIDGE ROAD, NW, SUITE J, NORCROSS, GEORGIA 30071
PHONE: (770) 453-9790 FAX: (770) 453-9619 EMAIL: MERLINOS@MERLINOSINC.COM

Of those doctors that responded to the survey, 6% reported premium increases of over 200%, 5% reported increases from 101% to 200%, 20% reported increases from 51% to 100%, and 54% reported increases of 26% to 50%. Only 15% of doctors reported a 25% or less increase. While there doesn't appear to be a crisis of availability, there is a question whether premiums are affordable. Anecdotal evidence suggests that affordability may be more of an issue in rural areas of the state.

It appears that premiums will continue to increase in 2003. Per a letter to its policyholders dated September 19, 2002, Medical Assurance Company of Mississippi ("MACM") has advised that they will institute a 45% across the board premium increase for all standard policyholders next year. Given their market position, it is likely that other companies will also implement rate increases.

The medical malpractice market for doctors is heavily concentrated. Per the survey, MACM insures about 60% of Mississippi doctors. MACM has absorbed a substantial portion of the business recently non-renewed by other carriers. MACM states in its letter to policyholders that its surplus has dropped 14 million this year. Given this surplus change and the premium increase that will result from the planned rate change, it is possible that they will not have the capacity to continue to increase their exposure. MACM has indicated to the insurance department that they must maintain room for growth for their current customers and may not have the capacity to further increase their exposure.

Our recommendations regarding a medical malpractice JUA are presented below. They assume that the legislature has decided to go forward with legislation activating a medical malpractice JUA. Our recommendations also consider the fragile nature of the current market.

General

1. In order not to stifle private carrier competition, ***it is recommended that the JUA be designed as a market of last resort.*** The JUA should not compete by offering lower rates, broader coverage or higher limits than the voluntary market. A market of last resort design might include the requirement that those seeking coverage show rejection for insurance in the voluntary market.

2. ***It is recommended that the legislature consider setting specific measurable criteria to determine when the JUA starts to provide coverage.*** The specific criteria should show that there is insufficient appetite by medical malpractice insurers to provide insurance.

3. ***It is recommended that any period for activation be limited in duration*** so the JUA will not remain active if it is no longer needed.

4. ***It is recommended that the eligibility requirements be broad enough to include those health care providers that can't purchase insurance in the voluntary market.*** What

specific providers are eligible for coverage, as well as when coverage becomes available for each type of type of health care provider should be addressed. ***It is also recommended that the JUA be able to reject some risks that do not meet underwriting criteria.***

5. ***It is recommended that the legislature consider having the JUA governed by a Board of Governors.*** If it is determined that a Board is needed, ***it is recommended that the Board members include representatives of health care providers and insurers. It is also recommended that some of the Board members have financial expertise.***

6. ***It is recommended that the JUA have a mechanism in place to cover any deficit that might result from its operations.*** Even with adequate rates, deficits can occur. It is the nature of medical malpractice insurance that variance from predicted results should be expected. A mechanism should be in place to address any potential deficiency. In designing such a mechanism, subsidies of the JUA should be minimized.

7. ***It is recommended that the JUA have the authority to purchase reinsurance protection in order to limit its exposure to adverse claim experience.***

8. ***It is recommended that the JUA be regulated by the Insurance Department similar to other insurance entities.***

9. ***It is recommended that the JUA be required to file audited financial statements and be subject to financial examination by the insurance department.***

10. ***It is recommended that the JUA be required to have separate actuarial opinions on rates and reserves filed with the insurance department.***

Rates, Coverage, and Limits

11. ***It is recommended that rates be actuarially sound.*** An actuarially sound rate is one that would cover all of the expected costs. It is a rate that is reasonable, not excessive, not inadequate, and not unfairly discriminatory. In order not to be unfairly discriminatory the rating plans should address territorial, specialty, class and other relativities normally addressed by private carrier plans. Sound underwriting must also be a part of an overall sound rating scheme.

12. ***It is recommended that rates be monitored and adjusted annually.*** Initially, it is recommended that rates be set as a function of market rates in anticipation of the anti-selection that is associated with a market of last resort. Once the initial rates are set, they need to be monitored and annually adjusted with recognition of the actual exposures insured by the JUA.

13. ***It is recommended that the coverage offered be no broader than that commonly purchased in the voluntary market.*** For doctors this is claims-made coverage. ***It is also***

recommended that the JUA offer mature claims-made coverage to doctors. Offering mature claims-made coverage is recommended so policyholders will not be forced to purchase reporting endorsement coverage from their current insurer at a typical cost of 150% to 200% of the annual premium and also purchase a first year claims-made policy from the JUA.

14. ***It is recommended that the JUA offer policy limits of no greater than the most common limit purchased in the voluntary market.*** For doctors, this is a policy limit of $1 million occurrence/ $3 million annual aggregate.

