

NOTICE OF AGENCY APPROVAL

LEGISLATIVE RULE: Medical Malpractice Annual Reporting
Requirements

The attached legislative rule constitutes the official rule approved by the Insurance Commissioner on the 29th day of May, 1987 and filed pursuant to law with the West Virginia Secretary of State and the Legislative Rule-Making Review Committee.



Fred E. Wright
Insurance Commissioner of
the State of West Virginia

FILED IN THE OFFICE OF
THE SECRETARY OF STATE
THIS DATE May 29, 1987
ADMINISTRATIVE LAW DIVISION

FISCAL NOTE FOR PROPOSED RULES

FILED
MAY 23 1952
SECRETARY OF STATE

Rule Title: Medical Malpractice Annual Reporting Requirements

Type of Rule: Legislative Interpretive Procedural

Agency Insurance Commissioner Address 2100 Washington Street, East,
Charleston, West Virginia 25305

1. Effect of Proposed Rule	ANNUAL		Current	FISCAL YEAR	
	Increase	Decrease		Next	Thereafter
Estimated Total Cost	\$5,000.00	\$ -0-	\$ -0-	\$5,000.00	\$5,000.00
Personal Services	-0-	-0-	-0-	-0-	-0-
Current Expense	\$5,000.00	-0-	-0-	\$5,000.00	\$5,000.00
Repairs & Alterations	-0-	-0-	-0-	-0-	-0-
Equipment	-0-	-0-	-0-	-0-	-0-
Other	-0-	-0-	-0-	-0-	-0-

2. Explanation of above estimates:

Services of a consultant will be required to analyze data filed with the Insurance Department as a consequence of this rule.

3. Objectives of these rules:

To establish guidelines and format for annual filing of information with the Insurance Department by medical malpractice insurers pursuant to §33-20B-6(b).

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries;
Specific groups of citizens.

Medical malpractice insurers may incur minimal costs in compiling data required to be filed with the Insurance Department under this rule.

C. Economic Impact on Citizens/Public at Large.

Data generated pursuant to this rule should allow more thorough review of medical malpractice rates by the Insurance Department and result in more equitable malpractice rates for medical professionals in West Virginia.

Date: May 29, 1987

Signature of Agency Head or Authorized Representative

Jack E. Wright

DATE: May 29, 1987

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: FRED E. WRIGHT, INSURANCE COMMISSIONER-

LEGISLATIVE RULE TITLE: Medical Malpractice Annual Reporting
~~WEST VIRGINIA ESSENTIAL PROPERTY~~
~~INSURANCE ASSOCIATION REQUIREMENTS~~

FILED
MAY 29 PM 3:52

SECRETARY OF STATE

1. Authorizing statute(s) citation West Virginia Code

§§ 33-20B-6(b), 33-2-10

2. a. Date filed in State Register with Notice of Hearing:

December 3, 1986

b. What other notice, including advertising, did you give of the hearing?

NONE

c. Date of hearing(s): January 21, 1987

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received _____
(See Exhibit A)

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

May 29, 1987

f. Name and phone number of agency person to contact for additional information:

Cheryl L. Davis

General Counsel

348-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Attached Not applicable

DESCRIPTION OF PROPOSED RULE

FILED
MAY 20 PM 3:52

RULE TITLE: Medical Malpractice Annual Reporting Requirements

West Virginia Code §33-20B-6(b) requires the Insurance Commissioner to promulgate a rule establishing procedures under which each insurer which provides five percent or more of the medical malpractice insurance coverage in West Virginia must report certain specified information concerning such coverage to the Insurance Commissioner on an annual basis.

This proposed rule establishes guidelines and procedures for the reporting of such information. A detailed Reporting Form is established. Standards for determination of those insurers subject to the Rule's reporting requirements and filing deadlines are provided. Penalties for non-compliance with the filing requirements as established by §33-20B-6(b) are repeated in the Rule.

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33-20B
SERIES XXII

FILED
MAY 20 PM 3:51
SOLICITORS

MEDICAL MALPRACTICE ANNUAL REPORTING REQUIREMENTS

- Section 1. General
- Section 2. Definitions
- Section 3. Insurers Subject To Reporting Requirements
- Section 4. Filing Deadline; Failure To Submit Information
- Section 5. Information Required To Be Reported
- Section 6. Severability

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

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MAY 29 PM 3:51
SECRETARY OF STATE

CHAPTER 33-20B
SERIES XXII

MEDICAL MALPRACTICE ANNUAL REPORTING REQUIREMENTS

Section 1. General

1.1 Scope - This legislative rule establishes guidelines and procedures under which every insurer providing five percent or more of the medical malpractice insurance coverage in West Virginia shall report to the Insurance Commissioner on an annual basis certain specified information concerning such medical malpractice insurance coverage.

