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MEDICAL MALPRACTICE REFORM AND HEALTHCARE COSTS

FINAL REPORT

MINNESOTA ATTORNEY GENERAL
HUBERT H. HUMPHREY III

JANUARY 1996

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TABLE OF CONTENTS

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Page

EXECUTIVE SUMMARY 1

INTRODUCTION 3

MEDICAL MALPRACTICE IN RELATION TO HEALTH CARE COSTS 3

Recommendation 4

LEGISLATIVE ACTIONS TAKEN TO DATE 5

THE MEDICAL MALPRACTICE INSURANCE INDUSTRY 7

Coverage Issues 7

Profitability of Medical Malpractice Insurance in Minnesota 7

Method of Setting Premiums 9

Recommendations 9

THE BOARD OF MEDICAL PRACTICE 10

BMP's Approach to Physician Discipline 10

Utilization of Medical Malpractice Information 11

Multiple Malpractice Actions 11

Citizen Information Regarding Physicians 11

Safeguarding the Reputation of Physicians 12

Recommendations 12

CAPS ON NON-ECONOMIC DAMAGES 13

Recommendation 16

THE RISK-FREE INFLUENCE OF MCOs 16

Recommendation 16

MANDATED PRACTICE PARAMETERS 17

Recommendation 17

CONCLUSION 17

REFERENCE MATERIALS 18

EXECUTIVE SUMMARY

As requested by the 1995 Minnesota Legislature, the Attorney General conducted a study of issues related to medical malpractice reforms and their potential for reducing health care costs. The Attorney General solicited input from the health care community, the insurance industry, attorneys who practice in the area of malpractice, and affected state agencies and authorities.[1]

The available information does not reveal any significant increase of health care costs as the result of medical malpractice. Reported data indicates that the direct costs of medical malpractice in Minnesota are low. Minnesota ranks 41st of 45 states in a comparison of the average premium for identical malpractice insurance coverage. Malpractice insurance rates in Minnesota have not increased since 1989 and the two primary insurers have issued substantial premium rebates to participating physicians in recent years.

The growth of managed care organizations is effectively decreasing the indirect costs associated with malpractice. Market pressure to practice efficient and competent medicine as a condition of affiliation with a managed care organization is an effective deterrent to the practice of unnecessary medical procedures.

Perhaps as a result of these market forces, or perhaps as a result of the substantial reform measures adopted in Minnesota in the past ten years, the number of medical malpractice lawsuits in Minnesota is not increasing. On average, the number of malpractice suits has increased less than 2% per year over the last five years. This is a significantly low rate of growth when compared to the 17% increase in other civil actions in the same timeframe. Available information suggests that defendants prevail in more than 75% of malpractice lawsuits, which in itself is a deterrent to the filing of unmeritorious claims.

Overall, the Attorney General's study determined that medical malpractice is <u>not</u> a significant driver of health care costs in Minnesota, and found no current need for further tort reform measures.

If the Legislature wishes to evaluate this area of public policy in the future, the Attorney General's study did reveal various matters which may bear further examination or legislative action. Identified throughout this report as recommendations for the Legislature's evaluation, these suggestions for further consideration include:

* Requiring the Board of Medical Practice (BMP) and the Department of Health to submit annual summary reports of the number and amounts of medical malpractice settlements and awards.

* Requiring medical malpractice insurance as a condition of licensure in the state for health care professionals, or at least all physicians, and establish a penalty for practicing without insurance.

* Requiring the Department of Commerce to conduct a valid and indepth analysis of the premium setting and reserve practices of medical malpractice insurers in Minnesota.

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1. The Attorney General published this report in draft form in December, 1995 and distributed it for comment. Written comments were received from the Minnesota Medical Association, The St. Paul Companies, the Minnesota Consumer Alliance, the Minnesota Department of Commerce, the American Insurance Association, and the Board of Medical Practice. The Attorney General's Office considered all suggested revisions and incorporated some into this final report as appropriate.

* Conducting or requiring additional analysis of the differences in premiums for Minnesota physicians practicing in various specialty categories.

* Amending Minn. Stat. § 147.035 (1994) to require that physicians requesting licensure in Minnesota inform the BMP of all pending malpractice claims as well as any malpractice settlements/awards regardless of whether the insurer is authorized to do business in Minnesota.

* Urging the BMP to utilize the National Practitioner Databank to evaluate the medical malpractice history of any physician licensed since 1991 who previously practiced in another state and those licensed physicians with current practices in other states.

* Requiring the BMP to include in its biennial report information regarding the number of physicians with multiple settlements/awards of malpractice.

* Requiring the BMP to include in its public report information relating to disciplinary actions related to a physician's use of drugs or intoxicants and identify physicians involved with multiple settlements/awards.

* Evaluating whether nominal settlements/awards should be excluded from any future publication requirement.

* Refusing to enact a limit on non-economic losses without compelling evidence that awards of non-economic losses are excessive and adversely impact medical malpractice premiums in the state.

* Continuing to evaluate the effect of pressure by managed care organizations and other health care organizations on the medical decisions made by physicians.

* Resisting any call for mandated practice parameters unless health care providers indicate that the current development of internal parameters is providing an inadequate response to malpractice claims.

INTRODUCTION

As part of the MinnesotaCare legislation, the 1995 Minnesota Legislature requested that the Attorney General conduct a study of medical malpractice reform as it relates to health care costs. The legislation provided:

> The attorney general shall study issues related to medical malpractice reform and shall present to the legislature, by December 15, 1995, recommendations and draft legislation for medical malpractice reforms that will reduce health care costs in Minnesota. In developing these recommendations, the attorney general shall consider medical malpractice laws in other states, with particular attention to medical malpractice laws in California.

1995 Minnesota Laws, Chapter 234, Article 8, Section 51.

In preparation of the following report, the Attorney General's Office (AGO) analyzed the current environment of medical malpractice litigation, reviewed legislative changes already accomplished in Minnesota, explored the components affecting medical malpractice litigation and studied various reform initiatives in an effort to make appropriate recommendations. As requested, the AGO considered the medical malpractice law changes and subsequent experiences of several other states to determine if similar reforms should be implemented in Minnesota.