15. ***It is recommended that the JUA policy have features for coverage termination and cancellation similar to those commonly available in the voluntary market.***

****

We realize that the reasoning behind our recommendations may require further explanation. We would be happy to give further details to you or other interested parties at your request.

Sincerely,

Matthew P. Merlino, FCAS, MAAA, FCA

APPENDIX V

Wyoming Healthcare Commission

T. Chris Muirhead, Chairman

Diane Harrop, Director
Emily Genoff, Assistant

MEDICAL MALPRACTICE INSURANCE

COMPARISONS OF RATES IN WYOMING & SURROUNDING STATES

Health care commission duties

W.S. 9-2-2803(a) The commission shall develop strategies to improve health care and reduce health care and medical liability insurance costs for Wyoming citizens by holding public meetings throughout the state, hearing from experts and other interested parties, studying and researching other states' actions on health care and medical liability insurance reform, studying and utilizing Wyoming data, considering past efforts, including, but not limited to, the report issued by the Wyoming health reform commission on December 1, 1994, and future possibilities that can be useful in decision making

Background:

By request of the Wyoming Healthcare Commission (WHC), the two physician liability insurers who write policies for over 80% of Wyoming physicians, The Doctor's Company and OHIC, were asked to provide base rate data which would allow WHC members to fairly and accurately view variations between physician liability insurance premiums for physicians in Wyoming and all adjacent states.

According to information supplied by Wyoming Insurance Commissioner, Kenneth G. Vines, the medical malpractice insurance market in Wyoming is considered a noncompetitive line since two companies supply over 80% of the market. According to the most recent NAIC Market Share Report (for 2001), OHIC accounted for 47.27% of the market while The Doctor's Company share was 36.15%. Together, these two companies comprised 83.42% of the total market. The next closest competitor in 2001 was the St. Paul Company (3.43%), which has since ceased writing medical malpractice policies.

For the purposes of this comparison, it is important to be able to compare Wyoming's rates for the same primary and specialty care areas with those of other states in our geographic region. Geographic considerations are important because it is logical to conclude that physicians who might choose to practice

medicine in Wyoming would also be attracted to surrounding states with rural and intermountain West characteristics. The list of comparables is by no means exhaustive, but includes common primary care designations such as family general practice with and without OB, general surgery, and emergency medicine; as well as several common specialty areas that are more likely to be available on a regional basis such as orthopedic surgery, cardiology and neurosurgery. All numbers are reported for $1 million/$3 million limits on claims.

Base rates were requested for the following states:

- **Wyoming**
- **Colorado**
- **Idaho**
- **Montana**
- **Nebraska**
- **North Dakota**
- **South Dakota**
- **Utah**

Base rates were requested for the following categories of physician practice:

- **Family Practice with OB**
- **Family Practice without OB**
- **General Surgery**
- **Emergency medicine**
- **OB/GYN**
- **Gynecology – major surgery**
- **Orthopedic Surgery**
- **Cardiology**
- **Neurosurgery**

<u>OHIC:</u>

OHIC's Melissa S. Denison, Director of Business Development, indicated that she was unable to provide the specific information requested for several reasons:

1) **OHIC does not write policies in any states surrounding Wyoming. At one time, OHIC did conduct business in Montana, but they chose to withdraw from the medical malpractice market in that state when insurance regulations became too onerous.**
2) **OHIC does not capture all the requested practice areas**
3) **OHIC classifies family practitioners who do over 30 deliveries per year as OB/GYNs for insurance purposes**

OHIC did send one chart (*see Attachment A*), which included some comparisons

of states they do cover: Ohio, Illinois, Indiana, Kansas, Kentucky, Maryland, Wisconsin, and Wyoming; and for the following categories: Family practice – no surgery; pediatrics – no surgery; family practice – minor surgery; anesthesiology; emergency medicine – no major surgery; orthopedic surgery; and OB/GYN surgery.

Since OHIC was not able to supply the exact data requested (base rates for Wyoming and 7 surrounding states; 9 specific practice areas), no in-depth analysis of the numbers reported by them has been done. Generally, however, it is interesting to note two things with respect to OHIC's chart:

1. Of the 8 states included, four (OH, IL, KY and WY) are designated "Crisis States" on the AMA's Liability Map (*see Attachment B*). In general, these states had higher base rates than the two states (IN, WI) listed as "currently okay".
2. According to Ken Bruce, OHIC Sr. Underwriter, Kansas and Indiana both have an insurance stabilization fund system in place where the private carrier (OHIC) provides the primary layer and the state provides an additional layer of coverage. In Kansas, OHIC sells $200,000/$600,000 and the hospital or physician purchases one of three different additional limits from the state to bring total individual coverage to $100,000/$300,000; $200,000/$600,000; or $800,000/$2,400,000. The doctor chooses the additional layer and a surcharge is paid according to the state's formula. In Indiana, OHIC sells $250,000/$750,000 to the physician and the state provides an additional $1 million of coverage. Clearly, the Indiana system seems to be more effective in stabilizing premiums than the one being used in Kansas based solely on base rates comparisons.