1.2 Authority - West Virginia Code §§ 33-20B-6(b), 33-2-13.

1.3 Filing Date -

1.4 Effective Date -

Section 2. Definitions - As used in this legislative rule:

2.1 Annual Financial Statement - Shall mean the financial statement required to be filed annually with the Commissioner pursuant to West Virginia Code §§ 33-3-14 and 33-4-14.

2.2 Commissioner - Shall mean the Insurance Commissioner of the State of West Virginia.

2.3 Insurer - Shall mean any insurance company licensed by the Commissioner and authorized to write medical malpractice insurance coverage in the State of West Virginia.

Section 3. Insurers Subject To Reporting Requirements

3.1 Insurers Subject to Annual Reporting Requirements - This rule shall apply to every insurer which provided five percent or more of the medical malpractice insurance coverage in West Virginia during the preceding calendar year.

3.2 Notification By Commissioner - The Commissioner shall annually, on or before May 1, notify in writing those insurers which he has determined provided five percent or more of the medical malpractice insurance coverage in West Virginia during the preceding calendar year of their obligation to report to the Commissioner the information specified in Section 5 of this rule.

Ins. Commissioner
Leg. Rule 33-20B
Series XXII, Sec. 3

3.3. Method Of Determination - The Commissioner's determination pursuant to sub-section 3.2 shall be based upon a proportionate comparison of every insurer's gross direct written malpractice premiums in West Virginia during the preceding calendar year as reflected in the insurer's annual financial statement for that calendar year.

Section 4. Filing Deadline; Failure To Submit Information

4.1 Filing Deadline - Insurers shall submit all information specified in Section 5 of this rule to the Commissioner on or before August 1 immediately succeeding notification by the Commissioner pursuant to sub-section 3.2.

4.2 Failure To Submit Information - Any insurer which fails to timely submit any and all information specified in Section 5 of this rule to the Commissioner shall be fined ten thousand dollars for each of the first five such failures per year and shall be fined one hundred thousand dollars for the sixth and each subsequent such failure per year.

Section 5. Information Required To Be Reported

5.1 Information Required To Be Reported - The information required to be reported to the Commissioner shall be that specified in the Annual Medical Malpractice Reporting Form, attached to and made a part of this rule as Exhibit A.

5.2 Information By Individual Coverage Classification - A separate Annual Medical Malpractice Reporting Form must be filed for each and every individual coverage classification written by the insurer in West Virginia.

Section 6. Severability

6.1 Severability - If any provision of this legislative rule is held invalid, the remainder of the rule shall not be affected thereby.

EXHIBIT A

ANNUAL MEDICAL MALPRACTICE REPORTING FORM

1. Company Name _____

Part of group: _____

2. Coverage Classification _____

3. a) Term of policies written _____

b) Is this coverage written on a claims-made or occurrence basis?

Claims-Made _____ Occurrence _____

c) Company written premium (latest calendar year)

West Virginia _____ Countrywide _____

4. Number of West Virginia policies in force in each of the last five years.

	# of Policies	% Change
5th Prior Year 19____	_____	_____
4th Prior Year 19____	_____	_____
3rd Prior Year 19____	_____	_____
2nd Prior Year 19____	_____	_____
1st Prior Year 19____	_____	_____
Report Year 19____	_____	_____

5. Provide the following information:

WEST VIRGINIA

	Earned Premium (000)	Incurred Losses (000)	Change in IBNR (000)	Loss Ratio
5th Prior Year 19____	_____	_____	_____	_____

Ins. Commissioner
 Leg. Rule 33-20B
 Series XXII

4th Prior Year 19__	_____	_____	_____	_____
3rd Prior Year 19__	_____	_____	_____	_____
2nd Prior Year 19__	_____	_____	_____	_____
1st Prior Year 19__	_____	_____	_____	_____
Report Year 19__	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

COUNTRYWIDE

	Earned Premium (000)	Incurred Losses (000)	Change in IBNR (000)	Loss Ratio
5th Prior Year 19__	_____	_____	_____	_____
4th Prior Year 19__	_____	_____	_____	_____
3rd Prior Year 19__	_____	_____	_____	_____
2nd Prior Year 19__	_____	_____	_____	_____
1st Prior Year 19__	_____	_____	_____	_____
Report Year 19__	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

6. Relative to No. 5 above, address in narrative form the following requests for information. If the ratemaking methodology changed from one year to the next, explain the specific change(s) and the year(s) in which the methodology changed.
- a) Explain loss development and loss adjustment expenses. Provide detailed data showing the quantification and formulation of loss development and loss adjustment expenses, along with an explanation of the methodology used to determine such costs. Provide a clear indication of the cost components of these expenses by significant categories.
 - b) Explain trending methods used. Provide trended loss data (by significant loss category) and provide a clear

explanation of the trending methodology and mathematics. Provide all formulas and calculations used in formulation of the trended data.