The AGO gave particular attention to a series of California statutes known collectively as the Medical Injury Compensation Reform Act (MICRA). California's MICRA legislation contains many tort reform measures, including: (1) a $250,000 cap on non-economic damages; (2) a limitation on the contingency fees charged by attorneys; (3) consideration of collateral sources in calculating awards; (4) installment payments for future damages; (5) a three year statute of limitation; and (6) voluntary participation in binding arbitration.

MEDICAL MALPRACTICE IN RELATION TO HEALTH CARE COSTS

Debate concerning the alleged link between medical malpractice claims and rising health care costs has raged for at least a decade. Those on one side of the argument insist that rising rates of malpractice litigation and enormous verdicts for injured patients account for a substantial percentage of the nation's ever-rising health care costs. Others argue just as adamantly that the risk of malpractice litigation is substantially unrelated to the cost of health care. While both sides of the issue may have been correct at different periods in recent history, the resolution of the debate today must be based on an evaluation of the rate of malpractice filings and the evidenced health care costs associated with the fact of litigation.

Statistics from the Minnesota Supreme Court indicate that the number of malpractice filings has remained relatively stable for the past five years. Malpractice filings totaled 219 in 1989. Although filings increased annually between 13% and 15% for 1990, 1991 and 1992, filings decreased by 18% in 1993 and 12% in 1994. There were 237 malpractice filings in 1994, an increase of just 9% over 1989 filings. On average, malpractice filings increased only 2% per year from 1989 to 1994.[2]

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2. In Minnesota, a civil action is commenced at the time of service, and filing is not required. The possibility exists, therefore, that the reported number of filings is not a complete picture of the amount of malpractice litigation. There is no reason to believe that the rate of unfiled claims of medical malpractice, as compared to the filed claims, is any greater or lesser than the rate of any other type of unfiled claim compared to its rate of court filings. Therefore, the fact that the Supreme Court statistics reflect only filings and not the total actions commenced is not relevant to a comparison of medical malpractice claim growth compared to that of general civil litigation.

Most malpractice cases do not result in a trial. In 1989, only 10% of the cases resulted in a full trial; 39% required no court activity. In 1994, 15% went through a full trial; 20% had no court activity.

The annual 2% increase in medical malpractice filings is substantially less than the increase for other civil actions. The number of civil actions filed in Minnesota has increased 17% from 1989 to 1994. The number of cases involving court activity, including trial, has increased 53% from 1989 to 1994.

Several potential explanations exist for the relatively stable number of malpractice filings as compared to the rising rate of litigation generally. Reform legislation enacted to date has likely moderated the increase in filings. In addition, the low percentage of plaintiff victories in medical malpractice cases which proceed to trial is a likely disincentive to potential plaintiffs considering the costs and benefits of pursuing claims. In 1992, defendants prevailed in 74% of the medical malpractice claims. (See Reference No. 1. Further citations to specific reference materials are denoted as "Ref. __."). According to the 1989 Medical Malpractice Claims Study completed by the Minnesota Commerce Department, the defense prevailed in 81% of the 110 claims decided by a jury from 1982 to 1987. (Ref. 2.)

To thoroughly evaluate whether medical malpractice litigation has influenced health care costs in Minnesota, the AGO intended to examine the number and amount of settlements and jury verdicts rendered in favor of malpractice plaintiffs. Minn. Stat. § 147.111 (1994), requires insurers to provide information regarding settlements and verdicts involving individual physicians to the Minnesota Board of Medical Practice (BMP). As required under Minn. Stat. § 144.693 (1994), insurers (including self-insured entities) for hospitals, outpatient surgery centers and health maintenance organizations must report information including the total number and amount of settlements/awards for malpractice to the Minnesota Department of Health. The BMP tracks the number of reports received but does not track the amounts of the settlements/awards reported. Instead, the BMP files the actual report with the records of the identified physician, and can access this information later if disciplinary action is initiated. As a result, the AGO could not readily obtain information regarding the total amount of settlements/awards reported annually.

To examine whether malpractice litigation is a significant cause for increased health care costs today, it is necessary to differentiate between "direct costs" and "indirect costs." "Direct costs" include malpractice settlements and awards, insurance payments and the costs borne by hospitals in self-insuring against malpractice claims. "Indirect costs" refers to the costs of medical procedures performed primarily to reduce the risk of malpractice litigation. While the practice of "defensive medicine" can result in earlier identification of medical conditions or in more efficient diagnosis, which would in turn reduce subsequent health care spending, the practice of defensive medicine in cases where no treatable medical condition is identified results in increased costs without any corresponding benefit. It is these "unnecessary" costs that are referred to as the "indirect costs" of medical malpractice.

The "direct costs" of medical malpractice (settlements/awards, insurance premiums and self-insurance costs) are low. According to the federal Office of Technology Assessment, they account for only 1% of total health care expenditures nationally. (Ref. 3.) As measured by specified premium rates, the direct costs of malpractice in Minnesota are lower than in most other states. When ranking premiums for identical malpractice coverage[3] in 45 states, Minnesota's premium rate was almost the lowest; the State ranked 41st. (Ref. 4.) If this ranking is consistent across specialty lines, the "direct costs" of medical malpractice in Minnesota are low.

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3. The ranking was based upon a comparison of malpractice premiums for $1,000,000/$3,000,000 coverage for an orthopedic surgeon. (Ref. 4.)

