The Commonwealth of Massachusetts

INTERIM REPORT

of the

SPECIAL COMMISSION

ESTABLISHED TO MAKE AN INVESTIGATION

AND STUDY OF MEDICAL PROFESSIONAL

LIABILITY INSURANCE AND THE NATURE AND

CONSEQUENCES OF MEDICAL MALPRACTICE

(under Section 12 of Chapter 362
of the Acts of 1975)

JANUARY 8, 1976
The Commonwealth of Massachusetts

Members of the Special Commission on Medical Professional Liability Insurance.

Senator Daniel J. Foley, Chairman
Representative Raymond M. LaFontaine, Vice Chairman
Senator Arthur J. Lewis
Senator John F. Aylmer
Representative William C. Mullin
Representative Max Volterra
Representative Iris K. Holland
Commissioner James M. Stone
Dr. Richard F. Gibbs
Mr. Thomas D. Burns
Mr. Michael O’Hare
Mr. Patrick Carroll
Mr. Richard J. Underwood
The Special Commission on Medical Professional Liability Insurance was established by Section 12 of Chapter 362 of the Massachusetts Legislative Acts of 1975. A copy of this chapter, which became effective immediately upon its passage on June 19, 1975, is attached and marked Appendix A.

It became apparent in late 1974 and early 1975 that unless legislative action was taken, medical professional liability insurance would become unavailable to many physicians in the Commonwealth. Further, for those who would be able to secure such coverage, the likely premium could be prohibitively high. As a near term result, Chapter 362 assured continued availability of a professional liability insurance market by the establishment of a Joint Underwriting Association. The problem of extraordinary premium increases, however, remains with us, and a solution to this problem, in all likelihood, depends on our ability to achieve a much better understanding of the nature and causes of the malpractice insurance crisis than has heretofore been possible.

Acrimonious accusations levelled by doctors against lawyers or lawyers against doctors, or by either of these against insurance companies, have characterized the malpractice insurance debate, perhaps more so in other parts of the country than in the Commonwealth. Most people who have studied the problem or are affected by it have their own perception of what the problem is and tailor their recommendations for cure to that perception. Very often these perceptions are not based on any empirical data. In other words, the various perceptions of the problem, while they may have some value in fostering an intelligently discussion of the problem, may still be viewed as biases, personal opinions, clinical prejudices, or whatever other term is used for a judgment when a deficiency in supporting data exists.

This Special Commission wishes to develop as much basic data and analytical information as possible in order to determine which perceptions of the malpractice insurance problem comport with reality.
Methodology

The remainder of this Interim Report will take the form of stating a series of questions which the Special Commission believes must be answered in order to provide the foundation for an informed solution to the malpractice insurance crisis. The Commission is publishing these questions in an Interim Report in order that all concerned parties may be informed as to the direction of our study. The list of questions should not be viewed as exhaustive, because as more information is developed other questions may have to be asked. A great deal of the information necessary to answer our questions exists in court records and in the files of insurance companies. Our requests for information will be directed to those concerned and voluntary compliance with our requests encouraged. We hope to phrase our requests in such a way that indicated responses will fully meet the Special Commission’s needs, while at the same time impose the smallest possible burden on the reporting agency. It should be clearly understood, however, that while our requests will undoubtedly impose varying degrees of burden on different parties, this burden must be accepted. As a matter of public policy, the malpractice insurance crisis must not be allowed to reach the point where major dislocations in the availability of necessary health care are likely to result. Given this basic position, it should be clearly understood by all that this Special Commission will use every appropriate means within its power to secure the data necessary to complete its tasks.

In more specific terms, the Special Commission intends to implement a survey of court dockets and insurance company files since 1960. In other words, for policy year 1960 onward we wish to assemble all pertinent experience and relate it back to the initial policy year. A court docket survey somewhat along these lines has been performed recently by the Physicians Crisis Committee of Michigan. Their report, dated July 29, 1975, may be obtained from the Physicians Crisis Committee, 1930 Buhi Building, Detroit, Michigan 48226. This court docket survey will be referred to below in this Interim Report as the Michigan Report.

The Concept of Fault

Malpractice may be defined for our purposes as the improper treatment or culpable neglect of a patient by a provider of health care services. It is based on the notion that the provider of service does not
live up to the standard of care to which he is held. In other words, he does something which he should not do, or does not do something which he should do.

Malpractice, in a particular sense, has its principal impact on the provider and recipient of service. If the recipient suffers irreversible damage as a result of malpractice, the consequences can be extreme, ranging to death itself. As for the culpable provider, malpractice has the potential effect of modifying or denying his professional status and exposing him to financial loss. This last flows principally from our generally accepted legal precept that if one person causes harm to another in a manner which Society defines as legally wrong, the person causing the harm must bear the consequences of his act. If the person harmed, or his legal representative, cannot show that he has suffered a legal wrong at the hands of the provider of service, the burden of loss remains with him and will not be shifted to the provider of service.

At least this is the theory. Significant questions have been raised as to whether the theory is consistent with current practice. In theory our system of medical injury compensation is based on fault principles. What is not clear, however, is whether our system of justice grants compensation to complaining patients irrespective of fault but rather in an attempt to shift the burden of loss from the plaintiff to someone whom they feel is better able to bear it (usually an insurance company).

It is of central importance to this Special Commission’s study to determine whether courts and juries, and thus our system of settling cases, have in practice rejected that “fault” principle. The answer to this question has particular significance in light of the suggestion by some that a “no-fault” system of patient compensation replace our present system based on fault. Here in Massachusetts substantial questions have been raised concerning the efficacy of “no-fault” principles, at least insofar as they are applied to the area of motor vehicle property damage insurance. Those who oppose, at least for now, the “no-fault” approach ask “if fault does not determine compensation, what does”. In other words, the compensible event must be defined. If that compensable event is defined as an unsatisfactory result of a medical encounter, it is possible that we may be sweeping a great deal more into our patient compensation system than we anticipated, at costs far in excess of anything we are now paying through our “fault”-based system.
The Special Commission intends to monitor closely the determinations made by the Tribunals established under Chapter 362. It is hoped that the experience of these Tribunals will give us at least a partial answer to our question concerning the continuing role of "fault". The Special Commission also wishes to construct a system for evaluation of past experience, which might shed some light on this issue.

The outcome of this study can have particular significance in determining where the ultimate solution to our problem lies. If we are to seriously consider the abandonment of the fault concept in medical injury cases, we must satisfy ourselves that the fault-based system has received a fair trial. If it turns out that the courts and juries have been making awards where no fault exists in fact, this could be taken as a clear indication that we should not move towards no fault concepts of medical injury compensation. Our options in such an event might include imposing further controls on our system of justice to assure continued compliance with our system which is supposed to award damages only where fault is shown to exist.

**Damages Awarded**

The Special Commission is acutely aware that juries have awarded very high damages to plaintiffs in some malpractice cases. The Special Commission wishes to compile data based only on the Massachusetts experience and, to the extent possible, determine for itself the various elements of damage which contributed to the final award or out of court settlement. It is well known that damage awards or settlements can include, among other things, compensation for lost earning capacity, compensation for the loss of physical capacity, compensation which will reimburse the plaintiff for continuing care necessitated by the act of malpractice, damages for conscious pain and suffering, as well as punitive damages in highly unusual cases. The survey of past experience should provide us with some help in this regard. If it does not, it may be that we should recommend legislation which would require that each element of damages awarded by juries should be separately identified.

**Lawyers' Fees**

Related to the foregoing question is the question of lawyers' fees. What do plaintiffs' lawyers in medical injury cases charge for their
services? Can we determine whether lawyers' compensation is factored into jury awards and settlements? In other words, if an injured plaintiff is found to be entitled to $100,000 in order to put him in the position in which he would have been if the malpractice had not occurred, will a jury make an award of $150,000 in the belief that one-third of that award, or $50,000, would go to the lawyer, thus leaving $100,000 for the plaintiff himself?

It has been suggested that the amount of money which flows into the hands of plaintiffs’ attorneys is improperly high. It also has been suggested that the contingency fee system leads to such high payment levels. Attorneys, on the other hand, counter that the contingency fee approach is the poor man's key to the courthouse door, and on an averaging approach, compensates the lawyer for his time and effort, which are his basic stock in trade, in no-recovery cases by what he earns in successful cases.

