

Notes

A Study of Medical Malpractice Insurance: Maintaining Rates and Availability

I. INTRODUCTION

An ugly situation has arisen in the past two years which has precipitated much ill feeling among the professions involved and potentially could have a severe negative effect on the American public—a crisis in the availability of medical malpractice insurance. Although attorneys, insurers, and patients must cope with recent changes in the insurance business, physicians are particularly affected by increased premium rates for insurance to protect them from financial distress in the event of a malpractice suit. The malpractice insurance rate problems have been the subject of numerous medical journal articles and editorials over the last 20 years.¹ In the past, physicians were able to cope with rising premium costs, often passing them on to their patients,² and enough companies competed for the business to enable physicians to obtain insurance at some price. Only recently has there been serious concern about the continued availability, even at exorbitant rates, of such insurance.³

Presently, both the number of medical malpractice claims and the amounts of settlements and judgments on these claims⁴ are on the increase; and as the costs of malpractice suits have increased, so have malpractice premium rates.⁵ In fact, some companies no longer consider the risk insurable.⁶

¹See, e.g., Tucker, *New Answer to High Malpractice Rates*, 35 MED. ECON. 71 (1958); *Malpractice Insurance Rates*, 86 CALIF. MED. 127 (1957); *Problem Clinic: Malpractice Insurance*, 36 MED. ECON. 161 (1959).

²"[H]e cannot absorb such mounting costs without some form of reimbursement." *Malpractice Insurance Rates*, 86 CALIF. MED. 127 (1957). Often, however, those costs are "passed on to patients, their health care insurance companies, and federal programs." Ribicoff, *Medical Malpractice: the patient vs. the physician*, 6 TRIAL, Feb.-Mar. 1970, at 10.

³See, e.g., PARADE, Feb. 16, 1975, at 8; American Medical News, Jan. 6, 1975, at 9, col. 1; N.Y. Times, Jan. 12, 1975, § 5, at 6, col. 2; Wall Street Journal, Dec. 12, 1974, at 10, col. 4.

⁴Bergen, '*. . . not a medical problem*,' 6 TRIAL, Feb.-Mar. 1970, at 24.

⁵Ribicoff, *supra* note 2, at 13.

⁶Asserting that doctors have become "virtually uninsurable," St. Paul Fire & Marine Insurance Company decided to cease offering traditional insurance coverage. N.Y. Times, Jan. 24, 1975, at 35, col. 1. An insurance

A myriad of medical, legal, social, and economic factors have combined to create this problem. The contribution of each factor to the decline in available and reasonably priced insurance is, however, difficult to ascertain because theories and statistics vary according to their sources. Some studies attribute the increases in malpractice claims and awards to a rise in the demand for medical services disproportionate to the number of practicing physicians. Thus, the probabilities of a malpractice claim are increased.⁷ Others consider the sophistication of modern medical practice a cause. As therapeutic developments "offer both greater potential benefit and significantly more risk than heretofore,"⁸ there is an increased likelihood of medically induced complications in no way related to malpractice. Even the media is criticized for fueling patients' expectations that modern medicine can effect cures for almost any ailment⁹ and for triggering litigation through extensive coverage of high malpractice judgments.¹⁰

In a vicious circle, physicians, attorneys, and insurance companies blame one another for creating and aggravating the problem. Physicians criticize attorneys for abusing the contingent fee system;¹¹ both groups berate insurers for having impersonal business philosophies.¹² The medical profession itself is attacked by attorneys, insurers, and patients for its diminishing physician-patient rapport and for permitting malpractice misadventures.¹³

Whatever the impetus, the expensive cycle continues, as higher judgments and settlements result in increased costs for insurance coverage. These costs are passed on to patients, who are now inclined to sue when dissatisfied with treatment and faced with high bills for medical care.¹⁴ As one attorney explains:

industry source is quoted as saying: "Unless there are drastic changes, the industry feels that malpractice is an uninsurable risk." *Moves Afoot To Shore Up Sagging Malpractice Coverage*, 10 HOSP. PRAC. 24, 25 (1975).

⁷Bergen, *supra* note 4, at 24. "Insurance companies report that in growing suburban areas, malpractice suits tend to rise in some direct proportion to the population growth." Ribicoff, *supra* note 2, at 10.

⁸Dornette, *Medical Injury Insurance—A Possible Remedy for the Malpractice Problem*, 1 J. LEGAL MED. 28 (1973). See also Smith, *The Malpractice and the Insurance Carrier*, 64 J. MED. ASS'N GA. 10 (1975).