While "indirect costs" are much more difficult to measure, it has been reported that only a very small number of diagnostic procedures, less than 8% nationwide, are performed for defensive reasons. (Ref. 5.) Through the increase in the popularity of managed care organizations (MCOs),[4] these "indirect costs" (costs associated with the practice of defensive medicine) of medical malpractice may be decreasing. (Ref. 5.) In 1976, health maintenance organizations (HMOs) insured only 6 million people in the United States. By 1994, this figure had increased to 51 million. In 1995, an expected 56 million people will receive their health care through an HMO. For businesses that provide health care coverage to employees, many more are turning to MCOs. In 1992, 44% of the nation's businesses that provided health care benefits offered a managed care option. This figure has grown to 67% by 1994. (Ref. 6.)

The fee-for-service system of third-party payment may have encouraged physicians to practice very low-risk medicine. In an environment where all services are insured, a physician's practices may reflect a low tolerance for possible malpractice liability. Therefore, some argue that the practice of defensive medicine is encouraged under such a system. (Ref. 5.) MCOs may be able to discourage the practice of defensive medicine by reducing the number of procedures used by their members. (Ref. 5.) MCOs affiliate with certain physicians to provide health care coverage. MCOs review the practices of affiliated physicians to measure their adherence to established practice guidelines in an attempt to limit procedures not believed to be cost-effective. A physician's failure to meet these guidelines may result in "de-affiliation" with the MCO which would have adverse financial consequences for the provider. (Ref. 7.) This environment of non-governmental oversight curtails the amount of defensive medicine practiced, probably more efficiently than any legislation could.

The pressure to minimize costs must be balanced with quality assurance mechanisms to ensure that Minnesotans are provided an appropriate level of health care. Short-term efficiency in medical treatment does not result in lower health care costs if the efficiency leads to more expensive long-term costs associated with future medical conditions which could have been prevented.

Recommendation

1. The Attorney General recommends that the Legislature require the BMP and the Department of Health to submit annual summary reports of the number and amounts of medical malpractice settlements and awards. This information will allow the Legislature to evaluate if current law is effectively reducing health care costs associated with medical malpractice.

LEGISLATIVE ACTIONS TAKEN TO DATE

Over the past ten years, the Minnesota legislature has enacted several measures to accomplish both medical malpractice reform and tort reform in general, including most of the components of California's MICRA. Some of Minnesota's most substantial reforms include:

1. Statute of Limitations. Minn. Stat. § 541.07 (1994), first enacted to apply specifically to physicians in 1927, provides a two year period for a plaintiff to bring a claim against a medical provider. The period begins to run after the treatment ceases, not when the patient discovers the malpractice. This limitation period has remained consistent for almost 70 years and is much more restrictive than in most other states. Minnesota's refusal to enlarge the limitation period, which has been the trend in other states, is recognized as perhaps the most important factor in the low rate of malpractice claims.

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4. The term "MCO" is used to encompass all health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

2. Affidavit of Expert Review. Minn. Stat. § 145.682 (1994) was enacted in 1986 in an effort to reduce the number of frivolous malpractice lawsuits filed by patients. The statute prevents a medical malpractice plaintiff from commencing litigation without sworn testimony evidencing that a medical expert has reviewed the claim and is prepared to testify in support of the claim of malpractice. No other category of personal injury litigation requires the filing of such testimony prior to an actual trial of the action.

3. Collateral Source Rule. Minn. Stat. § 548.36 (1994), also enacted in 1986, reduces the amount a liable defendant pays by the amount that the plaintiff receives from other specified sources such as workers compensation and insurance. The Collateral Source Rule applies to all tort actions. It reduces medical malpractice awards by requiring the court to subtract from the plaintiff's award costs of medical care already paid by an insurer. California's MICRA contains a similar provision.

4. Use of Alternative Dispute Resolution (ADR). Since 1991, Minn. Stat. § 484.76 (1994) and Rule 114, Minnesota General Rules of Practice, have required all parties to civil litigation in Minnesota to use some form of ADR in an effort to settle their dispute prior to trial. Minnesota law allows litigants to choose between nine types of ADR, including binding arbitration and mediation. Allowing this flexibility effectively leads to settlement since not every type of ADR is appropriate for every case.

   MICRA allows the voluntary use of binding arbitration for malpractice claims. Two of California's largest HMOs require binding arbitration for all enrollees and the American Medical Association supports the use of binding arbitration for all medical malpractice claims. (Ref. 3.)

5. Restrictive Punitive Damage Standard. In 1986, the Legislature amended Minn. Stat. § 549.20 (1984) to restrict punitive damage awards to situations where a plaintiff can show that the defendant deliberately disregarded the patient's rights and safety. A plaintiff's proof must meet the heightened "clear and convincing" standard of proof to establish a right to punitive damages.

6. Exception to Physician-Patient Privilege. Minn. Stat. § 595.02, subd. 5 (1994), enacted in 1986, provides an exception to the statutory privilege granted to physician-patient communications. While communications between a physician and patient are normally protected from disclosure to other persons, that privilege does not apply to patients who have commenced a medical malpractice action. By law, those patients are deemed to have waived the privilege with regard to all health care providers with whom the patient has treated. Any defendant in the malpractice action is authorized to conduct "informal discussions" with any health care provider who has examined or cared for the plaintiff-patient. If a health care provider refuses to participate in requested "informal discussions," the defendant can elicit the requested information through the formal discovery process.

7. Changes to Joint and Several Liability. Minn. Stat. § 604.02 apportions damage awards between jointly liable defendants in an effort to insure fairness. Since 1978, the Minnesota legislature has been adjusting the language of the statute to limit the amount of damages a defendant must pay in proportion to its percentage of fault for the plaintiff's injury.

8. Informal Complaint Resolution Process. 1995 Laws, Chapter 234, Article 2, Section 21, mandates that all health plan companies institute an informal complaint resolution process and an impartial appeals process by July 1, 1997. This requirement

may help ensure timely resolution of many malpractice complaints without the initiation of litigation.

THE MEDICAL MALPRACTICE INSURANCE INDUSTRY

Coverage Issues

Obtaining malpractice insurance coverage does not appear to be a problem in Minnesota. Two carriers, Midwest Medical Insurance Company (MMIC) and St. Paul Fire and Marine Insurance Company (SPF&M), provide the bulk of traditional physician medical malpractice coverage in the state.[5] MMIC is a stock insurance company completely owned by Midwest Medical Insurance Holding Company ("MMIHC"), and MMIHC is in turn owned by the physician policy holders. SPF&M is a wholly-owned subsidiary of The St. Paul Companies.