<u>The Doctor's Company:</u>

For this analysis, it is important to note that The Doctor's Company (TDC) is a physician-owned mutual company that returns any profits to policy-holders. Because of this, we have made the assumption that profit-making is not a primary driver in the setting of rates.

It is also important to note that the numbers quoted (in dollars) are for base rates and not for total premiums. In many cases, since rates fluctuate due to other variables such as years in practice and claims experience, we are finding that actual premiums are often much higher than these numbers. Because of these other factors, however, base rates are the only true comparables from state to state and across practice categories.

Michael O'Donohue, Sr. Vice-President with The Doctor's Company (TDC), was able to provide all information requested (*see Attachment C*). The numbers leave

little doubt that Wyoming physicians, overall, are indeed paying more for standard$1 million/$3 million coverage than their counterparts in surrounding states:

- **Of the 11 practice categories listed, Wyoming's rates were the highest among the eight regional states in all but 2 instances. In those 2 cases where Wyoming's rate was not the highest, Emergency Medicine and General Surgery, it was the third-highest, but still very close to the rates of those states that were second-highest.**
  In both cases where Wyoming's rates were not the highest, Utah's were. However it is important to note that Utah passed some reforms in March, 2003, which have not yet had time to affect medical liability rates. Montana's unfriendly insurance company climate has already been noted; and the rates listed for Colorado must be compared with COPIC rates (*attachment F*) for the same practice areas—specifically for General Surgery $44,320—TDC; $32,916—COPIC. Since COPIC covers about 80% of physicians who buy insurance in Colorado, according to COPIC Executive Vice President, George Dikeou, it is likely that the base rates quoted by TDC for Colorado reflect the probability that higher-risk physicians might be paying steeper rates to TDC after COPIC declines coverage.
- **South Dakota, Nebraska, and Idaho had the lowest overall rates.**
- **When identifying potential factors causing the medical malpractice base rates to be consistently lower in those 3 states, similarities in each state's liability reform laws were considered (*see attachments D and E*). Notable items include:**
  - **South Dakota has a $500,000 cap on total damages; Nebraska caps total damages to $1.75 million, but caps individual healthcare providers' liability at $200,000 with any additional damages being paid from an excess coverage fund; Idaho has a $250,000 cap on noneconomic damages and a $1 million cap on total damages, while Wyoming has no limits.**
  - **South Dakota, Nebraska, and Idaho all have Collateral Source Reforms, while Wyoming has none.**
  - **South Dakota and Idaho allow for periodic payment of damages, while Nebraska and Wyoming do not.**
  - **Nebraska and Idaho require pre-trial arbitration/screening panels. South Dakota has an arbitration panel that determines the existence of liability and allows time for parties to agree on damages. If parties cannot agree, the panel makes a determination. Wyoming permits—but does not require—arbitration.**
  - **South Dakota, Nebraska and Idaho all require expert testimony to establish negligence. Wyoming does not.**

P.O. Box 2760 (100 West Midwest Ave., Third Floor) · Casper, WY 82602
E-Mail: dharro@state.wy.us · *FAX (307) 235-3266* · *PHONE (307) 235-3227*

ATTACHMENTS

A

OHIC Insurance Company
State Rate Comparison
Mature Claims Made Physician Rates
$1 Million / $3 Million Limits

Specialty	OH	IL	IN	KS	KY	MD	WI	WY
	Rate (Terr 1)	Rate (Terr 3)	Rate (Terr 1)	Rate	Rate	Rate (Terr 1)	Rate	Rate
Family Physicians or General Practitioners - No Surgery 80420	13,452	10,661	5,791	10,559	9,315	6,246	5,629	8,965
Pediatrics - No Surgery 80267	13,452	11,342	5,791	11,233	9,911	6,644	5,629	9,538
Family Physicians or General Practitioners - Minor Surgery 80421	18,770	17,011	9,386	16,850	14,866	10,497	11,259	14,307
Anesthesiology 80161-3 / 80151	22,523	22,682	10,038	22,466	19,820	16,204	10,670	19,076
Emergencey Medicine - No Major Surgery 80102	31,283	23,817	10,908	33,699	20,812	16,078	12,665	28,613
Surgery - Orthopedic 80154	45,361	44,230	25,809	67,399	38,650	63,582	27,019	57,228
Surgery - Obstetrics - Gynecology 80153	64,131	66,047	27,098	43,809	59,462	28,303	32,086	37,198

State	Effective Date
Ohio	7/1/2003
Illinois	12/1/2002
Indiana	4/1/2003
Kansas	1/1/2003
Kentucky	4/1/2003
Maryland	4/15/2002
Wisconsin	11/1/2002
Wyoming	1/15/2003

Wyoming Medical Society

Physician Newsletter

June/July 2003

Inside this issue...