It is obvious that we require further information concerning the percentage of cases in which a plaintiff is paid money. It should be noted that the report of the HEW Commission on Medical Malpractice stated that plaintiffs' attorneys reported that some dollar amount was collected in approximately 80% of their cases. This included all cases during their survey period, whether terminated by trial or settlement. The docket survey referred to in the Michigan Report suggests that on their experience these recovery percentages were somewhat higher. If the Massachusetts experience proves to be consistent with the results of these other studies, we can then examine the contention of some plaintiffs' lawyers that the fee traditionally permitted under a contingent retainer in cases where a recovery is obtained is offset by those contingency fee situations where there is no recovery and where the lawyer does not receive any payment. It may be that no change in policy position with respect to contingency fees will be recommended, but at least we will be discussing the issue within the context of hard information.

Disposition of Malpractice Cases

The Special Commission wishes to map for the entire survey period the method by which malpractice suits filed in Massachusetts are finally resolved, whether by jury trial, by jury waived trial, by settlements, by allowances of motions to dismiss, and the like. It is clear that we will have to know when these resolutions occurred and
relate them back to their initial policy year, who prevailed in the final resolution, the amount of any damages paid, and the breakdown of the types of damages reflected in the award.

*Statistical Information*

At this point it seems fair to say that comprehensive data on malpractice insurance is not available. Individual carriers may have such data handled on an internally consistent basis within that company. Some doubt exists as to whether this information is in such form or has been handled in such a manner that it can be correlated with other companies' experience. At first glance it appears as though the malpractice insurance line of business has been handled by many of the companies as the stepchild of their larger concerns.

The Insurance Services Organization (ISO), an insurance company service group, is the only designated statistical filing agency for malpractice data. Without addressing ourselves for the moment to the accuracy of their data, it should be known that all malpractice insurance carriers do not report to ISO. For example, it was stated in the Report of the HEW Secretary's Commission on Medical Malpractice that for policy year ended December 31, 1969, physicians' and surgeons' malpractice premiums reported to ISO (all states) were less than $33,000,000, which was less than 25% of the estimated market.

If some sort of adverse selection with respect to ISO reporting comes into play, it could be that ISO statistics are unrepresentative. In other words, in order to responsibly address our charge, this Special Commission must satisfy itself that any information upon which it bases its recommendations must be reliable and fully representative of what is actually occurring.

This Commission, therefore, must address itself to the quantity of information regarding medical professional liability insurance that is required to make sound judgments. Significant questions also have been raised with respect to the quality of the ISO information. In a report on the medical malpractice insurance market prepared for the HEW Secretary's Commission on Medical Malpractice, the following statement was made:

In addition to lacking a widespread base of malpractice data, the quality of the entire ISO data base has been seriously challenged by the New Jersey Insurance Commissioner, who is reported to have audited
some insurance carriers' closed claims files and compared "actual" data items with the same items as shown in ISO's files. Discrepancies between the two were reportedly so gross that the only possible recommendation is that all other state insurance regulators should undertake similar spot audits. Officials of ISO acknowledged that they do not audit any of their data base used to set rates. In a study such as this, it is and was possible to obtain data from individual carriers who do not report to ISO. However, lack of uniformity in the collection and reporting of data is another major obstacle to obtaining larger data base.

In a somewhat more recent development concerning ISO statistics, The Superintendent of Insurance of the State of New York Insurance Department, on November 7, 1975, issued an Opinion and Decision in the Matter of the Medical Malpractice Insurance Association and Insurance Services Office. That opinion dealt with professional liability insurance rates for physicians and surgeons, and also with hospital malpractice insurance rates. Focusing for the moment on the hospital premiums, the New York Medical Malpractice Insurance Association had, in June 1975, requested a substantial rate increase which was based on a filing of the Insurance Services Office, namely a 150.2% increase in Greater New York and a 226.8% increase in the remainder of the State from the basic rates then in effect for Argonaut Insurance Company. This was disapproved by the State of New York Insurance Department on June 21 and the rates for hospitals then in effect were continued without change with the proviso that they would subsequently be reviewed. The Superintendent of Insurance then launched an investigation into the data submitted by the Insurance Services Office in support of this filing. As a result of the investigation, the Superintendent found "that the proposed rate filing of the Insurance Services Office has no validity and should remain disapproved".

To be more specific the field examiners from the New York Insurance Department stated the conclusions of their investigation as follows:

Based upon our investigation as herein briefly described it is concluded that:

1. The loss statistics submitted by ISO reflected serious territorial distortions which favored Territory 72 (New York City) at the expense of Territory 00 (Remainder of State).
2. I.S.O.'s loss statistic included substantial amounts of losses which should have been omitted.
3. Very large amounts of premiums and exposures were miscoded as to Territory.

4. A total of $153,000 of premiums of Insurance Company of North America were erroneously included and $1,283,000 of premiums of Argonaut Insurance Company were omitted. If we assume that I.S.O. statistics on the remaining three companies are correct, our examiners “missed” approximately $1,139,000 (typographical error; read $1,130,000) of premiums of such insurers.

5. I.S.O.’s loss and premium statistics contain gross errors, are incomplete and therefore lack credibility.

(Parenthetical comments inserted by Staff of Massachusetts Special Commission)

The New York Superintendent of Insurance, in commenting on the difficulties which his field examiners faced, made the following statements in his report:

Insurance Services Office furnished only summary data by company for the policy year 1972 and no data for the policy year 1971 (Insurance Services Office explanation was that summary data by company for the policy year 1971 was no longer available because of “retention of records”).

The examiners were unable to reproduce the Insurance Services Office summary for the policy year 1972 because none of the companies kept copies of information originally sent to Insurance Services Office and none of the companies were able to reconstruct such information.

None of the companies maintained control records of hospital malpractice policies or premiums. As a consequence, the examiners were unable to obtain a substantial number of hospital malpractice policies.

Using policies obtained from policy numbers in claims files, the examiners found bed exposures of 31,586 as compared with the Insurance Services Office figure of 35,998. It should be noted the examiners were unable to obtain audit reports for some policies and that their figures included some estimated exposures which they advise are probably significantly lower than actual exposures and premiums determined from audits.

Substantial amounts of Insurance Services Office exposures and premiums had been misclassified as to territory, i.e., Remainder of State Territory exposures and premiums were understated by approximately 30% and New York City exposures and premiums were overstated by approximately 55%.

What then are we in Massachusetts to believe? If the ISO statistics filed for the State of New York lack credibility, should we believe that ISO statistics filed in Massachusetts are credible? At this point, we
firmly believe the only answer to this can be no. The Commonwealth’s only alternative at this point appears to be the carrying out of an in-depth field investigation and reconstruction of malpractice insurance experience for a sufficiently long period of time to give us a significant number of policy years which are virtually closed. We also must correlate ISO statistical filings with the base data that exists in insurance company files. In other words, some form of audit must be carried out with respect to this line of business.

We are told that not all malpractice insurers file statistics with ISO. We see from New York and New Jersey that those statistics filed with ISO may not correlate with the base data in the insurance company files. It appears from the recent New York experience that ISO might not have properly handled information which it did receive from reporting companies. In short, ISO has a problem, and their problem is our problem. ISO has been described as the only reliable source of correlated malpractice insurance statistical data. This Special Commission is of the view that no such degree of faith can be placed in the ISO statistics at the present time. We in Massachusetts must perform our own field investigation and audit in order to allow us to determine whether ISO filings are worthy of any credibility. Until such an investigation is completed and appropriate conclusions drawn, we believe it would be irresponsible for this state to go forward and set new premium rates for medical professional liability insurance on the basis of ISO statistics.