If a health care provider cannot get insurance coverage through MMIC, SPF&M, or other insurers s/he can obtain coverage through the Joint Underwriting Association (JUA). JUA was established by legislation in 1975 and activated in 1985. The number of insureds covered by JUA has fluctuated dramatically due to the availability of insurance, or lack thereof, for certain categories of health care professionals. Just two years ago, JUA provided insurance coverage for approximately 400 health care professionals. According to its Administrator, JUA currently insures only 18 physicians.

While most hospitals require physicians with admitting privileges to carry coverage of $1 million per occurrence and $3 million per year, Minnesota law does not currently require physicians in the state to be insured. Data is not available on the number of doctors who are currently practicing in Minnesota without insurance.

Profitability of Medical Malpractice Insurance in Minnesota

According to the annual report of the National Association of Insurance Commissioners,[6] in 1994 medical malpractice insurers nationally experienced an overall loss of 4% on underwriting (expressed as a percent of direct premiums earned for the year) although the overall profit (expressed as a percent of direct premiums earned for the year) was

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5. In this section of the report, the AGO has not evaluated the substantial portion of the health care industry which is self-insured. An estimated 15-20% of Minnesota's hospitals and other health care entities are self-insured, but statistics concerning the costs of self-insurance were not readily available for the purposes of this report. The term "traditional" (insurance) is used to refer to coverage purchased from an outside source, as opposed to self-insurance against risk.

6. The National Association of Insurance Commissioners (NAIC) issues an annual report providing information filed by 2600 property and casualty insurers across the nation. The report includes a disclaimer against using the data for purposes of determining the adequacy of rates and also identifies some inherent data limitations resulting from the methodology used. The AGO report utilized this data only for the purposes specified, and cautions readers to consider the limitations of the data before extrapolating from it for other purposes. A copy of the Disclaimer is reprinted, with permission, following the Reference Materials section of this Report.

   The NAIC report does not contain information regarding self-insured entities, therefore, this section of the AGO's report relates only to insurers providing medical malpractice insurance in Minnesota. MMIC and SPF&M are the primary insurers offering malpractice coverage in Minnesota.

25.4%. (Ref. 8.) This difference can primarily be explained by the investment income earned on the companies' reserves and surplus funds.

Nationally, these insurers experience a return on net worth of 13.7%. (8) This percentage is determined by dividing profits by the amount of funds held in reserve and surplus.

In comparison, for 1994, Minnesota's malpractice insurers experienced a profit of 32.7% on underwriting. The total profit was 45%. Minnesota insurers experienced a 24.1% return on net worth on medical malpractice.

The average profit for Minnesota medical malpractice insurers over the period from 1985 through 1994 was 41%. This compares with a national average profit of 22.2% during this time period.

In Minnesota, the average profit for medical malpractice is nearly double that of any other line of insurance. The next most profitable line of business from 1985 until 1994 was "Other Liability" at 22.6%. The average profit of all lines of business in Minnesota for this time period was 11.8%. The average ten year return on net worth was 31.9% for medical malpractice. The total of all lines during this period was 15.6%

Minnesota insurers have generated these substantial profits while premiums have remained static or declined in every year since 1989. According to A.M. Best, a company which evaluates insurers, MMIC had a 34% increase in net income for 1994.[7] (Ref. 9.) MMIC's net income of $14,943,000 in 1994 was an increase of $5,046,000 over 1993 net income. (Ref. 9.) MMIC has taken steps to return some of these profits to insureds. From 1992 through November, 1994, MMIC returned nearly $6 million to its policyholders. (Ref. 10.)

From 1990 to the present, SPF&M has returned $5.2 million in unused premiums to its insureds. In 1990, SPF&M returned $1.5 million to its insureds and agreed to reduce its rates by 15% in compliance with a Consent Order issued by the Department of Commerce. The insurer operates a "retrospective rate return" program through which it returns to its policyholders a premium "rebate", which is the portion of the premiums reserved for claims and not paid out. These premium rebates are only paid to current policy holders who were also policy holders in a prior year for which a premium rebate is made.

The 1989 Medical Malpractice Claim Study completed by the Minnesota Department of Commerce evaluated the claims made[8] to both MMIC and SPF&M for the period between 1982 - 1987. While there was debate concerning the methodology used in the study and the resulting viability of the reported data,[9] the study did identify a historically consistent disparity between actual loss payments and reserves for those losses. (Ref. 2.)

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7. In 1993, MMIC merged with the Iowa Physicians Mutual Insurance Trust.

8. Both MMIC and SPF&M sell "claims made" policies of medical malpractice insurance. "Claims made" policies cover claims reported during the policy year (as opposed to claims that "occur" during the policy year). At the end of a policy year, the insurers have information regarding the total number of potential claims for that year. The insurers then can estimate the total amount of reserves to set aside for eventual claim payments.

9. The report was published in February, 1989 and examined all claims filed over the six year period between 1982 and 1987. Critics of the study argue that the analysis was skewed because the methodology did not take into account the anticipated increase in average paid claim amounts during the maturation of the claim cycle. Critics of the

(Footnote 9 Continued on Next Page)

According to information from A.M. Best, it appears that the practice of over-reserving may be continuing. For the year ended December 31, 1994, MMIC's "loss ratio" (actual losses and loss adjustment expenses expressed as a percentage of net premiums earned) was 39%. This ratio was 77% for the year ended December 31, 1993. The average loss ratio for the time period from 1990-1994 was 62%. (Ref. 9.) (The figures for SPF&M include several lines of insurance and could not be readily compared).