2 Update on Liability Reform

3 Annual Meeting Wrap-up

4 WMS Celebrates 100 Years!

5 Liability Problem Areas in WY

Special Insert: Sign up now to be a WMS Team Volunteer

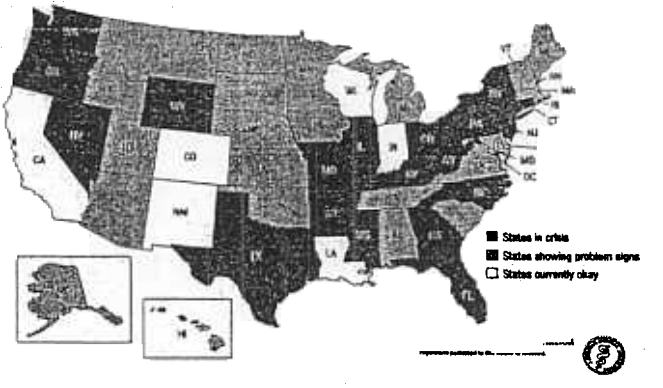
Brochure Enclosed: Wyoming DMA Seminar for Office Managers

Wyoming is Now a "Crisis State" on AMA Liability Map

On July 8, the American Medical Association declared Wyoming a medical liability insurance crisis state as more and more Wyoming doctors relocate, retire or restrict the services they provide to patients.

The AMA was "disheartened" to announce that Wyoming had been designated a crisis state because of increasing threats of further reductions in patients' access to health care and noted that the state's lack of liability reforms was a leading factor in surgeons and obstetricians leaving the state or no longer delivering babies.

America's Medical Liability Crisis: A National View



"When pregnant moms in towns like Newcastle face a 30-90 mile drive to have their babies delivered, we can no longer avoid a 'crisis' designation," Robert Monger, MD, Vice President of the Wyoming Medical Society, said.

According to AMA President Donald J. Palmisano, MD, "Wyoming patients are being hit particularly hard by the current crisis -- where even the loss of one physician can cripple a rural community." Wyoming is the 19th state declared to be in crisis by the AMA, but is the only one in the Mountain West, making it easier for doctors to relocate to neighboring states and making it much harder to recruit new doctors.

"Wyoming is already losing doctors and medical services," said Robert Stuart, MD, Vice President of Medical Affairs at United Medical Center in Cheyenne. "Under a crisis state designation, it will become even harder for hospitals to recruit the right mix of physicians to assure that we can continue to provide the necessary medical care for our communities."

The WMS list of "problem areas" where patients are in danger of losing care extends throughout the state. The most recent example highlights three family physicians in Newcastle who can no longer deliver babies due to unaffordable liability rates.

WMS President Stephen Brown, MD noted earlier that the Newcastle situation was not an isolated case. "More and more of our patients will be impacted as Wyoming's doctors are forced to consider the three R's of the medical liability crisis: restrict, relocate or retire. Physicians must make the difficult choice to restrict patient services, relocate to another state, or retire completely from practice," he said.

~ see Crisis State continued on page 8

Wyoming Medical Society
Physician*Newsletter*
P.O. Box 4009
Cheyenne, WY 82003

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~ *Crisis State continued from page 1*

The solution to the crisis, Dr. Monger said, is meaningful tort reform modeled on reforms enacted in California's MICRA legislation, including caps on non-economic damages. "The evidence is clear that those reforms have helped hold down costs and have protected patient access to care," Dr. Monger noted. "To make that happen will require an amendment to the Wyoming Constitution or passage of legislation in Congress."

U.S. Senator Mike Enzi has been actively participating in the medical liability debate being waged in the U.S. Senate. "This problem is not just about lawsuits and insurance rates. It's about people who can't get the medical attention they need. It's about communities without doctors to serve them. It's about a healthcare system in crisis," said Enzi. "The shortcomings of our medical litigation system make it clear that it is time for a major change. The legislation we must consider is an important step toward making the medical justice system work better for everyone, not just a fortunate handful of personal injury lawyers."

U.S. Senator Craig Thomas is also concerned about the effects of increasing liability insurance premiums on patient access, especially for seniors. "Rising liability premiums combined with low Medicare payments have caused many physicians to limit the number of Medicare patients they treat, creating access problems for Wyoming's seniors," he said. Medical liability legislation being considered in the U.S. Senate "will help us attract more doctors and keep the ones we've got," he added.

"This crisis designation points out the very real and very serious problem facing Wyoming," Dr. Stuart said. "Nobody wants to be named a 'crisis state' when we're talking about something as valuable as medical care for Wyoming families."