**Risk Classification**

As a prefatory note, we are aware that the decision on how to apportion the malpractice insurance premium burden reflect both statistical conclusions and public policy considerations. In other words, the actuarial data for the classification of a particular type of specialty might indicate that that specialty should be placed in a high risk category, but for other public policy reasons, it may be viewed as desirable to have that physician placed in a position where he carries a lesser premium burden. One thing is certain here, however, and that is our starting point must be the hard statistical data. Only after we understand what the reliable data is telling us, should we then go on to make the public policy decision as to the redistribution of premium burden.
In this connection we would like to develop a much better understanding of what the statistics are that have led to the present classification of risks. We are intrigued, for example, by a table which appeared in the July 29, 1975, report of the Michigan Physicians Crisis Committee. That Committee conducted a court docket survey of the malpractice cases filed in the Wayne, Oakland, and Macomb Circuit Courts in Michigan for the five years prior to the report. As a part of their survey, the Committee grouped the defendants in all of the malpractice cases, which they identified during the five year survey period, by specialty, and they then determined the number of claims filed against each such specialty. The number of doctors practicing each specialty in the tri-county area was obtained from the Michigan Medical Society. The result of this specific inquiry is set forth in the following table which shows the ratio of malpractice cases filed against members of each specialty per number of doctors practicing in the tri-county area in that specialty during the survey period. Also included in the table is the present insurance classification for each such specialty.

<table>
<thead>
<tr>
<th>M.D. SPECIALTY</th>
<th>RATIO OF CASES TO SPECIALISTS</th>
<th>INSURANCE CLASSIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro-Surgery</td>
<td>1 per 0.8</td>
<td>5</td>
</tr>
<tr>
<td>Orthopedic-Surgery</td>
<td>1 per 1.1</td>
<td>5</td>
</tr>
<tr>
<td>Otology</td>
<td>1 per 1.1</td>
<td>4</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>1 per 1.1</td>
<td>5</td>
</tr>
<tr>
<td>Obstetrics-Gyn.</td>
<td>1 per 1.9</td>
<td>5</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1 per 2.3</td>
<td>4</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>1 per 3.1</td>
<td>4</td>
</tr>
<tr>
<td>Urological Surgery</td>
<td>1 per 3.6</td>
<td>4</td>
</tr>
<tr>
<td>Otohinolaryngology</td>
<td>1 per 4.5</td>
<td>4</td>
</tr>
<tr>
<td>Radiology</td>
<td>1 per 5.6</td>
<td>1 (and 5)</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cardiovascular Surgery</td>
<td>1 per 6.5</td>
<td>4</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1 per 7.4</td>
<td>3</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1 per 9.6</td>
<td>2</td>
</tr>
<tr>
<td>General Practice</td>
<td>1 per 10.7</td>
<td>5</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1 per 10.7</td>
<td>2</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1 per 11.1</td>
<td>1</td>
</tr>
<tr>
<td>Allergy</td>
<td>1 per 11.6</td>
<td>1</td>
</tr>
<tr>
<td>Pathology</td>
<td>1 per 19.3</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1 per 23.9</td>
<td>1</td>
</tr>
</tbody>
</table>
The Physicians Crisis Committee, after developing this table, drew the following conclusion:

Analysis of Table 18 indicates general conformance in ranking with the insurance industry risk classifications of specialists — with a few disturbing exceptions. The Table discloses an immense discrepancy between the number of cases per anesthesiologists and the assigned "Class V" insurance risk classification, which is the highest and most expensive. For the cases in the Survey, anesthesiologists had a ratio of one malpractice claim for every 10.7 doctors in the specialty. In contrast, Pediatricians, with nearly an identical ratio of one claim per 9.6 doctors were assigned “Class I”, the lowest and least expensive. Anesthesiology was similarly out of rank with many Class III and Class IV Physicians. The Survey also raised questions about the insurance ranking of internists and cardiovascular surgeons.

Because of this discrepancy, Survey personnel checked and rechecked the initial figures with no significant change. The Committee has no explanation for it unless the size of the recoveries alone determines the classification for anesthesiologists.

This Special Commission is well aware of the fact that in order to obtain loss information, one must know not only the frequency of suit but also the severity of those suits. We, therefore, do not regard the above table as sufficient to allow any firm conclusion to be drawn, but it certainly does indicate to us that the Massachusetts experience in this regard must be determined. This also will be reflected in the survey to be carried out by this Special Commission.

Actuarial Procedures

The New York Superintendent of Insurance, in the November 7, 1975, report referred to above, also considered the matter of physicians’ and surgeons’ medical professional liability insurance premiums. As background, it should be known that in June 1975 the New York Medical Malpractice Insurance Association filed rates for such insurance which would have been 100% higher than the rates then in effect for Argonaut Insurance Company. The Department, on June 21, disapproved that filing and provided for an increase of 20%. The Superintendent of Insurance, by his November 7, 1975, finding, reaffirmed this action. He concluded that no consideration was given by the Association to the redundancy in case reserves (in the base data used by the Association) and to reductions in reported losses, which should have been made. Also, the rate calculations of MMIA did not properly reflect projections of reported losses to ultimate and
effect of investment yield on premiums held in reserve for payment of losses. While differing with MMIA on these specific items, the Superintendent of Insurance raised a much more fundamental question with respect to the inapplicability of standard actuarial procedures to this line of business. In his November 1975 report, the New York Superintendent of Insurance made the following statements:

In our further evaluation of the procedures applied by MMIA in their rate filing, we have noted that they have used standard actuarial procedures with some modifications for this special line. While one could differ with particular assumptions (e.g., trend factors, interest earnings), on balance the general methodology would be considered fundamentally sound by most actuaries.

The standard procedures, however, are based on the belief that the experience of the most recent past is the best indicator of future results. In addition, the procedures are accurate only to the extent that clear, definable trends in loss development and claim costs are present in the underlying data and thus can be assumed to continue in the future. In two absolutely critical areas—actual current reported incurred losses and anticipated development patterns (including both case basis developments and emerging IBNR claims) — the Employers, which was the original source of the underlying data, has challenged its own results. It contends that the patterns of recent years are atypical and cannot be expected to continue. Substantial weight must be given to this contention, since the Employers is obviously much closer to and has the best understanding of its own data. The Employers believes its reservations are so serious that it would be improper to use without change the traditional ratemaking method used by the MMIA. On the other hand, the MMIA has accepted all of the Employers' raw data without question.

The conflict over correct loss development factors deserves close examination. The MMIA observes that incurred losses have developed sharply upward in recent years, and believes that current reserves (before adjustment by Employers for redundancy) will run off just as poorly. The MMIA says, in effect, that these developments are indicative of outside pressures which are still increasing the costs of malpractice claims. There is good reason to believe, however, that the Employers itself produced these indicated developments by:

a) re-evaluating its older reserves and setting them at a more adequate level,

b) reserving new cases at the higher, more realistic levels, and

c) speeding up the settlement of large cases.
If this is the case and current total reserve levels (before adjustment for redundancy) are adequate, then current known incurred losses will not need to be adjusted further for their own future developments. In this event, known losses should be developed only to produce IBNR losses. For most lines of insurance, such differing approaches would produce only a moderate difference in final answers. In this line, however, loss development factors of 300% to 500% are typical, and an error in choosing the proper factor makes a critical difference in arriving at a proper rate. In the MMIA case, the challenged loss development factors serve roughly to double the estimated ultimate incurred losses.

Standard actuarial practice in large ratemaking organizations can reasonably ignore changes in individual company practices when establishing loss development factors. When a large rating bureau files revised rates, it theorizes that one company's possible reserve strengthening or accelerated payout rate is offset by another company's reserve slippage or payout slowdown. This Department has often departed from this view, when necessary, in the case of individual company rate filings. For example, a large independent automobile insurer asserted that its development factors were unreliable due to changes in claim practice and was permitted the use of loss developments different from those exhibited in the raw data. We recognize that, in such a case, judgment must be imposed in setting loss development factors more in line with what is most likely to occur in the future. In the present situation, we must weigh the conclusion of the examiners that current case reserves need no further development (except as indicated above for IBNR) against the MMIA contention that incurred cost estimates are less than half their ultimate cost. We would be forced to ignore the more current, more detailed, and more objective knowledge of our own examiners if we were to accept the MMIA position.

The speedup in payment of claims also affects the trend factors used by MMIA. Employers has informed us that it made a concerted effort to settle large claims quickly beginning in the early 1970's. As a result, average paid claim costs rose sharply during this period. The 16.1% severity trend calculated by MMIA from these figures is heavily influenced by these later years. It is possible that this trend factor is in part measuring real increases in claim costs, which it properly should, and in part the "one-shot" effect of a change in claim handling, which it should not. We would, in this connection, observe that the severity trend factor falls from 16.1% for the period from 1967 through 1974 to 13.1% for 1967 through 1973, to 11.4% for 1967 through 1972, to 9.2% for 1967 through 1971.
To summarize, the standard actuarial procedure would be proper if there were regular trends to be observed and projected in the underlying data, and if it could be shown that these trends were the result only of increased costs of the business itself. In this case, however, we must use judgment to modify the patterns appearing in the data, since these patterns are unstable at best.