Perhaps because this insurance line appears to be lucrative, several other companies have begun to enter the market in recent years. While SPF&M and MMIC continue to write approximately 80% of the traditional medical malpractice insurance policies in the State, they are meeting increased competition from national and international companies. This competition should serve as an incentive to keep premiums low.

The narrow specialty of medical malpractice does not generate many purchasers. Companies selling insurance products prefer to spread risk among a number of purchasers. 13,924 physicians were licensed to practice medicine in Minnesota as of June 30, 1994. (Ref. 11.) No more than 6,300 carry insurance through MMIC and SPF&M. (Ref. 12.) The others are either affiliated with other insurers, are covered as employees of self-insured hospitals, clinics and/or HMOs, or are not insured.

Method of Setting Premiums

Insurers classify physicians into various categories and premiums are based on the past experience for the relevant category. In many states, insurers have classified physicians into between 12 and 19 different categories. While the wide array of categories allows insurers to charge premiums based on the past experience for that specialty, it does not spread risk effectively throughout the medical community. For example, the 1993 average rates for policies providing $1,000,000/$3,000,000 coverage to physicians practicing in Texas ranged from $7,410 ($9,877 in Houston) for family practitioners performing no surgery to $54,834 ($73,089 in Houston) for physicians specializing in obstetrics and gynecology. (Ref. 13.) Collapsing the number of categories would increase premiums somewhat for many physicians, but would also reduce rates for those in high risk specialties (e.g., obstetrics/gynecology). Perhaps because this result would lead to increased competition for the lowest-risk physicians and a potential unavailability of coverage for those in high-risk specialties, most States that have considered similar action have decided against it.

Other than by physician specialty, medical malpractice insurance for physicians is usually not experience-rated. As a result, insurance rates are generally insensitive to a physician's malpractice history. A physician's malpractice claims history can lead to denial or termination of coverage. (Ref. 3.) Coverage for large health care groups, clinics, and hospitals is sometimes experience-rated based on the claims history specific to the insured entity.

Recommendations

1. To increase the protection of the public and further broaden the risk of loss, the Attorney General recommends that the Legislature require medical malpractice insurance as a condition of licensure in the state and establish a penalty for health care professionals, or at least all physicians, practicing without insurance. Alternatively, the Legislature should consider requiring health care professionals to provide written notice to their patients if they are not insured.

(Footnote 9 Continued)

study believe that the methodology utilized, and the lack of actuarial expertise in the analysis of the data, resulted in invalid conclusions.

2. The Attorney General also recommends that the Legislature require the Department of Commerce to conduct a valid and indepth analysis of the premium setting and reserve practices of medical malpractice insurers in Minnesota. A current report will provide the Legislature, health care providers and the public with accurate information concerning claims made, claims paid and reserves associated with anticipated claims. With updated information the Legislature can make more informed decisions regarding whether the rates charged by medical malpractice insurers are excessive, in violation of Minn. Stat. § 70A.04 (1994).

3. The Attorney General recommends further that the Legislature conduct or require additional analysis of the differences in premiums for Minnesota physicians practicing in various specialty categories. Such analysis would inform the Legislature regarding the advisability of collapsing the number of categories to spread risk more uniformly among the various medical specialties.

THE BOARD OF MEDICAL PRACTICE

BMP's Approach to Physician Discipline

One obvious means to reduce medical malpractice claims is to reduce malpractice by medical providers. One way to reduce provider malpractice is to discipline physicians effectively. The Health Care Liability Alliance, an organization comprised of many medical specialties, medical insurance companies and other health-related organizations, and the American Trial Lawyers Association support strengthening state licensing boards and the peer review process to better identify and discipline incompetent and unethical health care providers as a means of reducing malpractice. In 1991, about 2,000 of the nation's 615,000 licensed physicians--less than 1/2 of 1%--were sanctioned by State medical boards. (Ref. 14.)

Under the authority of Minn. Stat. § 147.01 (1994), et seq., the Board of Medical Practice (BMP) is responsible for the licensing and discipline of physicians working in Minnesota. In 1993, the BMP disciplined 5.1 of every 1000 physicians; in 1994, the BMP disciplined 4.9 of every 1000 physicians in the state.[10] (Ref. 11.)

A report issued by the Public Citizen's Health Research Group identified Minnesota as one of the least effective states in terms of physician discipline. According to this report, which was based on information from the Federation of State Medical Boards, the BMP took 30 "serious actions" against physicians (revocation, suspension, license surrender and probation) in 1994: 2.66 serious actions per 1000 physicians. The national average for 1994 was 4.29 serious actions per 1000 physicians. Minnesota ranked 45th among the 51 states (including the District of Columbia), down from 31st in 1992 and 33rd in 1993. (Ref. 15.)

The BMP does have statutory authority to take non-disciplinary action against physicians faced with claims of impairment. Since August, 1994, the BMP has diverted approximately 75 physicians into the Health Professionals Services Program as a means of addressing claims of substandard practices short of a disciplinary action. The BMP has also required remedial education of approximately 50 physicians--another approach that potentially decreases the number of physicians ever faced with disciplinary action in Minnesota. In addition, it is possible that the low rate of physician discipline in Minnesota is explained, in part, by a high level of physician competency in the State.

10. These figures are based on all status changes except reinstatements.

Utilization of Medical Malpractice Information

The BMP receives quarterly information from insurers regarding malpractice settlements/awards affecting physicians. Under the authority of recent legislation urged by the BMP, insurers must report malpractice settlements/awards made in the name of a hospital or clinic along with the names of physicians who were involved in the underlying claim. (1995 Minnesota Laws, Chapter 44, Section 1, subd. 5.) This additional information should provide the BMP with a more complete list of physicians associated with malpractice.

Other than the reports from insurers, the BMP receives self-reported information from physicians planning to practice in the state. Minn. Stat. § 147.035 (1994) requires physicians to provide a five-year history which includes the number, date and disposition of any medical malpractice settlements or awards made relating to the quality of medical treatment. If the claim is still pending, the physician is not required by law to report it but the BMP does routinely request the information. Minn. Stat. § 147.111, subd. 7 (1994) requires physicians practicing in Minnesota to self-report settlements and awards if the insurer is authorized to do business in Minnesota. Therefore, if a claim is pending at the time of application and closed after licensure, the statute requires the physician to report any settlement or award only if the insurer is authorized to do business in Minnesota.