⁹Pohlman, *Testimony on Malpractice Insurance*, 70 OHIO MED. J. 656 (1974).

¹⁰Ribicoff, *supra* note 2, at 10.

¹¹Pohlman, *supra* note 9.

¹²Gibbs, *Insurance Crisis: Availability to Physicians in Jeopardy*, 3 J. LEGAL MED. 29 (1975).

¹³*Id.*

¹⁴Ribicoff, *supra* note 2, at 11. "Studies of insurance companies and medical societies show that a large percentage of malpractice suits are filed in reaction to high bills and bill collection agency tactics." *Id.*

There's been a mixed reaction to that \$4,000,000 award—a grudging admiration for the brilliance of the attorney who won it, but a lot of shaking of heads to the effect that this is getting awfully close to killing the goose that lays the golden eggs.¹⁵

The subject of medical malpractice extends too far to allow a comprehensive study of its causes, frequency of occurrence, ability to be controlled, and overall effect within the limited space of one Note. Therefore, this Note will focus on the problem of maintaining the availability of medical malpractice insurance at reasonable cost. To present some background in the area before offering any solutions, this Note will examine the role of the insurance company: the need for professional liability insurance,¹⁶ the factors that have caused companies to retreat from the business, the effect of substantial increases in the number of claims and the amounts of judgments and settlement on premium rate-setting, and the manner and means of state regulation of insurance. Within that scope, the Note will examine proposed and enacted legislation dealing with malpractice insurance and analyze possible means by which states can maintain insurance availability and supervise rates through control of an insurer's activities. Finally, the Note will suggest a workable solution, composed of elements from recently enacted legislation, proposed bills, and existing statutory powers.

II. THE MALPRACTICE INSURANCE SYSTEM

A. *The Need for Insurance*

Malpractice insurance plays a vital role in a legal system in which fault is the basis of liability. Much has been written about the viability of systems of compensation for medical injury which would not require any determination of fault. The discussion has centered on suggestions of strict liability in the form of no-fault medical insurance funds,¹⁷ patients' self-insurance against surgical

¹⁵121 CONG. REC. S305 (daily ed. Jan. 16, 1975) (remarks of Senator Nelson).

¹⁶The terms "malpractice insurance" and "professional liability insurance" will be used interchangeably in this Note.

¹⁷See, e.g., S. 215, 94th Cong., 1st Sess. (1975), which would establish a medical injury compensation fund supported by premiums charged to participating health care providers. Strict liability for medical maloccurrences would be optional under the plan, which also would provide federal malpractice insurance for traditional tort law suits, if patients choose not to bring claims in the federal no-fault system.

risks, similar to "trip insurance,"¹⁸ and some form of social insurance.¹⁹ Although no state has legislatively authorized a complete departure from the traditional tort system, debate continues as to the advantages and disadvantages of instituting such plans.²⁰ Under a tort theory, a physician must have negligently caused an injury in order to be held liable for money damages to the injured party. On the other hand, a purely compensatory system would

¹⁸U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 128 (1973) (Hoffman, Dissenting Statement) [hereinafter cited as HEW REPORT]. The dissenting statement describes patients' self-insurance as similar in theory to health, disability, accident, and life insurance. Limited to surgical patients, insurance could be purchased by an individual to cover any unanticipated adverse consequences upon entering the hospital. Insurance benefits received under the plan would be offset against damage awards. In a variation of that idea, a physician could surcharge patients for surgical events and pay the surcharge to his insurer prior to performing the operation. In the event of medically induced injury to the patient or a worsened condition, and in place of damages, the insurer would compensate the patient for medical expenses and loss of income, and make some adjustment for pain and suffering as well as future detriment. See Brophy, *Why is Coverage for Errors and Omissions Evaporating? What Can be Done About It?*, A.B.A. SECT. INS., NEGLIG., & COMP. L. PROCEEDINGS 354 (1970).

¹⁹Social insurance is explained as a government-financed disability system concerned only with the fact that a disability arose in connection with medical treatment, whether or not it was an expected or even beneficial result of treatment. Rubsamen, *No-Fault Liability for Adverse Medical Results—Is it a Reasonable Alternative to the Present Tort System?*, 117 CALIF. MED. 78, 91 (1972). A fallacy of the proposal is that compensation would not be available for a patient whose condition remained unaltered by treatment, though negligently so, while a patient whose disability resulted necessarily from a life-saving operation would be covered. *Id.* A limited form of social insurance would be similar to workmen's compensation, with strict requirements as to compensable disabilities. The plan would necessitate a determination of causation to ascertain whether a patient's physical condition arose out of and in the course of treatment or was pre-existing. "[B]enefits would be scheduled by legislative enactment depending on the type and extent of injury, without regard to negligence, and claims would be handled by state officials or boards." 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* § 1.07, at 12 (1973).