Dr. Monger asked patients, physicians and other concerned citizens to consider how serious Wyoming's problem is, and urge both the U.S. Congress and the Wyoming Legislature to take action soon. "Ask yourself, 'Will my doctor be there when I need medical care?'" ■

THE DOCTORS COMPANY, AN INTERINSURANCE EXCHANGE
$1M/$3M Limit Mature Claims-Made Coverage

SPECIALTY	State							
	WY	CO	ID	MT	ND	NE	SD	UT
PHYSICIANS/SURGEONS								
Cardiology (Invasive)	27,789	16,504	13,297	20,015	15,829	12,510	9,292	19,363
Emergency Medicine	25,733	24,744	20,032	26,216	22,602	18,642	13,693	28,535
Family General Practice (No Surgery-Hospital Care)	12,593	8,918	6,747	9,550	7,872	6,542	4,715	9,824
Family General Practice(Minor Surgery-No Obstetrics)	16,583	12,716	9,513	13,619	11,085	9,232	6,403	13,860
Family General Practice (Restricted Major Surgery-No Obstetrics)	26,237	16,971	13,832	20,015	15,133	12,576	9,129	19,024
Family General Practice (With Obstetrics)	38,945	23,539	19,287	28,977	21,979	17,740	12,745	27,232
General Surgery	44,320	44,927	37,203	38,697	38,959	33,438	23,226	50,227
Gynecology (Major Surgery)	32,977	22,660	18,530	25,947	20,103	16,697	12,063	25,139
Neurosurgery	89,927	74,494	62,100	74,304	59,856	52,200	34,934	75,619
Obstetrics & Gynecology	68,608	51,074	40,416	57,166	47,341	39,209	28,951	60,332
Orthopedic Surgery	51,438	34,529	26,440	38,178	31,056	25,567	17,796	38,523

D

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Damage Caps	Collateral Source Reform	Periodic Payments Permitted	Joint Liability Reform	Attorney Fees Limited
Colorado	$300,000 cap on noneconomic damages, including damages for physical impairment and disfigurement $1,000,000 cap on total damages. Separate $250,000 limit on derivative noneconomic damages (nonpecuniary harm to person other than person suffering from direct injury or loss). (1988)	Yes, benefits from collateral sources must be disclosed and used to reduce recoverable economic damages, minus any amount paid by the claimant to secure the benefit.	Yes. Mandatory for awards of future damages greater than $150,000. Discretionary for damage awards $150,000 or less.	Yes. Defendants are responsible only for their proportionate share of negligence unless persons have consciously conspired and deliberately pursued a common plan or design to commit a tortious act.	No
Idaho	$250,000 cap on noneconomic damages per claimant in all personal injury and wrongful death actions. Cap will be adjusted annually beginning on July 1, 2004 based on the average state wage increase. Cap does not apply to willful or reckless conduct or felonious acts. (2003)	Yes, collateral sources may be submitted to the judge following the verdict. Judgments may be entered only for amounts that exceed recovery from collateral sources.	Yes, upon the request of either party, at the discretion of the court, and only in PI cases, where damages exceed $100,000. May not be ordered for intentional torts, gross negligence or an extreme deviation from reasonable standard of conduct.	Yes. Defendants are responsible only for their proportionate share of negligence, except where co-defendants were acting in concert or a person is an agent or servant of a party.	No
Montana	$250,000 cap on noneconomic damages (1995, 1997)	Yes, in cases where damages exceed $50,000. Total damages must be reduced by amount of prior payment from collateral sources that do not involve rights of subrogation.	Yes. Upon any party's request, the court must enter an order for periodic payment of future damages exceeding $50,000.	Any party whose negligence is 50% or less of the combined negligence of all persons is severally liable only. The remaining parties are jointly and severally liable for the total less the amount attributable to the claimant. A party may be jointly liable for all damages caused by the negligence of another if both acted in concert or if one party acted as an agent of the other.	No

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Damage Caps	Collateral Source Reform	Periodic Payments Permitted	Joint Liability Reform	Attorney Fees Limited
Nebraska	$1.75 million in total damages. Health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability insurance and pay surcharge into excess coverage fund) shall not be liable for more than $200,000 in total damages. Any excess damages shall be paid from the excess coverage fund. (1975, 1984, 1986, 1992)	Yes. The court shall determine in a separate hearing the amount of any credit against a claimant's damages based on any non-refundable insurance benefits reimbursed to the claimant. This information, however, is not admissible as evidence.	No	Yes. Defendants are responsible only for their proportionate share of negligence, except where parties have acted in concert and caused harm as part of a common enterprise or plan.	No, but upon motion of either party, the court must review and determine reasonableness of fees.
South Dakota	$500,000 cap on total general damages (1985)	Yes, but no evidence of payments subject to subrogation and not purchased by the claimant or paid by the government.	Yes. If a party makes an effective election and both parties agree or a timely objection is not filed, or if a timely objection is filed but the claimant can prove future damages are in excess of $200,000.	No. Each party is jointly and severally liable, but parties who are allocated less than 50% of the total fault may only be jointly liable for more than 2xs the percentage of fault allocated to that party.	No
Utah	$250,000 cap on noneconomic damages, indexed for inflation. For causes of action arising on or after 7/1/2001 but before 7/1/02 limit increased to $400,000. Limit adjusted annually for inflation thereafter. (1986, 2001)	Yes. Court must reduce damages by any collateral sources of payment received by the claimant, except for benefits from payors with subrogation rights. Reduction shall be offset by amount paid by claimant to secure such benefits.	Yes. Any party may request periodic payments, and the court must order such payments if future damages exceed $100,000.	Yes. Defendants are responsible only for their proportionate share of negligence.	Yes. Total compensation may not exceed 1/3 of total damages.
Wyoming	None - Constitution prohibits caps	No	Not mandated	Yes. Defendants are responsible only for their proportionate share of negligence.	No