Since 1990, federal law has required all malpractice insurers to report all settlements and awards to the National Practitioner Databank. (Ref. 5.) This Databank has a record of all malpractice settlements/awards since its inception. The BMP does not utilize this information for two major reasons: (1) it is expensive--it costs between $2 and $10 per inquiry, and (2) the National Practitioner Databank requires the use of a credit card for billing and the State of Minnesota does not issue credit cards in the name of state agencies. Instead the BMP relies on the databank of the Federation of State Medical Societies, which contains only information relating to disciplinary actions taken by states and not malpractice information.

Multiple Malpractice Actions

From 1993 to 1995, the BMP received reports of 462 malpractice incidents. Because state law does not require any evaluation of the number of physicians involved in multiple malpractice settlements/awards, the AGO could not determine if a small number of physicians are responsible for a disproportionately high number of malpractice actions in Minnesota.

Several states have noted the identification of particular doctors involved in multiple claims as a means of limiting malpractice. The State of Michigan examined multiple cases of malpractice for the time period 1985-1988. Michigan had 9,791 malpractice suits during this time in comparison to 1,139 in Minnesota. Michigan's report indicated that 843 licensees were involved in three of more malpractice suits. Of these, 198 licensees were involved in 1,245 suits. Two licensees were involved in 17 suits each and a third was involved in 16 suits. (Ref. 16.) A report prepared by the Coalition for Consumer Rights in 1987 indicated that 2% of all physicians practicing in Cook County, Illinois were defendants in 36% of the medical negligence litigation filed over a 14 year period. (Ref. 17.) In 1987, the Public Citizen reported that 7.5% of the physicians practicing in Texas accounted for 65% of all malpractice claims filed between 1978 and 1984. (Ref. 17.)

Citizen Information Regarding Physicians

The Minnesota House of Representatives sponsored two hearings during the past five months regarding medical malpractice. According to the testimony of the citizens who appeared at the hearing, the public believes that physicians are not being sanctioned appropriately and that more information should be available to the public so that citizens can make better health care choices. This opinion is consistent with the results of a recent poll

conducted in Michigan which reported that 66% of that state's voters supported strengthening the physician discipline system and 87% supported the creation of a center to provide citizen access to the practice records of health care providers. (Ref. 18.)

In October 1993, the Medical Board of California authorized disclosure of the following information to the public:

- felony convictions;
- referrals to the Attorney General for disciplinary action;
- disciplinary actions taken in other states;
- medical malpractice judgments.

This Board also continues to disclose California disciplinary history to the public. (Ref. 19.)

Minn. Stat. § 147.02, subd. 6, 6a (1994) requires the BMP to annually publish and release a description of all the disciplinary measures taken by the Board other than those related to a physician's use of drugs or intoxicants, illness or as a result of any mental or physical condition including deterioration through the aging process or loss of motor skills. These actions are not published but are released to any individual requesting information on a specific physician from the BMP.

Safeguarding the Reputation of Physicians

Currently, all settlements/awards of medical malpractice must be reported to the BMP. Some percentage of these reported transactions may involve small amounts of money. Some cases may settle for a nominal amount either because the possibility of proving malpractice is negligible or the nature of the malpractice action is minor. The reporting of minor settlements may unfairly tarnish the reputation of physicians. In recognition of such situations, California requires the reporting of only settlements/awards in excess of $30,000.

Recommendations

1. The Attorney General recommends that the Legislature amend Minn. Stat. § 147.035 (1994) to require that physicians requesting licensure in Minnesota inform the BMP of all pending malpractice claims as well as any malpractice settlements/awards regardless of whether the insurer is authorized to do business in Minnesota. The Attorney General also recommends that the BMP begin utilizing the National Practitioner Databank to evaluate the medical malpractice history of any physician licensed since 1991 who previously practiced in another state and those licensed physicians with current practices in other states. In support of this recommendation, the Attorney General urges the BMP to seek billing arrangements with the National Practitioner Databank that do not rely on the use of credit charges, or, in the alternative, that the BMP negotiate with the Department of Finance to obtain the necessary authority to comply with the Databank's regular billing practices.

2. In conjunction with the expanded use of the National Practitioner Databank, the Attorney General recommends that the Legislature require the BMP to include in its biennial report information regarding the number of physicians with multiple settlements/awards of malpractice. Based on this information, the Legislature may wish to further expand or strengthen Minn. Stat. § 147.091 (1994) by adding multiple malpractice settlements/awards as an additional ground for disciplinary action.

3. The Attorney General recommends that the Legislature require the BMP to include in its public report information relating to disciplinary actions related to a physician's use of drugs or intoxicants and identify physicians involved with multiple settlements/awards.

With more information, citizens will be better able to avoid previously disciplined or convicted physicians which should result in fewer malpractice claims.

4. If the Legislature chooses to require the BMP to report malpractice settlements/awards to the public, the Attorney General recommends that the Legislature evaluate whether nominal settlements/awards should be excluded from publication. If the Legislature decides to expand the information available to citizens concerning disciplinary actions, it may wish to limit the publication of malpractice information to those settlements/awards greater than a specified amount.

CAPS ON NON-ECONOMIC DAMAGES

In 1986, Minnesota enacted legislation imposing a $400,000 cap on damages for certain intangible losses in all civil actions. The capped intangible losses included embarrassment, emotional distress and loss of consortium but did not include pain, disability or disfigurement. The 1990 Legislature repealed this statute apparently in response to a recommendation by the Injury Compensation Study Commission. According to the report of the Commission, this limitation only impacted a very small category of cases and was unnecessary given the existing power of the judicial system to reduce excessive awards. (Ref. 20.)