- c) Explain the manner in which credibility of data is considered in your ratemaking process. Show all formulas, applications and methodology used to formulate credibility measurements.
 - d) Explain your permissible loss ratio including the manner in which this value was determined. Provide formulas, budgets, etc. which show the formulation of this ratio.
 - e) Explain your indicated rate level. Provide all mathematical formulas and calculations which show the complete delineation of the method used to calculate the indicated rate level.
 - f) Explain the manner in which investment income is considered when a final rate level is selected. Provide a complete breakdown of the formulas, variables and methodology used to calculate the investment income yield. Further, provide a breakdown of all variables, methodology and calculations which apply the calculated investment income to the ratemaking process. Explain the manner in which investment income is used as a variable during the formulation of the indicated rate levels.
 - g) ~~Provide an Actuarial Memorandum showing all of the above.~~
7. Provide a summary of the developed data and experience in No. 6 as follows:

	Current Level Earned Premium	Trended Developed Incurred Losses	Loss Ratio
5th Prior Year 19__	_____	_____	_____
4th Prior Year 19__	_____	_____	_____
3rd Prior Year 19__	_____	_____	_____

Ins. Commissioner
 Leg. Rule 33-20B
 Series XXII

2nd Prior Year 19	_____	_____	_____	_____
1st Prior Year 19	_____	_____	_____	_____
Report Year 19	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

Provide all calculations, formulas and data utilized to calculate the trended developed incurred losses, referred to above.

8. Provide the following information in regard to business expense provisions which are used to determine a permissible loss ratio.

Commission and Brokerage	_____	§
New Acquisition	_____	
General	_____	
Taxes, Licenses, Fees, Etc.	_____	
Other	_____	
Profit and Contingencies	_____	
TOTAL EXPENSES	_____	
Pure Permissible Loss Ratio		_____
Loss Adjustment Expense		_____
Allocated		_____
Unallocated		_____
TOTAL PERMISSIBLE LOSS AND LOSS ADJUSTMENT EXPENSE RATIO		_____

- a) Provide all factors, vectors, allocators, variables and considerations which would assign the stated costs and revenues requirements to West Virginia operations.

b) Provide a breakdown of the calculations, variables or managerial policies which would show the details of the delineation of the value placed in the profit and contingency blank of the annual financial statement.

9. Provide the following information in regard to an insurance expense exhibit and incurred ratios (%) on a written premium basis.

	19__	19__	19__	19__	19__	Combined Average
a) Commission and Brokerage	_____	_____	_____	_____	_____	_____
b) New Acquisition	_____	_____	_____	_____	_____	_____
c) General	_____	_____	_____	_____	_____	_____
d) Taxes, etc.	_____	_____	_____	_____	_____	_____
e) SUBTOTAL (a) + (b) + (c) + (d)	_____	_____	_____	_____	_____	_____
f) West Virginia Loss Ratio (Ques.9)	_____	_____	_____	_____	_____	_____
g) Combined Ratio (e) + (f)	_____	_____	_____	_____	_____	_____
h) Investment Gain/(Loss)	_____	_____	_____	_____	_____	_____

10. Provide the following information in regard to specific claims, underwriting and investment results for the reporting year.

a) The number of claims filed per category	_____
b) The number of civil actions filed	_____
c) The number of civil actions compromised or settled	_____
d) The number of verdicts in civil actions	_____
e) The number of civil actions appealed	_____

Ins. Commissioner
 Leg. Rule 33-20B
 Series XXII

- f) The number of civil actions dismissed _____
- g) a) The total dollar amount paid in claims
 compromised or settled \$ _____
- h) The total dollar amount paid pursuant to
~~verdicts~~ judgments in civil actions. \$ _____
- i) The number of claims closed without
 payment and the amount held in reserve
 for all such claims by vintage year \$ _____
- j) The total dollar amount expended for loss
 adjustment expenses, commission and
 brokerage expense:
 - Loss Adjustment Expense \$ _____
 - Commissions \$ _____
 - Brokerage Expenses \$ _____
 - TOTAL _____
- k) The total dollar amount expended in
 defense and litigation of claims \$ _____
- l) The total dollar amount held in reserve
 for anticipated claims:
 - Incurred & Reported \$ _____
 - Incurred But Not Reported \$ _____
 - TOTAL _____
- m) ~~New~~Net profit or loss _____

Ins. Commissioner
Leg. Rule 33-20B
Series XXII

- n) Investment and other income on net realized capital gains and loss reserves and unearned premiums _____
- o) The number of malpractice insurance policies canceled for reasons other than nonpayment of premiums _____

Explanatory notes for #10 above:

- a) 10(i) This dollar figure is the reserve released when a claim involving no payment to the plaintiff is closed.
- b) 10(m) This amount is determined by using your West Virginia premium, claims and expense data in exactly the same manner as required in the annual financial statement, Underwriting and Investment Exhibit's section on "Underwriting Income." The calculations of this report.
- c) 10(n) If your company has not separately accounted for investment income including net realized capital gains, and other income derived from assets representing loss reserves and unearned premium reserves on medical malpractice business you wrote in West Virginia, you must calculate the required figure in the following manner:
 - i. Divide the sum of loss reserves, including loss adjustment expense reserves, and unearned premium reserves on West Virginia medical malpractice business by the total of all liabilities and that portion of your surplus in excess of your minimum capital and surplus requirement.
 - ii. Determine the investment income and other income including capital gains attributable to your West Virginia medical malpractice business by multiplying each figure in the "Investment Income" and "Other Income" sections of the Underwriting and Investment Exhibit of your annual financial statement for the preceding calendar year by the ratio calculated in (a) above.

Ins. Commissioner
Leg. Rule 33-20B
Series XXII

~~11. Attach as Exhibit B a copy of all rules, rates and rating plans currently in effect in West Virginia for this individual coverage classification.~~

12- 11. Attach as Exhibit B your loss experience in West Virginia for this individual coverage classification during the preceding calendar year using the same format as Schedule P of the annual financial statement.

13- 12. Attach as Exhibit B C your West Virginia experience for this individual coverage classification using the same format as the Underwriting and Investment Exhibit of the annual financial statement.

The above information is correct to the best of my knowledge and belief.

Name (type or print)

Title

Address

Telephone Number

Signature

STATE OF WEST VIRGINIA



FILED
MAY 29 PM 3:51

SECRET

FRED E. WRIGHT
INSURANCE COMMISSIONER

OFFICES OF THE
INSURANCE COMMISSIONER
LEGAL DIVISION
2100 WASHINGTON STREET, EAST
CHARLESTON, WEST VIRGINIA 25305
TELEPHONE (304) 348-0401

ARCH A. MOORE, JR.
GOVERNOR

May 29, 1987

Ms Debra Graham, Assistant Counsel
Legislative Rule-Making Review Committee
Room 438, Main Unit State Capitol
Charleston, WV 25305

Re: Medical Malpractice Annual Reporting Requirements
Proposed Legislative Rule Of The Insurance Commissioner

Dear Ms Graham:

Enclosed for filing please find fifteen (15) copies of each of the following:

- 1) proposed legislative rule
- 2) description of proposed rule
- 3) fiscal note
- 4) copy of agency approval and submission to Legislative Rule-Making Review Committee
- 5) Legislative Rule-Making Review Committee questionnaire

Please contact me if further information is required.

Sincerely,

Cheryl L. Davis
General Counsel

CLD/pss
Enclosure

cc: Richard O. Hartman, Director
Administrative Law Division
Office of the Secretary of State

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EXHIBIT A

- 1) List of persons who appeared at hearing
- 2) Copy of hearing transcript
- 3) Written comments received
 - January 20, 1987 comments by West Virginia Hospital Insurance Company
 - January 20, 1987 comments by CNA Insurance Companies
- 4) Insurance Commissioner's response to written comments prepared by Daniel L. Selby, CPA, consultant to the Insurance Commissioner on malpractice issues
- 5) Amendments

PUBLIC HEARING

1/2/87

Name

Representing

Do you wish to speak?

Flaherty	Asst. Rep.	no
Mark Smith	Asst. Rep.	no
George Dwyer	Dept. of Justice	no
Thomas J. Quinn	W.H.C.	No

INSURANCE COMMISSION OF THE STATE OF WEST VIRGINIA
PUBLIC HEARING

IN RE: Emergency Rule
 Medical Malpractice Annual Reporting
 Requirements

 Transcript of a public hearing held in the
above-styled matter at 9:30 a.m., on the 21st day of
January, 1987, in Room 522, Building No. 3, Capitol
Complex, Charleston, West Virginia, pursuant to West
Virginia Code .33-20B-4(d).

BEFORE: CHERYL L. DAVIS, General Counsel, Office
 of the Insurance Commissioner.

APPEARANCES: (See attached appearance sheet.)

GENERAL REPORTERS
2020 Kanawha Boulevard, East
Charleston, West Virginia 25311
344-4862

I N D E X

Commissioner's Exhibit Marked

Exhibit No. 1, Letter dated
January 20, 1987 3

MS. DAVIS: I'd like to call this public hearing to order. This is a public hearing on an emergency regulation entitled, "Medical Malpractice Annual Reporting Requirements." The regulation was filed with the Secretary of State's Office on December 3rd, 1986, as an emergency rule.

The notice of public hearing was filed with the Secretary of State on that same day and setting the public hearing for Wednesday, January 21st, 1987, at 9:30 a.m. in Room 522, Building No. 3, State Capitol Complex.

I would also like to note for the record that this regulation has been certified by the Secretary of State's Office as a true and proper emergency regulation and that decision number by the Secretary of State is 1-87.