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Arbitration/Mediation and Pre-Trial Screening Panels	Expert Testimony & Qualifications	Affidavit/ Certificate of Merit	Statute of Limitations
Colorado	Arbitration is not mandated but is permitted. (CRS §13-64-403 (2002))	Experts must be licensed to practice in the state and be substantially familiar with the applicable standards of care and practice as they relate to the act or omission which is the subject of the claim on the date of the incident. The court shall not permit an expert in one medical subspecialty to testify against a physician in another medical subspecialty unless the expert shows substantial familiarity between the specialties and that the standards of care and practice in the two fields are similar. The limitations in this section shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment. (C.R.S. § 13-64-401)	A certificate of review must be filed by the plaintiff or his attorney within 60 days after a complaint is served. The certificate must state that an expert was consulted, and the expert is competent to express a medical opinion on the case at issue. Failure to file a certificate will result in dismissal of the claim. (C.R.S. § 13-20-602)	Medical malpractice: within two years of the date when the alleged negligent act took place, and when its cause is known or should have been known. In no case may a claim be brought more than three years after the cause that gave rise to the action is known, unless the act or omission: was knowingly concealed; involved leaving a foreign object in the body; or both the act and injury otherwise could not have been discovered through the reasonable exercise of due diligence. Minors: minors under the age of 6 on the date of the alleged act or omission, must file an action before his or her eighth birthday Mentally incompetent or legally disabled: within two years of the discharge of disability status or within the applicable statute of limitations, whichever is later. Wrongful death: within two years of the date of death (CRS §§ 13-80-102.5, 13-8-103)
Idaho	Arbitration is permitted but not required. (7-901) Informal and nonbinding pre-trial screening panels are mandatory. Hearing Panels are appointed by the Board of Medicine and shall include a physician, attorney, and layperson agreed to by the panelists. In cases involving hospitals a hospital administrator shall also be appointed to the panel. (Idaho Code §§ 6.1001 through 6.1011)	To establish medical malpractice, the plaintiff must affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence, that such defendant negligently failed to meet the applicable standard of care. The expert must possess professional knowledge and expertise coupled with actual knowledge of the applicable community standard to which his or her expert opinion testimony addresses. (Idaho Code §§ 6-1012, 6-1013)	No	Medical malpractice: within two years from the time of the occurrence of the wrongful act or omission at issue Foreign objects: within two years of when the claimant became aware of the injury, or one year following the date of the accrual, whichever is later Wrongful death: within two years of the date of death (Idaho Code § 5-219)

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Arbitration/Mediation and Pre-Trial Screening Panels	Expert Testimony & Qualifications	Affidavit/ Certificate of Merit	Statute of Limitations
Montana	Claimants must submit all malpractice claims or potential malpractice claims filed against health care providers to the panel prior to filing a complaint. Six members shall sit on the panel, including three attorneys and three providers from the same profession as the defendant (i.e. if the defendant is a physician, three physicians). The panel must decide whether there is substantial evidence that the acts complained of occurred, that they constitute malpractice, and whether there is a reasonable probability that the patient was injured thereby. The panel's decision must be in writing, but is not binding on any party. The panel's decision is not admissible in court, and no member of the panel may be called to testify at a subsequent trial. The panel may recommend an award, as well as discuss and approve settlement agreements. (Mont. Code Ann. § 27-6-101, et al.)	Expert testimony is generally required to establish a cause of action for medical malpractice. (Mont. Code Ch. 10 Rule 702)	No	Actions for injury or death based on alleged professional negligence shall be filed within three years of the date of the alleged negligence or the date when the negligence should have reasonably been discovered. No claims may be brought more than five years after the alleged negligence occurred. Minors under four: statute is tolled until the eighth birthday, or death, whichever is earlier, or during any period the child does not reside with a parent or guardian. (Mont. Code Ann. § 27-2-20
Nebraska	A medical review panel shall provide their expert opinion as to whether the defendant failed to meet the standard of care, or if there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury. The panel shall consist of three physicians and one non-voting attorney who shall chair the panel. Each party to the action shall select one physician and these physicians shall agree on a third physician to sit on the panel. A fourth member shall be added in cases involving hospitals. The decision by a majority of the members of the panel shall be submitted to the court in writing. Either party may request a copy of the minority report if one exists. The majority and minority report may be submitted as evidence and any member of the panel may be called as a witness. (RRS Neb. §§ 44-2840 through 44-2847)	Expert testimony is required to establish a prima facie case of negligence in common law.	No	Medical malpractice: within two years after the act/omission giving rise to the action, or within one year after the claimant discovered/should have discovered the act/omission. Ten year statute of repose. (RRS Neb. § 44-2828) Under age 21: statute is tolled until claimant reaches age 21. (RRS Neb. § 25-213) Mental disorder: Statute is tolled until the disorder is removed. (RRS Neb. § 25-213)
South Dakota	Not mandated, but permitted. Arbitration panel determines existence of liability, then gives the parties 30 days to agree on damages. If the parties fail to agree, the panel will make a determination. (SD Codified Laws § 21-25B-1 et al.)	Expert testimony must be introduced to establish negligence.	No	Medical malpractice: within two years from the date of the alleged malpractice. Minor – within three years after the alleged malpractice, error, mistake, or failure to cure occurred, unless the minor is less than six years of age at the time the alleged malpractice occurred then within two years after the minor's sixth birthday. (SD Codified laws §§ 15-2-14.1 and 15-2-22.1 and 15-2-22)