The medical profession strongly supports some limit on non-economic damages in medical malpractice cases. Empirical studies have shown that a limit on non-economic damages should reduce some direct malpractice costs. (Ref. 3.) A study completed for the Medical Liability Mutual Insurance Company in January 1995 projected a 28% reduction in professional liability costs in New York if a limit of $250,000 was established. (Ref. 21.) Those who resist such a limitation allege that such limits are ineffective at reducing health care costs and are unfair when applied to those with the most severe injuries. (Ref. 22.)

Many states have implemented limits on non-economic losses in their attempts at tort reform. The states with limits on non-economic damages include Alaska, California, Hawaii, Maryland, Massachusetts, Michigan, Missouri, Oregon, Utah, West Virginia, and Wisconsin. In some of these states, certain results of malpractice are excluded from the limitations. Alaska excepts cases involving disfigurement or severe physical impairment. Massachusetts excepts cases involving substantial or permanent loss or impairment of bodily function or substantial disfigurement. Michigan has several exceptions including death, intentional torts and injuries to the reproductive system.

In some states, limits on non-economic losses have been overturned by courts as unlawful restrictions on the constitutional protections of due process, equal protection and the right to trial by jury. Idaho and Kansas originally had non-economic loss limitations for malpractice actions which were overturned by the courts. In response to the court ruling, Idaho expanded the limitation to all torts and Kansas expanded its limitation to all personal injury suits.

California's $250,000 limitation on non-economic losses is one of the most controversial in the nation. Its limit has not been increased since its enactment in 1975. Other states, including Michigan, Missouri and Idaho, regularly increase the limits based on an established formula. It is estimated that the $250,000 limit in California would have grown with inflation to nearly $800,000 in 1995. (Ref. 23.)

While the limitation on non-economic damages may have helped to stabilize medical malpractice premiums in some states, it does not appear to be a major determinant of the amount of premiums paid. The following comparison was developed based on premium information provided by the National Association of Insurance Commissioners. It allows a comparison between the average premium paid in Minnesota (where there is no cap on

non-economic damages) and the average premium paid in California (where the $250,000 cap has been in place for 20 years):

	California		Minnesota	
Year	Physicians	Avg Prem	Physicians	Avg Prem
1993	102,891	$5,470	14,408	$4,100
1994	102,622	5,620	13,924	3,950

The figures indicate that the cap on non-economic damages does not, by itself, reduce the cost of premiums.

A similar conclusion is reached when evaluating the premium rates for identical coverages in the same medical specialty nationwide. The following chart identifies the average malpractice premium for orthopedic surgeons on a state-by-state basis for 1994:[11]

SEE CHART ON NEXT PAGE

11. The source report evaluated a total of 50 states and the District of Columbia. The following six states were removed from the analysis because they had insurance limits lower than the $1,000,000/$3,000,000 standard coverage: Indiana, Kansas, Louisiana, Nebraska, Pennsylvania and Wisconsin.

State	Avg. Premium	Rank[12]	Limits on Damages
Alabama	$12,860.00	26	$1,000,000 total damages
Alaska	45,203.00	5	$500,000 non-economic damages
Arizona	22,307.00	15	
Arkansas	5,388.00	45	
California	35,218.00	7	$250,000 non-economic damages
Colorado	10,943.00	30	$1,000,000 total damage
Connecticut	14,729.00	22	
Washington D.C.	25,023.00	10	
Delaware	14,079.00	23	
Florida	73,788.00	2	
Georgia	13,360.00	24	
Hawaii	24,500.00	12	$375,000 non-economic damages
Idaho	10,624.00	32	$400,000 non-economic damages
Illinois	21,764.00	16	
Iowa	9,462.00	36	
Kentucky	10,383.00	34	
Maine	10,050.00	35	
Maryland	19,287.00	18	$350,000 non-economic damages
Massachusetts	36,190.00	6	$500,000 non-economic damages
Michigan	108,762.00	1	$225,000 non-economic damages
Minnesota	7,537.00	41	
Mississippi	12,952.00	25	
Missouri	23,395.00	13	$465,000 non-economic damages
Montana	10,889.00	31	
Nevada	28,739.00	9	
New Hampshire	11,148.00	29	
New Jersey	22,982.00	14	
New Mexico	30,770.00	8	$500,000 total damages
New York	65,451.00	3	
North Carolina	7,320.00	42	
North Dakota	12,032.00	27	
Ohio	17,366.00	21	
Oklahoma	18,299.00	19	
Oregon	10,415.00	33	$500,000 non-economic damages
Rhode Island	46,045.00	4	
South Carolina	6,497.00	43	
South Dakota	5,875.00	44	$1,000,000 total damages
Tennessee	8,057.00	39	
Texas	24,868.00	11	
Utah	7,597.00	40	$250,000 non-economic damages
Vermont	8,564.00	37	
Virginia	8,246.00	38	$1,000,000 total damages
Washington	18,258.00	20	
West Virginia	20,502.00	17	$1,000,000 non-economic damages
Wyoming	11,549.00	28	

(Ref. 4.) This information suggests that factors other than a limit on non-economic damages account for the disparity in medical malpractice premium amounts.

In a report to the United States House of Representatives regarding the Medicare Preservation Act of 1995, the Congressional Budget Office (CBO) projected that the provision of a $250,000 limitation on non-economic damages would result in a decrease in Medicare spending of approximately $200 million over seven years. (Ref. 24.) The CBO reached this

12. The rankings shown differ from those in the source document. They have been changed to account for the deletion of the six states with insurance limits lower than the $1,000,000/$3,000,000 standard coverage.

conclusion by making several assumptions concerning the rate of increase in medical malpractice insurance premiums and the corresponding level of the Medicare economic index, the AGO surmises that the bulk of the projected decrease in Medicare spending would result from lower jury awards in states with historically high awards (e.g., New York, Florida). This result should not have much significance in the debate concerning medical malpractice reform in Minnesota.