²⁰See, e.g., Dornette, *supra* note 8, at 28. One medical-legal authority offers the example of Massachusetts' no-fault automobile liability insurance to show that the number of claims and average claim costs should decrease substantially. *Id.* Another authority foresees a flood of administrative proceedings for establishing causation and determining compensable events, and a continued need for analysis of medical facts to separate preventable from truly unpreventable, recognized risks of treatment. Rubsamen, *supra* note 19, at 83-84. Rubsamen also points out constitutional problems of equal protection in denying tort actions and jury trials for patients suing physicians and hospitals, but not for tort actions against others in society, noting that no-fault automobile statutes apply only to comparatively minor injuries, the tort system covering the rest. *Id.*

not require proof of malpractice for a patient to merit compensation for medical injuries. Since a physician assumes responsibility under the tort system for medical injuries he causes, insurance can help him bear financial liabilities he might incur. The risk of a malpractice judgment shifts to the insurer in exchange for the consideration of the premium price.

The hesitancy of states to abandon tort liability in the face of the insurance crisis echoes the opinion of the Department of Health, Education, and Welfare Commission on Medical Malpractice regarding no-fault and other medical injury compensation systems: "The Commission . . . does not believe that we should leap headlong from a system that works (with however many faults) into an untested one that may cause even more severe problems."²¹ Putting the merits of the various alternatives aside, as long as the present system requires that physicians be held responsible for medical injuries negligently induced by malpractice,²² professional liability insurance will be essential.²³

B. *The Nature of a Malpractice Insurance Contract*

Whether for physicians, attorneys, architects, or engineers, malpractice insurance is by definition specialized and limited in coverage as compared to comprehensive insurance; nevertheless malpractice policies are very similar to general liability insurance policies.²⁴ In its most simplified terms, a liability insurance policy is defined as a contract whereby one party, the insurer, agrees to assume loss or liability imposed by law on the other party, the insured, in exchange for a specified consideration, a premium.²⁵ More particularly, professional liability insurance protects physicians, attorneys, or other members of a profession from liabil-

²¹HEW REPORT, *supra* note 18, at 101.

²²"Medical malpractice" is defined as the failure of a physician or surgeon to exercise the required degree of care, skill, and diligence. The standard is stated as follows:

A physician need only exercise the ordinary degree of skill, care, and judgment exercised by members of his profession practicing in the same or a similar locality in the light of the present state of medical science.

1 R. LONG, THE LAW OF LIABILITY INSURANCE § 12.01, at 12-2 (1975).

²³The Secretary's Commission found that continued availability of adequate malpractice insurance was an "absolute necessity." HEW REPORT, *supra* note 18, at 38.

²⁴1 LONG, *supra* note 22, § 1.02, at 1-4. The insurable interest under a liability insurance contract is the legal obligation of the insured to pay damages for injury to another resulting from his carelessness. *Id.* § 1.05, at 1-10.

²⁵*Id.* § 1.02, at 1-4.

ity arising from special risks inherent in the practice of their profession.²⁶

Many conflicts similar to those arising from general liability policies appear in a professional liability insurance context. Since insurance companies dictate and draft the terms of standard form insurance policies,²⁷ these policies are recognized as classic examples of adhesion contracts.²⁸ The potential insured party, with little or no bargaining power as to the terms of the contract, has only a choice among standard insurance provisions. An opportunity for oppression underlies such contracts, especially since the insured, unlike some other consumers dealing with standardized contracts, receives only the conditional promises of the policy as his benefit in the bargain. Therefore, there exists a possibility that the insurer may avoid its responsibilities.

From the liability insurer's point of view, however, the selection and limitation of the risks he assumes is vital in order to meet the financial burdens of the business. Courts have recognized this need and have held that insurance provisions limiting liability do not violate public policy if the terms are unambiguous.²⁹ "An insurer may limit the risk it assumes and fix its premium accordingly,"³⁰ and if it is unwilling to cover certain risks, it may exempt them from policy coverage.³¹ Beyond the wording of the policy, insurance underwriters also attempt to control their risks by carefully selecting whom to insure.

To counterbalance the apparent control given to insurance companies in liability insurance transactions, a number of court decisions have favored the insured party. For example, professional liability policies are subject to the rule that courts will interpret adhesion contracts in light of the insured's reasonable ex-

²⁶Grieb v. Citizens Gas Co., 33 Wis. 2d 552, 556-57, 148 N.W.2d 103, 106 (1967).