State Liability Reform Laws: Wyoming & Surrounding States

Source: American Medical Association Advocacy Research Center

State	Arbitration/Mediation and Pre-Trial Screening Panels	Expert Testimony & Qualifications	Affidavit/ Certificate of Merit	Statute of Limitations
Utah	Arbitration agreements between a patient and health care provider are valid and enforceable. (78-14-17) Claimants may request a pre-litigation hearing. The panel conducting the hearing shall include a lawyer, health care provider who is practicing and knowledgeable in the same specialty as the proposed defendant, a lay person, and if the claim is against only a hospital or their employees a hospital administrator. The panel shall issue a written opinion whether the claim(s) against the defendant(s) has merit or no merit, and if a claim is determined to have merit, whether the conduct resulted in harm to the claimant. The panel's decision shall not be subject to judicial review or appeal and their decision shall not be admissible as evidence in any subsequent action. Members of the panel may also not be called to testify. The panel's decision may be binding if agreed to in writing by the parties. (78-14-12 through 78-14-16)	Expert testimony must be presented to establish a deviation below the standard of care, unless the facts are knowledgeable to a lay person.	No	Medical malpractice: within two years of the date the injury was/should have been discovered, but in no event more than four years after the negligent act. Wrongful death: same Foreign object: within one year from the date the object was/should have been discovered (four year limit does not apply) Minors/disabled: Same (NOTE: limits ruled unconstitutional for minors) (Utah Code Ann. § 78-14-4)
Wyoming	Arbitration permitted but not required. (Wyo. Stat. 1-36-101)	None	No	Medical malpractice claims must be brought within two years from the alleged act, error, or omission. If the claimant can prove the alleged act, error, or omission was not discoverable within a two year period, or failed to discover it within the two years despite due diligence then the cause of action must be brought within two years from the date of discovery. (if act discovered during the 2nd year of the two year period from the date of the act, the statute of limitations shall be extended six months) Minor: must be brought before minor's eighth birthday or as above, whichever is greater. Disabled: within one year from the removal of the disability. (Wyo. Stat. 1-3-107)

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COPIC INSURANCE

2003 Premiums for Colorado Physicians

Rates filed September 2002 with the Colorado Division of Insurance; approval expected for rates to take effect with renewals beginning January 2003.

Rates shown are for COPIC's claims-made reporting form insurance and take effect with your 2003 renewal. Rates shown assume:

1) Liability limits of $1 million/$3 million
2) 10% discount for participation in the Colorado Medical Society Safety Group; and
3) 10% discount for earning at least six points in COPIC's Experience Rating System (ERS).

The column "2003 Net" shows the approximate effect of the $9.6 million distribution to be credited in 2003.

Most of our insured physicians qualify for additional discounts based on practice size, number of years in practice, etc. Contact your Underwriter for more information.