Recommendation

1. The Attorney General recommends that the Legislature not enact a limit on non-economic losses without compelling evidence that awards of non-economic losses are excessive and adversely impact medical malpractice premiums in the state.

THE RISK-FREE INFLUENCE OF MCOs

Many Minnesota citizens get their health care coverage from a MCO. Generally, these organizations do not employ their own physicians. Instead they provide a network of physicians from which the individual can choose. Historically, HMOs were protected from legal action under ERISA,[13] which precluded injured plaintiffs from bringing malpractice actions against MCOs. This protection has been eroding and courts are beginning to recognize a plaintiff's right to sue MCOs for their actions that are causally linked to malpractice.

MCOs have tremendous influence over the medical care provided to citizens. As a rule in the world of managed care, general practitioners serve as gatekeepers and limit a patient's use of specialists. MCOs monitor the number and expense of procedures performed by physicians. This information may be used to determine which physicians provide "too much" care to individuals, care which is not justified by its cost. By falling outside established ranges, physicians may lose their affiliated status with the MCO. In an area where a majority of patients are covered by MCOs, participation in MCO programs is critical and losing affiliated status can have serious financial consequences to physicians. (Ref. 7.)

By having the power to influence medical decisions, MCOs can reduce costs and make the health care system more efficient. This pressure can effectively reduce the extent of unnecessary defensive medicine. Some physicians contend, however, that MCOs are undermining sound medical judgment for their own financial gain. (Ref. 25.) To guard against this possibility, the Legislature has been monitoring the influence of MCOs on the practice of medicine and held hearings in November, 1995 on this topic.

Recommendation

1. The Attorney General recommends that the Legislature continue to evaluate the effect of pressure by MCOs and other health care organizations on the medical decisions made by physicians. If it finds that lowered health care costs result in significantly reduced enrollee premiums, it may determine that a reduction in health care services is an appropriate trade-off for lowered premiums. If it determines that MCO pressure is seriously impacting a physician's sound medical judgment, the Legislature may consider some means of spreading the risk of malpractice to MCOs. If the evaluation leads to a conclusion short of either of these extremes, the Legislature would be armed with the necessary information to take whatever action is appropriate, if any.

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13. "ERISA" refers to the Employee Retirement Income Security Act of 1974, 29 U.S.C § 1001, et seq.

MANDATED PRACTICE PARAMETERS

The legal standard of care in a given medical malpractice case is established on a case-by-case basis through the expert testimony of physicians. A physician does not know at the outset of a patient encounter the exact legal standard of care to which s/he will be held accountable if the patient subsequently alleges that an injury resulted from the physician's negligence. This uncertainty may compel physicians to perform the unnecessary diagnostic tests and treatment procedures that are frequently identified as factors leading to increased health care costs. (Ref. 26.)

The use of practice guidelines may create more predictability regarding the legal standard of care. The state of Maine is currently evaluating the use of guidelines in a five year pilot program legislated in 1991. The highlights of this program include the development of guidelines in certain high-risk areas (anesthesiology, emergency medicine, obstetrics/gynecology, radiology), participation by more than 85% of the doctors in each of these fields, the use of prelitigation panels to look solely at whether the physician abided by the practice parameters and the use of these parameters as an affirmative defense to malpractice. Maine officials expect that the demonstration project will decrease a physician's motivation to perform medically unnecessary diagnostic tests and treatment procedures and will lead to lower health care costs. Several participating physicians indicate that the guidelines have given them confidence not to administer procedures that they may have before. (Ref. 26.)

The 1992 Minnesota Legislature authorized the development of practice parameters. (Minn. Stat. § 62J.34 (1992).) According to the Department of Health, parameters were under development in three specialty areas. Before the parameters could be implemented, however, the legislation was rescinded by the 1995 Legislature. (1995 Laws, Chapter 234, Article 5, Section 24.)

Some MCOs are apparently developing their own internal practice parameters in an effort to ensure the provision of appropriate medical treatment. These nongovernmental efforts to standardize practice norms and decrease malpractice claims are not only commendable but are most likely the most cost-effective method of addressing the concerns raised by physicians.

Recommendation:

1. The Attorney General recommends that the Legislature resist any call for mandated practice parameters unless health care providers indicate that the current development of internal parameters is providing an inadequate response to malpractice claims.

CONCLUSION

Medical malpractice is not a significant influencer of health care costs in Minnesota. The Minnesota Legislature has already accomplished significant reforms in the area of malpractice, and these reforms have been effective. To ensure that medical malpractice does not proliferate in the future and lead to increased health care costs, the Legislature should consider further evaluation of the malpractice insurance industry, further oversight of the Board of Medical Practice and further dissemination of information to the public.

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The NAIC *Report on Profitability By Line By State* contains some caveats regarding the data used in the report, the procedures used to compile the data, and the validity of that data for various uses. These caveats are contained in the introductory and explanatory material in the first section of the report. Selected caveats are shown or summarized below:

> **"The report cannot and should not be used to determine whether current rates are adequate to cover future costs." (page 1)**
>
> "It is necessary to emphasize that because of inherent data limitations and the need to apply a "one size fits all" methodology, the profitability report provides only approximations of actual profits earned by line and by state. Actual profits in a particular state and line could differ significantly from the results shown in the report." (page 1)
>
> "To the extent possible, the data from the annual statement utilized in the report are adjusted to approximate figures on a generally accepted accounting principles (GAAP) basis." (page 1)
>
> "Federal taxes are estimated..." (page 5)
>
> "...the report shows investment gain and profits including realized capital gains and losses but excluding unrealized capital gains and losses." (page 7)
>
> The data for all companies in all states are aggregated prior to allocation of that data by line by state. Data which the companies do not allocate by state and which the report allocates by state from countrywide aggregates for all companies combined includes: net worth, investment gain, federal taxes, general expenses, unallocated loss adjustment expenses, other acquisition expenses, and the effects of consolidation of affiliated insurers. (Summary of portions of pages 1-33.)

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