The purpose of the hearing is to receive comments concerning the regulation. We received one written comment which I'd like to make a part of the record as Exhibit 1. It is from the West Virginia Hospital Insurance Company dated January 20, 1987. It is a two-page letter and it is written by William G. MacLean, Senior Vice President. This will be

made a part of the record as Exhibit 1.

(WHEREUPON, the document referred to was marked for identification as Commissioner's Exhibit No. 1 and received in evidence.)

Does anybody present wish to submit any written comments or make any oral comments for the record concerning this regulation? Is there anything further to be heard concerning the regulation? Then this public hearing is concluded.

(WHICH WAS ALL THE PROCEEDINGS HEARD
IN THE ABOVE-ENTITLED MATTER.)

STATE OF WEST VIRGINIA,
COUNTY OF KANAWHA, to wit:

I, the undersigned, Sybil J. Martin,
Certified Court Reporter, do hereby certify that
the foregoing is, to the best of my skill and
ability, a true and accurate transcript of all the
proceedings as set forth in the caption hereof
during said public hearing.

Given under my hand this 30th day of
January, 1987.

Certified Court Reporter

GENERAL REPORTERS
2020 Kanawha Boulevard, East
Charleston, West Virginia 25311
344-4862



WEST VIRGINIA HOSPITAL INSURANCE COMPANY
3422 Pennsylvania Avenue
Charleston, WV 25309
P.O. Box 3906
304/347-1546

RECEIVED

JAN 21 1987

LEGAL DIVISION
W. VA. INS. DEPT.

Com Ex	
EX #	1
DATE	1-21-87
[Signature]	

January 20, 1987

The Honorable Fred E. Wright
Insurance Commissioner
Department of Insurance
State of West Virginia
2100 Washington Street, East
Charleston, WV 25305

Attn: Cheryl L. Davis

Re: Medical Malpractice Annual Reporting Requirements

Dear Cheryl:

This letter will provide the West Virginia Hospital Insurance Company's (WVHIC) comments on the new Medical Malpractice Annual Reporting Requirements.

WVHIC will comply with the reporting requirements as written.

We have interpreted several of the questions where their meaning was not clear to us. Our comments below identify where we have made such interpretations.

Questions 6 and 7 - These questions request information that WVHIC would expect to include in its rate filing. WVHIC would intend to respond to Questions 6 and 7 with pertinent information for our then-current rate filing.

Question 10a - This question asks for "the number of claims filed per category". The term "category" does not appear to be defined. If what is meant is "hospital", as separate from "dentist" or "physician" claims, WVHIC currently insures only hospitals and hospital employees. Although some insured employees are physicians, it is usually not possible to identify claims as being only "hospital" or "physician" in character. WVHIC's intent here is to report all claims in the "hospital" category.

The Honorable Fred E. Wright
Medical Malpractice Annual Reporting Requirements
January 20, 1987
Page Two

Question 10m - Shown as "new" profit or loss, we assume this is meant as "net" profit or loss.

Question 10n - Your explanatory note c)i defines a ratio one element of which is "that portion of your surplus in excess of your minimum capital and surplus requirement". WVHIC interprets the referenced "minimum capital and surplus requirement" as being the minimum capital and surplus required, under the West Virginia Insurance Code, to support our net retained risk after reinsurance.

Our sole concern about these reporting requirements is the magnitude of the fines for non-compliance, or more accurately, the fact that no provision is made for relief for inadvertent errors or omissions. We understand that the new Law is specific on this, but would hope that the Department of Insurance will be permitted to use judgment as to its applicability where minor reporting errors or omissions occur.

Please let us know if our interpretations are not proper.

Sincerely,



William G. MacLean
Senior Vice President

WGM/dgs

cc: K. M. Rutledge, President-WVHIC

RECEIVED

JAN 21 1987

LEGAL DIVISION
W. VA. INS. DEPT.

CNA INSURANCE COMPANIES

CNA Plaza, Chicago, Illinois 60685

January 20, 1987

Cheryl L. Davis
State of West Virginia
Offices of the
Insurance Commissioner
Legal Division
2100 Washington Street, East
Charleston, West Virginia 26305

RE: Medical Malpractice Annual Reporting Requirements

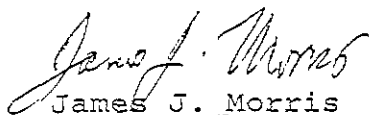
Dear Ms. Davis:

The attached comments are submitted on behalf of the following CNA Insurance Companies which are licensed to write medical malpractice insurance in West Virginia:

American Casualty Company of Reading, Pennsylvania
Continental Casualty Company
National Fire Insurance Company of Hartford
Transcontinental Insurance Company
Transportation Insurance Company
Valley Forge Insurance Company

I request that these comments be made a part of the formal records of the January 21, 1987 public hearing on this subject.