The apparent volatility of the professional liability insurance market, coupled with possible changes in settlement procedures of companies operating in Massachusetts, suggest that reliable data is the cornerstone of our effort to achieve a better understanding of the malpractice insurance crisis and the most reasonable methods of meeting it.

Investment Income

When we consider the delays encountered in reporting and settling losses in medical professional liability insurance business, it can be seen that investment earnings will result on premiums held by the companies to pay claims. The report on the medical malpractice insurance market, which was prepared for the HEW Secretary's Commission on Medical Malpractice, stated that:

Such investment income can amount to a substantial sum, since there may be a long delay between the date of occurrence of the event and the date of payment of the resulting claim. The actuary for Employers' Insurance of Wausau has testified that, on the average, claims against that company under the physicians' and surgeons' professional liability coverage are paid out approximately as follows:

<table>
<thead>
<tr>
<th>Year Reported and Evaluated</th>
<th>Cumulative Percent Paid</th>
<th>Percent Paid During Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Second year</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Third year</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Fourth year</td>
<td>31%</td>
<td>15%</td>
</tr>
<tr>
<td>Fifth year</td>
<td>45%</td>
<td>14%</td>
</tr>
<tr>
<td>Sixth year</td>
<td>61%</td>
<td>16%</td>
</tr>
<tr>
<td>Seventh year</td>
<td>72%</td>
<td>11%</td>
</tr>
<tr>
<td>Eighth year</td>
<td>80%</td>
<td>8%</td>
</tr>
<tr>
<td>Ninth year</td>
<td>94%</td>
<td>14%</td>
</tr>
<tr>
<td>Tenth year</td>
<td>95%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Five percent of the dollar amount of claims for the year 1962 were still outstanding in 1971. An official of another company has estimated that the investment income from a mature book of professional liability insurance will equal approximately 15% of premiums.

More recently, the New York Superintendent of Insurance commented on this subject in the following manner:

In view of the delays encountered in reporting and settling losses in this line of insurance, it is customary to give consideration to investment earnings on premiums held by the company to pay claims.

In its filing, the MMIA considered such investment earnings to be 18% which were reflected in their rate calculations. Our review of the data submitted found that the investment earnings included in these calculations were not supported.

We, accordingly, made our own independent study based on the latest available data of Employers which indicated the average payout period to be 6 1/2 years. Recognizing the shortened statute of limitations for medical malpractice cases provided in the recently enacted legislation, we assumed a reduced payout period, namely 5 1/2 years. Based on a 5% interest rate compounded annually, after taxes, which was the same rate considered by MMIA, we arrived at investment earnings of 30.8%. We accordingly used 30% in our rate calculations.

This Special Commission has determined that in order to acquire sufficient information to allow full understanding of the malpractice insurance problem, we must have credible data from the companies on investment earnings generated by malpractice premium dollars.

Massachusetts Experience

One of the most troubling aspects of the problem springs from the fact that while the primary activity seeking solutions is at the state level (and we believe this is where it should remain), the argument is made that the experience from any single state is statistically insignificant and thus cannot be used as the basis for rate projections. This is particularly disheartening when one considers that Massachusetts, for example, has never had a discovery rule recognized, thus essentially avoiding extension of the statute of limitations and the exposure of Massachusetts physicians and their insurers. Nevertheless, it is unlikely that Massachusetts physicians have received any benefit from this fact in their insurance rates in past years. Furthermore, the usual response from actuaries to any changes in substantive tort law is that of saying "Well, let us wait a few years until the data becomes available to justify our making a downward
projection in loss experience or the like”. This Special Commission will have to examine the validity of statements that the Massachusetts experience, by itself, is not sufficiently large to be statistically significant. In order to do this we will have to start again with the basic information. If, indeed, it is concluded that the Massachusetts data base by itself is insufficient, then further effort will have to be devoted towards making our data base compatible with the data base in other states which are operating under conditions similar to our own. After such information is assembled, it may be that this Special Commission will recommend action along the lines of an inter-state compact for the pooling of such information, but which restricts membership in such compact to only those states which meet certain minimum standards with respect to discipline of physicians, meet statistical reporting standards and have taken basic steps with respect to the tort law as it exists in their state.

**Conclusion**

The Special Commission has concluded from its preliminary examination that there is virtually no reliable data available upon which to make the difficult decisions which face us concerning cost and availability of medical professional liability insurance. It is this Special Commission’s task, working together with the Insurance Commissioner, with physicians, with hospitals, with the insurance industry, and with the concerned public, to develop this data. This statistical study will have to be done properly or not at all. It may be relatively expensive, possibly on the order of several hundreds of thousands of dollars. We must view this, however, in the context of examining our alternatives. If medical professional liability insurance is priced beyond reach, the capability of our health care system to provide necessary service will decrease. This will have an immediate and adverse impact on the public health. Further, it is possible that it could lead to a shutdown of some of our health care institutions. This could deal a further blow to the general economy of Massachusetts, and aggravate our unhappy employment situation in the Commonwealth.

The price and availability of malpractice insurance — on which our preliminary investigations will focus as a matter of necessity — are only a part of the evaluation that we must perform. The legal, insurance and medical system with which we now deal with
malpractice is a means to an end, and the end is the efficient and equitable delivery of high quality medical care to all who need it. Accordingly, one principal concern of the work this commission expects to do will be to analyze the effect of various ways of dealing with medical malpractice on the quality of care available to consumers of medical services. This research, like the price and availability studies discussed above, will be expensive and difficult to perform, but the Commission feels that the influence of any solution to the malpractice problem on the cost and quality of medical care is a fundamental measure of such a solution's merit.

This Special Commission is committed to the proposition that before a solution to the malpractice insurance problem can be found, we must be able to identify the true dimensions of that problem. We must step back from arguing our prejudices and devote our common effort to developing that hard information which will allow us to go forward in a well-informed manner. Only after we have reliable information can we move toward any reasonable long-term solution to the problem.

We respectfully solicit the active cooperation and assistance in this common task which is so important to us all.

Respectfully submitted,

Special Commission on Medical Professional Liability Insurance

Daniel J. Foley, Chairman
Raymond M. LaFontaine, Vice Chairman
Senator Arthur J. Lewis
Senator John F. Aylmer
Rep. William C. Mullin
Rep. Max Volterra
Rep. Iris K. Holland
Dr. Richard F. Gibbs
Mr. Michael O’Hare
Mr. Patrick Carroll
Attorney Thomas D. Burns
Whereas, The deferred operation of this act would tend to defeat its purpose, which is, in part, to guarantee the continued availability of medical malpractice insurance, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 13 of the General Laws is hereby amended by striking out section 10, as most recently amended by section 2 of chapter 1099 of the acts of 1971, and inserting in place thereof the following section:

Section 10. There shall be a board of registration and discipline in medicine, in this and the following section called the board, consisting of seven persons appointed by the governor, who shall be residents of the commonwealth, five of whom shall be physicians registered under section two of chapter one hundred and twelve, or corresponding provisions of earlier laws, and two of whom shall be representatives of the public, subject to the provisions of section nine B. Each member of the board shall serve for a term of three years.

No member shall be appointed to more than two consecutive full terms; provided, however, a member appointed for less than a full term may serve two full terms in addition to such part of a full term, and a former member shall again be eligible for appointment after a lapse of one or more years. Any member of the board may be removed by the governor for neglect of duty, misconduct, malfeasance or misfeasance in office
after being given a written statement of the charges against him and sufficient opportunity to be heard thereon. The board shall elect from its members a chairman, vice-chairman and secretary who shall serve for one year and until their successors are appointed and qualified. The board shall meet at least once a month or more often upon the call of the chairman at such times and places as the chairman shall designate.

Members of the board shall, subject to appropriation, be paid thirty-five dollars for each day or part thereof spent in performing their duties, and shall receive their necessary traveling and other expenses while engaged in the business of the board, provided that the amount for expenses shall not be more than twenty dollars per day, except for traveling expense which shall not be more than eight cents per mile.