MEDICAL SPECIALTY	YEAR 1	YEAR 2	YEAR 3	MATURE	2003 NET (with credits)
Administrative Medicine	$3,748	$4,636	$5,300	$5,968	$5,032
Allergy	3,748	4,636	5,300	5,968	5,032
Anesthesiology	7,440	9,352	10,788	12,220	10,306
Cardiology	10,852	13,636	15,724	17,808	15,018
— Noninvasive	6,824	8,568	9,872	11,180	9,427
Colon and Rectal Surgery	7,776	9,700	11,152	12,600	10,624
— Minor	5,596	6,996	8,044	9,092	7,669
Dermatology	5,596	6,996	8,044	9,092	7,669
Emergency Medicine	10,852	13,636	15,724	17,808	15,018
Family Practice					
— Major Surgery (Abdominal)	19,808	24,996	28,888	32,780	27,642
— Major Surgery (C-section)	10,852	13,636	15,724	17,808	15,018
— Minor Surgery	10,852	13,636	15,724	17,808	15,018
— Obstetrics	10,852	13,636	15,724	17,808	15,018
— Office/Ambulatory	6,824	8,568	9,872	11,180	9,427
Forensic Medicine	3,748	4,636	5,300	5,968	5,032
General Surgery	23,500	29,716	34,376	39,036	32,916
— Local Anesthetic	5,596	6,996	8,044	9,092	7,669
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Geriatrics	6,824	8,568	9,872	11,180	9,427
Gynecology					
— Major Surgery	14,884	18,708	21,576	24,444	20,611
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Hand Surgery	14,884	18,708	21,576	24,444	20,611
Hospitalist	6,824	8,568	9,872	11,180	9,427
Hyperbaric Medicine	5,596	6,996	8,044	9,092	7,669
Internal Medicine not otherwise classified	6,824	8,568	9,872	11,180	9,427
— Endocrinology	6,824	8,568	9,872	11,180	9,427
— Gastroenterology	7,776	9,700	11,152	12,600	10,624
— Hematology	6,824	8,568	9,872	11,180	9,427
— Infectious Disease	6,824	8,568	9,872	11,180	9,427
— Neoplastic Disease	6,824	8,568	9,872	11,180	9,427
— Nephrology	6,824	8,568	9,872	11,180	9,427
— Pulmonary Disease	6,824	8,568	9,872	11,180	9,427
— Rheumatology	6,824	8,568	9,872	11,180	9,427

* Because of its unique nature, claims-made reporting form insurance allows COPIC to offer reduced premiums for the first three years of coverage. These reductions account for the fact that claims tend to develop over a number of years rather than immediately. Year 1 is priced at approximately 60% of mature premium; Year 2 is priced at approximately 75% of mature premium; and Year 3 is priced at approximately 90% of mature premium.

2003 Premiums for Colorado Physicians

Rates filed September 2002 with the Colorado Division of Insurance;
approval expected for rates to take effect with renewals beginning January 2003.

Rates shown are for COPIC's claims-made reporting form insurance and take effect with your 2003 renewal. Rates shown assume:

1) **Liability limits of $1 million/$3 million**
2) **10% discount for participation in the Colorado Medical Society Safety Group; and**
3) **10% discount for earning at least six points in COPIC's Experience Rating System (ERS).**

The column "2003 Net" shows the approximate effect of the $9.6 million distribution to be credited in 2003.

Most of our insured physicians qualify for additional discounts based on practice size, number of years in practice, etc. Contact your Underwriter for more information.

With credits

MEDICAL SPECIALTY	YEAR 1	YEAR 2	YEAR 3	MATURE	2003 NET
Neonatology	5,596	6,996	8,044	9,092	7,669
Neurology (including child)	11,468	14,420	16,636	18,852	15,897
Neurosurgery	50,920	64,664	74,968	85,276	71,905
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Nuclear Medicine	3,748	4,636	5,300	5,968	5,032
Obstetrics & Gynecology	21,040	26,572	30,720	34,868	29,400
Occupational Medicine	3,748	4,636	5,300	5,968	5,032
Ophthalmology	3,748	4,636	5,300	5,968	5,032
Oral Surgery	5,596	6,996	8,044	9,092	7,669
Orthopaedics	19,808	24,996	28,888	32,780	27,642
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Osteopathic Manipulative Medicine	3,748	4,636	5,300	5,968	5,032
Otorhinolaryngology	14,884	18,708	21,576	24,444	20,611
— Minor	5,596	6,996	8,044	9,092	7,669
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
Pathology	7,776	9,700	11,152	12,600	10,624
Pediatrics	5,596	6,996	8,044	9,092	7,669
Physical Medicine and Rehabilitation	3,748	4,636	5,300	5,968	5,032
Plastic Surgery	22,604	28,492	32,912	37,328	31,476
Podiatry	5,596	6,996	8,044	9,092	7,669
Preventive Medicine	5,596	6,996	8,044	9,092	7,669
Psychiatry	3,748	4,636	5,300	5,968	5,032
Radiation Oncology	7,776	9,700	11,152	12,600	10,624
Radiology — Diagnostic/Invasive	7,776	9,700	11,152	12,600	10,624
Thoracic Surgery	27,528	34,784	40,228	45,664	38,507
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Toxicology	3,748	4,636	5,300	5,968	5,032
Urology	14,884	18,708	21,576	24,444	20,611
— Office Practice Only	3,748	4,636	5,300	5,968	5,032
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Vascular Surgery	27,528	34,784	40,228	45,664	38,507
— Office/Surgical Assisting	5,596	6,996	8,044	9,092	7,669
Volunteer Physician Program**	n/a	n/a	n/a	n/a	n/a

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** The COPIC Trust pays the premium for physicians insured under this program.