Very truly yours,



James J. Morris
Counsel
Law Department, 42S
(312) 822-6557

JJM:kc

Attachment

cc: - D. Lowry
D. Anderson

CNA

For All the Commitments You Make®

STATEMENT
OF THE
CNA INSURANCE COMPANIES
REGARDING
PROPOSED MEDICAL MALPRACTICE
REPORTING REQUIREMENTS

PREPARED BY:
JAMES J. MORRIS
COUNSEL

1. Paragraph 6 of proposed Exhibit A (Reporting Form) requires insurers to report in "narrative form" information relating to medical malpractice rate-making methodology.

These items include:

- (a) loss development and loss adjustment expenses with a clear indication of the cost components by significant categories;
- (b) explanation of the trending methods;
- (c) all formula, applications, and methodology used to formulate credibility measurements;
- (d) all mathematical formulas and calculations which show the complete delineation of the method used to calculate;
- (e) etc.

This requirement is both unnecessary and oppressive. The requested information relates to the adequacy of rates on file at the Department. If this information is needed to justify a rate filing, it should be requested during the review of the rate filing not with the annual medical malpractice report. If this information is not needed to justify the rate filing, it should not be requested at all.

In this regard, it should be noted that Section 33-20 B-4 of the Insurance Code requires a public hearing for any rate increase of ten percent or more and permits a public hearing for any other rate request. Any questions relating to the information requested in paragraph 6 of the proposed form can be asked at the hearing and the "narrative form" answers made a part of the formal records. It is unnecessary

and oppressive to require that this information also be submitted with the annual experience reports.

2. Paragraph 11 of the proposed Exhibit A (Reporting Form) requires that a copy of all rules, rates and rating plans currently in effect in West Virginia be attached to the report.

Since these rules, rates and rating plans are already on file in the West Virginia Insurance Department, it is unnecessary to require that a second set be attached to the report.

3. Section 5.2 requires that a separate form be submitted "for each and every individual coverage classification." What is a "coverage classification?"

4. Line 10a of Exhibit A (Reporting Form) requires "the number of claims filed per category." What is a "category" and how does it differ from "coverage classification?"

5. Line 10g of Exhibit A (Reporting Form) requires that the dollar amount of structured settlements be shown separately from ordinary payments. Is the amount to be reported the present value or the ultimate value of the structured settlements?

6. Line 10h of Exhibit A (Reporting Form) requires "the total dollar amounts paid pursuant to verdicts in civil actions." I believe that the word "judgments" should be used rather than "verdicts."

7. What is the meaning of the term "new profit or loss" used in item 10(m) of Exhibit A (Reporting Form)? Given the instructions for the calculation of this item, a more appropriate title for this amount might be "allocated profit or loss."

8. Line 10c of Exhibit A (Reporting Form) requests certain information "by vintage year." What is the definition of "vintage year?"

9. The proposed regulation should permit insurance companies which are members of insurance groups to report either on a group or individual insurer basis.

10. The proposed regulation should state that amounts be reported without deduction for reinsurance ceded.

SELBY & ASSOCIATES

CERTIFIED PUBLIC ACCOUNTANTS

12 CAPITOL STREET
P.O. BOX 2509
CHARLESTON, WV 25329

(304) 344-0323

218 WHITE & BROWNING BLDG.
P.O. BOX 1762
LOGAN, WV 25601

(304) 752-0809

DANIEL L. SELBY, C.P.A.

May 19, 1987

Ms. Cheryl Davis
Attorney at law
West Virginia Insurance Commission
2100 Washington Street East
Charleston, West Virginia 25305

Re: MEDICAL MALPRACTICE ANNUAL REPORTING REQUIREMENTS;
COMMENTS BY CNA AND WVHIC

Dear Ms. Davis:

In compliance with your earlier requests, I have reviewed the comments that have been filed by CNA and WVHIC and extend the following discussion as my response to such comments.

First, I will address the comments filed by the West Virginia Hospital Insurance Company.

(1) WVHIC comments that items 6 and 7 are those items which they would expect to file with a rate filing. I assume that they object to an annual disclosure of this information, in the absence of a request for a change in rates through the filing of a rate case. It is appropriate and important that we be provided with the items embedded in points number 6 and 7 on an annual basis exclusive of any rate filing for the following reasons.

Ms. Cheryl Davis
May 19, 1987
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(a) The information referred to in 6 and 7 of our questionnaire reflect historical information which lets us determine, in the proper context, how the companies' operating results were determined and influenced over time by internal methodologies and rate making approaches, and managerial interpretations. The active companies have had increases over prior periods, while those that have not, like WWHIC, will be filing in the future. The requested new rates will be designed to try to make up for short-falls of revenues originating in prior periods. It is important for a competent review of the current and future posture of the profitability and availability of insurance for us to be aware of the trends and methodologies used by the companies during the formulation of their revenue requirements. It is important to recognize that the regulatory process in West Virginia is prospective in nature, and requires the formulation of a comparative data base, so that we can not only be aware of specific company operations but have the ability to look at the operations of all of the active companies in West Virginia, relative to various operational cost levels.