The board shall adopt, amend, and rescind such rules and regulations as it deems necessary to carry out the provisions of this chapter; may appoint legal counsel and such assistants as may be required; may make contracts and arrangements for the performance of administrative and similar services required, or appropriate, in the performance of the duties of the board; and may adopt and publish rules of procedure and other regulations not inconsistent with other provisions of the General Laws.

SECTION 2. Chapter 112 of the General Laws is hereby amended by striking out section 2, as most recently amended by chapter 138 of the acts of 1975, and inserting in place thereof the following section:-

Section 2. Applications for registration as qualified physicians, signed and sworn to by the applicants, shall be made upon blanks furnished by the board of registration and discipline in medicine, herein and in sections three to nine A, inclusive, called the board. Each applicant who shall furnish the board with satisfactory proof that he is eighteen years of age or over and of good moral character, that he has completed
two years of premedical studies in a college or university, that he has attended courses of instruction for four years of not less than thirty-two school weeks in each year, or courses which in the opinion of the board are equivalent thereto, in one or more legally chartered medical schools and that he has received the degree of doctor of medicine, or its equivalent, from a legally chartered medical school in the United States or commonwealth of Puerto Rico or Canada having the power to confer degrees in medicine, shall upon payment of one hundred and twenty-five dollars, be examined, and, if found qualified by the board, be registered as a qualified physician and entitled to a certificate in testimony thereof, signed by the chairman and secretary. An applicant who has received from a medical school, legally chartered in a sovereign state other than the United States, the commonwealth of Puerto Rico or Canada, a degree of doctor of medicine or its equivalent shall be required to furnish to the board such documentary evidence as the board may require that his education is substantially the equivalent of that of graduates of medical schools in the United States and such other evidence as the board may require as to his qualifications to practice medicine, and shall, unless granted an exemption by the board, be required to present a Standard Certificate granted after examination by the Educational Council for Foreign Medical Graduates; provided, however, that an applicant who shall furnish the board with satisfactory proof that he is eighteen years of age or over and of good moral character, that he has completed two years of premedical studies in a college or university of the United States or Canada shall not be required to possess a certificate by the Educational Council for Foreign Medical Graduates and shall be admitted to the examination for licensure if he has studied medicine in a medical school outside the United States which is recognized by the World Health Organization, has completed all the formal requirements for the degree
corresponding to doctor of medicine except internship and social service or internship or social service, has satisfactorily completed one academic year of supervised clinical training sponsored by an approved medical school in the United States or Canada, and has completed one year of graduate medical education in a program approved by the Liaison Committee on Graduate Medical Education of the American Medical Association. If the board shall be satisfied as to his education and his qualifications, the board shall, upon payment of one hundred and twenty-five dollars by the applicant, admit him to the examination for licensure.

An applicant failing to pass an examination satisfactory to the board shall be entitled to two reexaminations within two years at a meeting of the board called for the examination of applicants upon payment of a further fee of seventy-five dollars for each reexamination; but two such reexaminations shall exhaust his privilege under his original application.

The board may without examination grant certificates of registration as qualified physicians to such graduates of medical schools: (1) who shall furnish with their applications satisfactory proof that they have the qualifications required in the commonwealth to entitle them to be examined and have been licensed or registered upon a written examination in another state whose standards, in the opinion of the board, are equivalent to those in the commonwealth, or (2) who are diplomates of specialty boards recognized by the American Medical Association or the American Osteopathic Association; provided that any person who has previously attempted unsuccessfully to secure registration in the commonwealth shall be registered under the provisions of this paragraph without examination only at the discretion of the board. The fee for such
registration without examination shall be seventy-five dollars.

Notwithstanding any other provisions of this chapter the board may without examination grant a certificate of registration as a qualified physician to such person as shall furnish with his application satisfactory evidence that he is: (1) a graduate of a Canadian medical school and is licensed by the Medical Council of Canada and by a provincial licensing authority; or (2) is licensed in the commonwealth of Puerto Rico or in the province of Saskatchewan in Canada upon obtaining a grade of seventy-five per cent or better in the federation licensing examination of the federation of state medical boards of the United States. Any person granted a certificate of registration under the provisions of this paragraph shall pay a fee of seventy-five dollars.

The board shall require that all physicians registered in the commonwealth renew their certificates of registration with the board effective January the fifteenth, nineteen hundred and seventy-six and at two year intervals thereafter. The renewal application shall be accompanied by a fee of fifty dollars and shall include the physician's name, license number, home address, office address, his specialty or specialties, the principal setting of his practice, and whether he is an active or inactive practitioner.

The board shall mail a renewal application to each registered physician sixty days prior to the renewal date. The certification of registration of any physician who does not file a completed renewal application together with the fee shall be automatically revoked, but shall be revived upon completion of the renewal process. The expenses and compensation of the board of registration and discipline in medicine shall be paid by the commonwealth, but said expenses and compensation shall not be in excess of the amounts received by the commonwealth for certificates of renewal or any registration fees under this section.
SECTION 3. Said chapter 112 is hereby further amended by striking out section 5, as amended by section 12 of chapter 425 of the acts of 1937, and inserting in place thereof the following section:

Section 5. The board shall investigate all complaints relating to the proper practice of medicine by any person holding a certificate of registration under sections two to twelve A, inclusive, or of section sixty-five so far as it relates to medicine and report the same to the proper prosecuting officers.

The board may, after a hearing pursuant to chapter thirty A, revoke, suspend, or cancel the certificate of registration, or reprimand, censure, or otherwise discipline a physician registered under said sections upon proof satisfactory to a majority of the board that said physician:

(a) fraudulently procured said certificate of registration;

(b) is guilty of an offense against any provision of the laws of the commonwealth relating to the practice of medicine, or any rule or regulation adopted thereunder;

(c) is guilty of gross misconduct in the practice of medicine or of practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions;

(d) is guilty of practicing medicine while the ability to practice is impaired by alcohol, drugs, physical disability or mental instability;

(e) is guilty of being habitually drunk or being or having been addicted to, dependent on, or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects;

(f) is guilty of knowingly permitting, aiding or abetting an unlicensed person to perform activities requiring a license for purposes of fraud, deception or personal gain, excluding activities permissible under any provision of the laws of the commonwealth relative to the
training of medical providers in authorized health care institutions and facilities;

(g) is guilty of violating any rule or regulation of the board, governing the practice of medicine.

The board shall, after proper notice and hearing, adopt rules and regulations governing the practice of medicine in order to promote the public health, welfare, and safety and nothing in this section shall be construed to limit this general power of the board.

If the physician is found not guilty the board shall forthwith order a dismissal of the charges and the exoneration of the accused.

SECTION 4. Chapter 175A of the General Laws is hereby amended by inserting after section 5 the following section:

Section 5A. The commissioner shall, annually on or before December first, after due hearing and investigation, fix and establish fair and reasonable classification of risks and adequate, just, reasonable and nondiscriminatory premium charges on claims made and occurrence basis to be used and charged by companies in connection with the issue or execution of medical malpractice insurance for the ensuing calendar year or any part thereof. In fixing and establishing premium charges in accordance with the provisions of this section, the commissioner shall prorate equally all charges to the insured according to actual calendar days of coverage. The effective dates of procurement or cancellation of insurance from insurance companies shall determine the cost to the insured for each coverage on an equal per diem basis established for the calendar year cost of insurance policies. The commissioner shall, on or before said date, sign memoranda of the classifications and premium charges fixed and established by him in such form as he may prescribe and file the same in his office and cause a duly certified copy of such classifications and schedule of premium charges forthwith to be transmitted to each company authorized to issue such policies. During said calendar year,
the classification and premium charges fixed and established by the commissioner from such policies may be used as a maximum charge by a company issuing such policies, however such premiums below the premiums established by the commissioner shall be uniform for all such classifications throughout the commonwealth. Such deviation shall be filed with the commissioner and he shall allow such deviation only if the commissioner finds that the premium charges the insurer desires to use are adequate, just, reasonable and nondiscriminatory and will not be used by the insurer as a means of attracting only such risks as are regarded as presenting less hazard of loss than others in the same classification. Every application for permission to so deviate shall be filed with the commissioner subsequent to and within thirty days of his having filed in his office the memorandum aforesaid and shall specify the basis thereof and shall be accompanied by the data upon which the applicant relies. The commissioner shall then set the time and the place for a hearing on such applications at which the applicant may be heard and shall give the applicant not less than ten days written notice thereof. The time so established for the hearing shall not be later than thirty days after receipt by the commissioner of the application. If the commissioner finds that the deviation is justified and the resulting premium charges satisfy the requirements of this section, he shall issue an order permitting the deviation to be used by the applicant for the ensuing calendar year beginning January first.