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Relative to item 6(a), we wanted disclosure of the components of the loss development and adjustment expenses that are incurred on an actual and forecasted basis, relative to historical policy years. We will be examining the specific make-up and volume of costs, as we trace the expenses from one year to the next. We want the data so that we may know the trend and volume of these expenses which the companies want to embed in the premium levels that they want us to approve from one year to the next. Even in the absence of a rate increase application, we will need to know this information to determine the current posture of these expenses, as it will impact our short-run and long-run view of the profitability and the prospects relative to current and future availability. Given the current and anticipated long-run view of the operating environment, I would expect that the companies will need to assemble this data, as a matter of course, as they will be filing annually for rate adjustments.

Relative to item 6(b), we are requiring the filing of an explanation as to the trending methodologies employed by the companies in an effort to have annual disclosure as to the mathematics and variables used in the formulation of trended loss data and expense data. Since ratemaking is properly viewed in the prospective light, one would be quite interested in the

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changes that take place from one year to the next in the process of forecasting losses. The narrative route provides a clear assembly of the facts, variables and assumptions used during the trending process. To provide the Insurance Department with the result of the trending process does not provide an audit trail, nor does it provide the background necessary to review the propriety of the companies' methodologies from period to period. WWHIC objects to the filing of this data and information on an annual basis in the absence of a request for a change in the rates. Again, I fully expect that an annual filing is forthcoming from the companies still active in the provision of medical malpractice insurance; thus the formulation of this information will be necessary, exclusive of this disclosure requirement. If the companies do not file annually for a rate increase, it is still important for us to have the ability to determine the direction and content of the companies' losses, given our need to be aware of the profitability and availability of this line of insurance. In addition, it is important for us to be aware of excess rates as well as inadequate rates in the various lines of medical malpractice (ie. nurses). The annual disclosures, relative to losses and expenses, will allow us to be aware of trends on a timely basis, as the companies also become aware of the direction and magnitude of trends. The request for disclosure of all formulas and variables merely

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provides us with the ability to review accurately and check the companies' results, and avoids misunderstandings as to applications.

Relative to item 6(c), it is important that we are aware of the companies' view of the credibility of the state data that they have accumulated by their experience in West Virginia on an annual basis, even in the absence of a filing. This is very important, in that we will need to know what level of credibility the companies would have us place on the above referred to trended data. Trended data would be of little value if one did not have a determination as to the level of reliance that should be placed upon this data. I find it somewhat amazing that the credibility studies would not be accomplished annually, along with the trending of losses, regardless of a filing, given the companies' need to assess their financial position annually. If a company is not assessing its position annually, I would be quite surprised. Given our records in the areas of increases for all lines of medical malpractice, it is quite clear that an annual review has in fact taken place for most companies.

As a result, I see no burdensome attribute to our request.

Relative to item 6(d), we are interested in the annual

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flucuations in the permissible loss ratios for the different malpractice lines. Obviously, we wish to see the amount of each premium dollar that is available to cover losses, regardless of a filing. This, again, specifically ties to our need to test the environment in WV. Knowledge of the deterioration of the permissible loss ratio interfaces with our ability to detect loss trends and expense frame changes. Thus, we have more annual insight into the profitability of these lines of insurance and the ultimate availability of insurance. Given the current concern over the shrinking number of carriers, I think that it is paramount that we know, annually, exclusive of any filing, to what extent the expenses, assigned to the various lines, leave dollars available for coverage of losses.

Relative to item 6(e), as the companies trend their losses annually, and match the trended losses to current premium levels, an indicated rate level falls out. This component shows another parcel of information as to the companies' position with the policy lines. Annually, one would want to know the extent that current rates were adequate or in need of adjustment, even in the absence of a rate filing.

Relative to item 6(f), investment income is quite important, in that it potentially serves as a large offset to trended losses.

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We need to know the companies' position annually as to the availability of investment income and its role in the assessment of their position with individual policy lines. An infusion of investment income in the ratemaking process and the assessment of financial position has very large ramifications. In the interest of responsible assessment of the market and operating environment, one would want to collect the companies' views as to the cashflow realized by any investment income and the impact on the ability to sustain the current rate design.

Because interest and investment income is subject to fluctuation from period to period, such an annual disclosure is needed even in the absence of any decision to file a rate case.

Relative to item 6(g), I will agree that it is repetitive and should be eliminated.

Relative to item 7, this asks for the trended loss data using the historical data gathered from item number 5 of the disclosure questionnaire. This is merely the resulting data that is generated by items in number 6, referred to above.

Items 6 and 7 of the questionnaire are designed to gather data on an annual basis, exclusive of whether a company wants an

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increase, to accomplish the following main points.