In fixing and establishing the charges, as provided in this section, the commissioner shall take into account investment income and potential income from unearned premiums, loss reserves and all cash flows.

No company shall be authorized to issue a policy of medical malpractice insurance unless it makes a mandatory offer to issue to the purchaser of such a policy, at his election, coverage on either a claims made or occurrence basis.
The commissioner may make, and at any time, alter or amend, reasonable rules and regulations to facilitate the operation of this section and enforce the application of the classifications and premium charges fixed and established by him, and to govern hearings and investigations under this section. The commissioner may at any time require any company to file with him such data, statistics, schedules or information as he may deem proper or necessary to enable him to fix and establish or secure and maintain fair and reasonable classifications of risks and adequate, just, reasonable and nondiscriminatory premium charges for such policies. Every company selling medical malpractice insurance coverage in the commonwealth shall file with the commissioner complete financial records showing the amount of profit or loss made on every classification of medical malpractice insurance during the previous year, and shall also file records showing profits from investment income including investment income on net realized capital gains and loss reserves and unearned premiums. The commissioner may issue such orders as he finds proper, expedient or necessary to enforce and administer the provisions of this section, to secure compliance with any rules or regulations made thereunder, and to enforce coherence to the classifications and premium charges fixed and established by him. The supreme judicial court for the county of Suffolk shall have jurisdiction upon the complaints of the commissioner, and upon a summary hearing, to enforce all lawful orders of the commissioner. Memoranda of all actions, orders, findings and decisions of the commissioner shall be signed by him and filed in his office as public records open to public inspection.

Any person or company aggrieved by any action, order, finding or decision of the commissioner under this section may, within twenty days from the filing of such memorandum thereof in his office, file a complaint in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decision. An order of notice returnable
not later than seven days from the filing of such complaint shall forthwith issue and be served upon the commissioner. Within ten days after the return of said order of notice, the complaint shall be assigned for a speedy and summary hearing on the merits. The action, order, finding or decision of the commissioner shall remain in full force and effect pending the final decision of the court unless the court or a justice thereof after notice to the commissioner shall by a special order otherwise direct. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision, shall review all questions of fact and of law involved therein and may make any appropriate judgment. The decision of the court shall be final and conclusive on the parties. The court may make such order as to costs as it deems equitable. The court shall make such rules or orders as it deems proper, governing proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon.

If, for any reason, classifications of risks and premium charges fixed and established as aforesaid on or before December first in any year for the ensuing calendar year are not effective for the said year, the classifications of risks and premium charges in effect for the then calendar year shall remain in full force and effect and shall be used and charged in connection with the issue of medical malpractice insurance policies for said ensuing calendar year until classifications of risks and premium charges for said ensuing calendar year are finally fixed and established. Classifications of risks and premium charges when finally fixed and established for said ensuing calendar year shall become effective as of January first of said year, and all premium charges affected by any change thereby made which have been paid or incurred prior to the time when such charges are finally fixed and established shall be adjusted in accordance with such change, as of said January first.

Every mutual company issuing medical malpractice insurance policies
shall constitute such policies as a separate class of business for the purpose of paying dividends. Any dividends on such policies shall be declared on the profits of the company from said class of business.

Insurance companies shall, at the option of the insured, accept payment of medical malpractice insurance premiums in installments under plans, rates and charges approved by the commissioner, after such notice as shall be prescribed by the commissioner and after public hearing thereof, provided, however, that each insurance company shall offer at least one installment payment plan for each policy which either gives the insured the option to pay the annual premium in a minimum of six monthly installments or gives the insured the option to pay the annual premium in four quarterly installments.

Effective sixty days after the inception of a medical malpractice insurance contract no notice of intention to terminate the contract or, if the contract is a renewal, no notice of intention not to renew the contract shall be effective unless the insurer at least ninety days prior to the effective date of such cancellation or the end of the contract period, as the case may be, mails or delivers to the insured at the address shown on the policy such notice of cancellation or intention not to renew except where the cancellation is for nonpayment of premium, or where the insured has lost his license to practice medicine, or if the insured is a hospital, no longer possesses a valid operating certificate.

For the purposes of this section, a medical malpractice insurance contract shall mean an insurance contract covering liability arising out of the practice of medicine by a duly licensed physician or the operation of a duly certified hospital with respect to the treatment of patients, including all acts of its agents and employees.

SECTION 5. Chapter 231 of the General Laws is hereby amended by inserting after section 60A the following four sections:
Section 60B. Every action for malpractice, error or mistake against a provider of health care shall be heard by a tribunal consisting of a single justice of the superior court, a physician licensed to practice medicine in the commonwealth under the provisions of section two of chapter one hundred and twelve and an attorney authorized to practice law in the commonwealth, at which hearing the plaintiff shall present an offer of proof and said tribunal shall determine if the evidence presented if properly substantiated is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result.

Said physician shall be selected by the single justice from a list submitted by the Massachusetts Medical Society representing the field of medicine in which the alleged injury occurred and licensed to practice medicine and surgery in the commonwealth under the provisions of section two of chapter one hundred and twelve. The list submitted to the single justice shall consist only of physicians who practice medicine outside the county where the defendant practices or resides or if the defendant is a medical institution or facility outside the county where said institution or facility is located. The attorney shall be selected by the single justice from a list submitted by the Massachusetts Bar Association. The attorney and physician shall, subject to appropriation, each be compensated in the amount of fifty dollars.

Where the action of malpractice is brought against a provider of health care not a physician, the physician's position on the tribunal shall be replaced by a representative of that field of medicine in which the alleged tort or breach of contract occurred, as selected by the superior court justice in a manner he determines fair and equitable.

Where there are codefendants representing more than one field of health care the superior court justice shall determine in his discretion who shall represent the health care field on the tribunal.
Each such action for malpractice shall be heard by said tribunal within fifteen days after the defendant's answer has been filed. Substantial evidence shall mean such evidence as a reasonable person might accept as adequate to support a conclusion. Admissible evidence shall include, but not be limited to, hospital and medical records, nurses' notes, x-rays and other records kept in the usual course of the practice of the health care provider without the necessity for other identification or authentication, statements of fact or opinion on a subject contained in a published treatise, periodical, book or pamphlet or statements by experts without the necessity of such experts appearing at said hearing.

The tribunal may upon the application of either party or upon its own decision summon or subpoena any such records or individuals to substantiate or clarify any evidence which has been presented before it and may appoint an impartial and qualified physician or surgeon or other related professional person or expert to conduct any necessary professional or expert examination of the claimant or relevant evidentiary matter and to report or to testify as a witness thereto. Such a witness shall be allowed traveling expenses and a reasonable fee to be fixed by the tribunal which shall be assessed as costs. The testimony of said witness and the decision of the tribunal shall be admissible as evidence at a trial.

If a finding is made for the defendant the plaintiff may pursue the claim through the usual judicial process only upon filing bond in the amount of two thousand dollars secured by cash or its equivalent with the clerk of the court in which the case is pending, payable to the defendant for costs assessed, including witness and experts fees and attorneys fees if the plaintiff does not prevail in the final judgment. Said single justice may, within his discretion, increase the amount of the bond required to be filed. If said bond is not posted within thirty days of the tribunal's finding the action shall be dismissed. Upon
motion filed by the plaintiff, and a determination by the court that the plaintiff is indigent said justice may reduce the amount of the bond but may not eliminate the requirement thereof.

For the purposes of this section, a provider of health care shall mean a person, corporation, facility or institution licensed by the commonwealth to provide health care or professional services as a physician, hospital, clinic or nursing home, dentist, registered or licensed nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

The expenses and compensation of said tribunal shall be paid by the commonwealth, provided, however, that the pro rata percentage of such expenses and compensation engendered by actions brought against providers of health care registered under chapter one hundred and twelve shall not be in excess of the amounts received by the commonwealth for registration fees for such providers of health care under said chapter one hundred and twelve, less the amount expended for expenses and compensation of the respective boards of registration of said providers of health care under said chapter one hundred and twelve.