(a) Allow us to obtain and maintain a data base that allows us to more closely monitor the medical malpractice losses, expenses, profitability, and the propensity to require rate adjustments.

(b) Allow us to monitor individual companies' market position on an individual policy basis (ie. nurses, physician).

(c) Allow us to monitor the field of participants (carriers) and their ability (desire) to remain in the business.

(d) Allow us to measure profitability.

(e) Allow us to develop adequate information to address legislative inquiry about losses and trends, along with the components of the losses. Also, the ability to address annual inquiry as to the role of investment income in the ratemaking process.

(f) All of the above items (a-e) will influence our view of current and future rate filings and the direction we take in the formulation of rates and the approval of rates.

(g) All of these items will influence any revision in the way we view contract provisions and underwriting provisions, which has

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an impact on the coverage levels.

(2) WWHIC asks for a definition of "category" in questionnaire item number 10a. Category, in this context, means by insured groupings that are tied to individual policies. For example, nurse anesthetists are to be grouped together as opposed to physicians. In the case of hospital coverage categories, WWHIC would be correct to report items asked for in number 10 under the category of "hospital". "Hospital" would be of like kind as "nurses".

(3) Item 10m should read "net" profit as opposed to "new".

(4) WWHIC is correct in its interpretation of item 10(n).

Relative to WWHIC's last paragraph, note the following points.

I believe that immaterial errors and "mistakes" would not trigger the Department to seek fines, as long as there appeared to be general intent to comply. The Department should have the discretion to make qualitative judgements as to the appropriate times to seek fines, given the circumstances. The severity of fines is appropriate, given the importance of the data requested. There must be adequate motivation to comply. The fines should be large enough to get the companies' attention.

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The following is an answer to CNA Insurance Company comments and questions.

(1) CNA indicates that the parts included in item 6 should only be provided during a rate filing. CNA obviously misses the larger issue and reason for the intent behind the disclosure rules. We are charged with the task of monitoring the results of operations and the methodologies used by the companies writing malpractice insurance for two main purposes. First the legislature wanted mere disclosure of the requested data to serve as an information base, relative to the profitability of malpractice operations and the companies writing the insurance. Secondly, the disclosures are needed to provide the means by which the Department can more effectively monitor and review current premium levels. In addition, the information would play a large role in allowing us to be aware of the market to better measure the participation of carriers in the market and the future availability of insurance by line category.

In the absence of a filing, under CNA's treatment, no information would be provided in a disaggregated form as shown in the Annual Statement. We would not have a handle on the operations of the individual insured categories if no one filed for marketing or financial reasons. Our review of the

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financial position of the disaggregated malpractice data would be solely dependent upon a company's desire for an increase. Given the large threats as to insured people leaving WV, and the companies leaving WV, we must have access to position data on an annual basis. The companies would not be prohibited from utilizing the data for rate filings.

(2) I see no disagreement with CNA's suggestion in # 2, relative to paragraph 11 of Exhibit A.

(3) "Coverage classification" means the insured group, ie. nurses, physician, etc.

(4) Same as (3) above.

(5) Structured settlements should be reported on a present value basis.

This is reflective of actual cost in the accident year.

(6) Judgements could be used. I do not object.

(7) A clerical error created the word "new" instead of "net" in item 10(m). Net profit means net underwriting profit.

(8) "Vintage year" means the "policy year" or claim year.

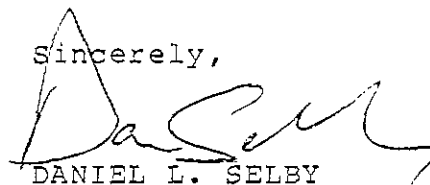
(9) Companies should be required to file on a single company

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basis instead of a group basis. The group basis will not allow for individual company disaggregated information. This has been part of the problem that the Department has had in prior periods in getting disaggregated data. Groups have submitted lumped data that could not be used to see individual company profitability.

(10) I see no problem with the data being reported without deduction for reinsurance ceded.

Sincerely,

A handwritten signature in cursive script, appearing to read "D. Selby", written over a horizontal line.

DANIEL L. SELBY

DLS/nlc

AMENDMENTS

- 1) AMENDMENT: Section 6 of the Reporting Form has been amended to remove the requirement in sub-section (g) of filing an Actuarial Memorandum.

REASON: The information in the Actuarial Memorandum would be repetitive of other information required by the Rule.
- 2) AMENDMENT: Section 10(h) of the Reporting Form has been amended to replace the word "verdicts" with the word "judgments".

REASON: More appropriate terminology.
- 3) AMENDMENT: Section 10(m) of the Reporting Form has been amended to read "Net profit or loss" rather than "New profit or loss".

REASON: Clerical error.
- 4) AMENDMENT: Paragraph number eleven (11) of the Reporting Form has been removed.

REASON: Requires filing of information already on file with the Insurance Commissioner.