Section 60C. No writ or complaint for malpractice, error or mistake against a provider of health care shall contain an ad damnum or monetary amount claimed against such defendant.

Section 60D. Notwithstanding the provisions of section seven of chapter two hundred and sixty, any claim by a minor against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect shall be commenced within three years from the date an action first occurs, except that a minor under the full age of six years shall have until his ninth birthday in which the action may be commenced.

Section 60E. In any civil action for malpractice, error or mistake
against a provider of health care where an impartial medical examination has not been ordered at a hearing under the provisions of section sixty B, the presiding justice at a trial may upon the application of either party or upon his own decision appoint an impartial and qualified physician or surgeon or other related professional person or expert to conduct any necessary professional or expert examination of the claimant or relevant evidentiary matter and to report to or testify as a witness thereto. Such a witness shall be allowed traveling expenses and a reasonable fee to be fixed by said justice.

SECTION 6. As used in this section the following words shall have the following meanings:

"Association", the joint underwriting association established pursuant to the provisions of this section.

"Commissioner", the commissioner of insurance.

"Health care provider", any doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, or a registered nurse licensed under the provisions of chapter one hundred and twelve of the General Laws, an intern, fellow, or medical officer registered under section nine of said chapter one hundred and twelve, or a certified hospital, clinic, or nursing home, and its agents and employees.

"Medical malpractice insurance", insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any health care provider.

"Net direct premiums", gross direct premiums written on personal injury liability insurance written pursuant to the provisions of chapter ninety and one hundred and seventy-five of the General Laws including the liability component of multiple paid package policies as computed by the commissioner less all premiums and dividends credited or returned to
policyholders or the unused or unabsorbed portions of premium deposits.

A temporary, nonexclusive, joint underwriting association is hereby established, consisting of all insurers authorized to write and engaged in writing, within the commonwealth on a direct basis, personal injury liability insurance pursuant to the provisions of chapter ninety and one hundred and seventy-five of the General Laws including insurers covering such perils in multiple peril package policies. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact such kind of insurance within the commonwealth. The purpose of the association shall be to provide medical malpractice insurance on a self-supporting basis.

The association shall, pursuant to the provisions of this section and the plan of operation with respect to medical malpractice insurance, have the power on behalf of its members to issue or to cause to be issued policies of insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under one policy and three million dollars for all claimants under one policy in any one year, or ten million dollars for all claimants under one policy in any one year, provided that the applicant is a hospital; to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform these functions; to assume reinsurance from its members; and to assign reinsurance.

The commissioner shall, after consultation with the joint underwriting association, representatives of the public, the Massachusetts Medical Society, Massachusetts Hospital Association and other affected individuals and organizations promulgate a plan of operation consistent with the provisions of this section, to become effective and operative no later than July first, nineteen hundred and seventy-five. Said plan of operation shall provide for economic, fair and nondiscriminatory administration
and for the prompt and efficient provision of medical malpractice insurance, and shall contain other provisions including, but not limited to preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers and procedures for determining amounts of insurance to be provided by the association. Said plan shall also provide that any profit achieved by the association shall be added to the reserves of the association or returned to the policyholders as a dividend. Amendments to the plan of operation may be made by the directors of the association, subject to the approval of the commissioner, or shall be made at the direction of the commissioner.

Any licensed physician or hospital upon proof that the physician or hospital has made a reasonable effort to obtain insurance and has been unable to obtain it shall be entitled to apply to the association for such coverage. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant. If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation and there is no unpaid, uncontested premium due from the applicant for prior insurance as shown by the insured having failed to make written objection to premium charges within thirty days after billing, the association, upon receipt of the premium, or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice insurance for a term of one year. If at any time the commissioner determines that medical malpractice insurance is not adequately available to any provider of health care in the commonwealth, other than a licensed physician or hospital, he shall, after proper notice and hearing, promulgate an order allowing the particular provider of health care to be eligible
for application to the association.

The rates, rating plans, rating rules, rating classifications, territories and policy forms applicable to the insurance written by the association and statistics relating thereto shall be subject to section five A of chapter one hundred and seventy-five A of the General Laws. Within such time as the commissioner shall direct, the association shall submit for the approval of the commissioner, an initial filing, in proper form, of policy forms applicable to medical malpractice insurance to be written by the association. In the event the commissioner disapproves such initial filing, the association shall amend such filing, in whole or in part, in accordance with the direction of the commissioner. If the commissioner is unable to approve such filing or amended filing, within the time specified, he shall promulgate the policy forms, and rules to be used by the association in writing such insurance.

Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by an assessment upon the policyholders, or a rate increase applicable prospectively, or both; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not.

Effective after the initial year of operation rates, rating plans and any provision for recoupment through policyholder assessment or premium rate increase, shall be based upon the association's loss and expense experience; and investment income from unearned premium and loss
reserves together with such other information based upon such experience as the commissioner may deem appropriate. The resultant premium rates shall be on an actuarially sound basis and shall be calculated to be self-supporting. In the event that sufficient funds are not available for the sound financial operation of the association, pending recoupment as provided hereinbefore, all members shall, on a temporary basis contribute to the financial requirements of the association in the manner hereinafter provided. Any such contribution shall be reimbursed to the members following recoupment as provided in this section. The association shall offer policies on both a claims made and occurrence basis so that applicants may select either policy at their option; provided, however, that the premium rate charged for both claims made and occurrence policies shall be at rates established on an actuarially sound basis and which are calculated to be self-supporting.

All insurers which are members of the association shall participate in its writings, expenses, and losses in the proportion that the net direct premiums of each such member, excluding that portion of premiums attributable to the operation of the association written during the preceding calendar year, bears to the aggregate net direct premiums written in the commonwealth by all members of the association. Each insurer's participation in the association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the commissioner. No member shall be obligated in any one year to reimburse the association on account of its proportionate share in the deficit from operations of the association in that year in excess of one per cent of its surplus to policyholders and the aggregate amount not so reimbursed shall be reallocated among the remaining members in accordance with the method of determining participation prescribed in this section after excluding from the computation the total net direct
premiums of all members not sharing in such excess deficit. In the event that the deficit from operations allocated to all members of the association in any calendar year shall exceed one per cent of their respective surplus to policyholders, the amount of such deficit shall be allocated to each member in accordance with the method of determining participation prescribed in this section.

The association shall be governed by a board of eleven directors, eight of whom shall be elected by cumulative voting by the members of the association, whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year. Three directors shall be appointed by the commissioner as representatives of the medical profession. The eight elected directors serving on the first board shall be elected at a meeting of the members, or their authorized representatives, which shall be held at a time and place designated by the commissioner. The other three directors serving on the first board shall be appointed on or before the date of such meeting.

Any applicant to the association, any person insured pursuant to this section, or their representatives, or any affected insurer, may appeal for review to the commissioner within thirty days after any ruling, action, or decision by or on behalf of the association, with respect to those items the plan of operation defines as appealable matters. On receipt of any such appeal, the commissioner shall, after due hearing and investigation, enter such finding or decision as he deems shall best meet the purpose of this section.

Any person aggrieved by any such finding, order or decision and any person aggrieved by any other rule or regulation of the commissioner made pursuant to this section may, within ten days of the filing of any such finding, order, decision, rule or regulation in the office of the commissioner, appeal therefrom to the superior court, for the county in
which the complainant resides. The court shall, after such notice to the parties as it deems reasonable, hold a summary hearing on such appeal and shall have jurisdiction to review all questions of fact and law, and to affirm or reverse such finding or order and to make any appropriate judgment.

The association shall file in the office of the commissioner, annually on or before the first day of March, a statement which shall contain information with respect to its transactions, condition, operations and affairs during the preceding year. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the commissioner. The commissioner may, at any time, require the association to furnish additional information with respect to its transactions, condition or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the association.

The commissioner shall make an examination into the affairs of the association at least annually. Such examination shall be conducted and the report thereon filed in the manner prescribed in section four of chapter one hundred and seventy-five of the General Laws.

There shall be no liability on the part of, and no cause of action of any nature shall arise against the association, its agents or employees, an insurer, any licensed agent or broker, or the commissioner or his authorized representatives, for any statements made in good faith by them in any reports or communications concerning risks insured or to be insured by the association, or at any administrative hearing conducted in connection therewith.

SECTION 7. The commissioner of insurance, hereinafter called the commissioner, is hereby authorized and directed to hold a public hearing on or before November fifteenth, nineteen hundred and seventy-six, relative to the earnings realized or to be realized by insurance companies
from medical malpractice insurance policies issued or executed in the
commonwealth for the year nineteen hundred and seventy-six. If the
commissioner determined from such hearings that said earnings either
have or may result in an unfair profit to said insurance companies, he
shall direct such insurance companies to set sufficient funds aside as a
special reserve, in an amount determined by him to be adequate to assure
the availability of funds to provide for a fair and reasonable sharing
of such profits by the policyholders.

If the commissioner is able finally to determine, prior to December
first, nineteen hundred and seventy-six the extent of any such unfair
profit, he shall direct the aforesaid insurance companies, under a
schedule determined by him, to return to its medical malpractice policyholders
for the year nineteen hundred and seventy-six such share of such profits
as he determines is fair and reasonable, said returns to be made by
payment to such policyholders or as an identified credit on policies or
bonds issued to such policyholders in the year nineteen hundred and
seventy-seven.

If the commissioner is unable finally to determine the extent of
any such unfair profit from the information available to him prior to
December first, nineteen hundred and seventy-six, he shall fix and
establish premium charges for the calendar year nineteen hundred and
seventy-seven under the provisions of section five A of chapter one
hundred and seventy-five A of the General Laws; provided, however, such
rates shall be provisional. The commissioner shall thereafter hold
another public hearing at a time in the year nineteen hundred and seventy-
seven selected by him when adequate information relating to the earnings
realized by insurance companies from medical malpractice insurance
policies issued in the year nineteen hundred and seventy-six becomes
available. The commissioner shall then finally determine the extent of
any such unfair profit and shall finally determine whether the premium
charges established by him provisionally for the calendar year nineteen hundred and seventy-seven meet the standards set forth in said section five A. After making said findings, the commissioner shall either direct the aforesaid insurance companies to return to their medical malpractice policyholders for the year nineteen hundred and seventy-six such share of such profits as he determines is fair and reasonable, or he shall adjust, if necessary, and set finally the premium charges under said section five A. The commissioner shall give appropriate credit to any such insurance company that has paid a dividend to policyholders or otherwise voluntarily returned profits on medical malpractice insurance policies issued or executed by it within the commonwealth for the year nineteen hundred and seventy-six.

The commissioner may also, if necessary, establish separate rates of return for each company providing medical malpractice insurance in the commonwealth.

The commissioner may direct that the insurance companies use all or part of the special reserve fund either to make payment of said returns or offset income loss on policies issued in nineteen hundred and seventy-seven because of any rate reduction authorized under the provisions of this act. The commissioner may also make such orders with respect to the disposition of the special reserve fund as may be necessary to effect the purpose of this act. Failure of the insurance companies to return the amounts as so determined by the commissioner shall be sufficient cause for him to revoke the right of the company to do business in the commonwealth after December thirty-first, nineteen hundred and seventy-six.

Any person or company aggrieved by any action, order, finding or decision of the commissioner under this chapter may appeal to the supreme judicial court under the provisions of and for the relief set forth for appeals in section five A of chapter one hundred and seventy-five of the
General Laws.

The court shall determine whether the filing of the appeal shall operate as a stay of any such order or decision of the commissioner. The court may in disposing of the issue before it, modify, affirm, or reverse the order or decision of the commissioner in whole or in part.

SECTION 8. The board of registration in medicine, established under the provisions of section ten of chapter thirteen of the General Laws, in effect prior to the effective date of this act, is hereby abolished as of January first, nineteen hundred and seventy-six.

SECTION 9. Of the members of the board of registration and discipline in medicine first appointed pursuant to section ten of chapter thirteen of the General Laws, amended by section one of this act, two shall be appointed for a term of one year, two for two years and three for three years and their successors shall be appointed for terms of three years.

SECTION 10. All books, papers, records, documents, equipment, facilities and other property, which immediately prior to January first, nineteen hundred and seventy-six, are in the custody of the board of registration in medicine, established under the provisions of section ten of chapter thirteen of the General Laws, in effect prior to the effective date of this act, and all duly existing contracts, leases and obligations of the board of registration in medicine are hereby transferred to the board of registration and discipline in medicine pursuant to said section ten, as amended by section one of this act.

SECTION 11. All petitions, hearings and other proceedings duly brought before, and all prosecutions and legal and other proceedings duly begun by, said board of registration in medicine which arise from or relate to the exercise of such powers or the performance of such duties, and which are pending immediately prior to January first, nineteen hundred and seventy-six, shall continue unabated and remain in force notwithstanding the passage of this act, and shall thereafter be completed.
before or by the board of registration and discipline in medicine pursuant to section ten of chapter thirteen of the General Laws, amended by section one of this act.

SECTION 12. A special commission, to consist of three members of the senate, four members of the house of representatives with minority party representation, the commissioner of insurance or his designee, and five persons to be appointed by the governor, one of whom shall be a representative of the Massachusetts Medical Society, one of whom shall be a representative of the Massachusetts Bar Association, one of whom shall be a representative of an insurance industry organization representing, at least in part, companies providing medical professional liability insurance coverage in the commonwealth, one of whom shall be a representative of the Massachusetts Hospital Association, and one of whom shall be a consumer of health care services who is not a physician, lawyer, or officer or employee of a hospital or insurance company, is hereby established for the purpose of making an investigation and study of medical professional liability insurance and the nature and consequences of medical malpractice. The secretary of consumer affairs or his designee, the secretary of human services or his designee and the chairman of the board of registration and discipline in medicine shall be ex-officio nonvoting members.

Said commission shall, in the course of its investigation and study, consider, among other questions it deems relevant, the scope and extent of the malpractice problem; reasons for the increase in malpractice claims; effects on the rise in malpractice claims on health care providers, including the increased use of defensive medicine and increased premium costs; effect of claims increase on patients, including increased costs; alternative approaches and proposed solutions to the malpractice problem; whether the presently threatened withdrawal of insurance from the medical professional liability insurance market was caused, at least in part, by the investment practices of said companies; whether the amounts that
companies set aside as loss reserves are fair and reasonable; whether and how present methods of regulating said companies should be modified; whether, and to what extent, the passage of an act establishing a joint underwriting association has had an impact on the availability and price of medical professional liability insurance in the commonwealth; whether an examination of malpractice cases in the commonwealth over at least the past ten years indicates that courts and juries have modified the classical definition of medical malpractice and that damage awards have been unjustifiably high; whether the imposition of limits on lawyers contingency fees in medical malpractice cases is warranted; whether the imposition of ceilings on medical malpractice damage awards is warranted; whether the collateral sources rule should be applied to medical malpractice cases; whether claims handling policies of insurance companies have an effect on whether aggrieved patients institute suit for medical malpractice; and whether the medical and legal professions have adequately discharged their obligations to the public to discipline their respective members who are guilty of medical malpractice or the unjustified institution of suit on the grounds of medical malpractice. Said commission may travel without the commonwealth, and may require by summons the attendance and testimony under oath of witnesses and the production of books and papers.

The commission may expend for expenses and for such legal, actuarial, research, clerical and other assistance such sums as may be appropriated therefor not to exceed eighty thousand dollars annually provided, however, that all costs of administration and operation of said commission shall be borne by all insurance companies licensed by the commonwealth to provide liability, multiple peril or accident and health insurance coverage and by nonprofit hospital and medical service corporations licensed under the provisions of chapters one hundred seventy-six A and one hundred seventy-six B of the General Laws. The commissioner of insurance shall apportion such costs among all such companies and shall assess them on a fair and reasonable basis.
Said commission shall meet at least quarterly and may report from time to time its findings and recommendations to the general court together with drafts of legislation necessary to carry its recommendations into effect, and shall file its annual report no later than the last Wednesday in December.

SECTION 13. Sections four, six and twelve of this act shall take effect upon their passage, and all other sections of this act shall take effect on January first, nineteen hundred and seventy-six. Section six of this act shall terminate on December thirty-first, nineteen hundred and seventy-seven.

SECTION 14. The provisions of this act are severable and if any of its provisions shall be held unconstitutional by any court of competent jurisdiction the decision of such court shall not impair any of the remaining sections.

Approved June 19, 1975.