²⁷"Even the provisions prescribed or approved by legislative or administrative action ordinarily are in essence . . . adoptions . . . of proposals made by insurers' draftsmen." R. KEETON, BASIC TEXT ON INSURANCE LAW 350 (1971). See also Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 631 (1943).

²⁸Zogg v. Penn Mut. Life Ins. Co., 276 F.2d 861 (2d Cir. 1960); Gray v. Zurich Ins. Co., 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966); RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 332a (Tent. Draft No. 6, 1960); Schultz, *The Special Nature of the Insurance Contract: A Few Suggestions for Further Study*, 15 LAW & CONTEMP. PROB. 376, 379 (1950).

²⁹Samuel N. Zarpas, Inc. v. Morrow, 215 F. Supp. 887 (D.N.J. 1963); Sherwood v. Stein, 261 La. 358, 259 So. 2d 876 (1972); Lehr v. Professional Underwriters, 296 Mich. 693, 296 N.W. 843 (1941).

³⁰1 LONG, *supra* note 22, § 12.10, at 12-14.

³¹*Id.*

pectations.³² If doubt or ambiguity exists in a policy, the question will be resolved against the insurance company.³³ As a result, an insured has some leverage in a dispute as to coverage under his contract.

Several provisions found in professional liability insurance contracts also operate to an insured party's advantage. Medical malpractice policies offer cancellation provisions that allow the physician to deliver the policy to the insurer with notice of cancellation at any time. The company, however, must deliver notice to the insured or his agent ten days in advance of the cancellation date.³⁴

Another provision peculiar to medical malpractice insurance policies,³⁵ the settlement clause, offers physicians considerable control. This clause gives a physician the right to determine whether his insurance company should settle a particular claim or suit.³⁶ However, if the physician refuses to settle and the insurance company loses the suit, the company's liability might be limited to the settlement offer.³⁷ Conversely, the refusal of an insurer to accept a reasonable settlement offer satisfactory to its insured may establish the company's liability for the full judgment, even if it exceeds policy coverage limits.³⁸ One policy form provides

³²*Orion Ins. Co. v. Firemen's Ins. Co.*, 46 Cal. App. 3d 374, 120 Cal. Rptr. 222 (1975); *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966); *Corgatelli v. Globe Life & Accident Ins. Co.*, 96 Idaho 616, 533 P.2d 737 (1975).

³³*Casey v. Transamerica Life Ins. & Annuity Co.*, 511 F.2d 577 (7th Cir. 1975); *Leist v. Auto Owners Ins. Co.*, 311 N.E.2d 828 (Ind. Ct. App. 1974); *Town & Country Mut. Ins. Co. v. Owens*, 143 Ind. App. 522, 241 N.E.2d 368 (1968); *Safian v. Aetna Life Ins. Co.*, 260 App. Div. 765, 24 N.Y.S.2d 92 (1940).

³⁴U.S. DEP'T OF HEALTH, EDUCATION & WELFARE, APPENDIX TO REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 508 (1973) [hereinafter cited as HEW APPENDIX]. Realistically, physicians are not likely to cancel policies with frequency, so the benefits of the provision are few.

³⁵*Id.* at 109. *But cf.* *Bergen*, *supra* note 4, at 25 (written consent is also required for an attorney's malpractice settlement).

³⁶Note, however, that some companies have eliminated the provision, believing that the individual doctor is not in a position to judge negligence. Other carriers have written provisions in group plans that either the individual doctor or some sort of peer review committee must give consent in order to settle a claim. HEW APPENDIX, *supra* note 34, at 508.

³⁷Hirsh, *Insuring Against Medical Professional Liability*, 12 VAND. L. REV. 667, 679 (1959); McNeal, *Patients, Litigation and Patience*, 33 INS. COUNSEL J. 408, 410 (1966).

³⁸Traditionally, only if the insurer was guilty of bad faith in refusing an offer of settlement would it be liable for the entire amount of a judgment against its insured without regard to policy limits. *See State Farm Mut. Auto. Ins. Co. v. Skaggs*, 251 F.2d 356 (10th Cir. 1957); *Dairyland Ins. Co. v. Hawkins*, 292 F. Supp. 947 (S.D. Iowa 1968); *Critz v. Farmers Ins. Group*,

that if the insured physician refuses to settle, the matter can be submitted to an advisory committee of the state medical society. That committee's majority decision is made binding on the insurer and the insured.³⁹

Another policy provision extending advantages to the insured party deals with coverage limitations. At present, many medical malpractice and other professional liability policies are written on a "claims-incurred" or an "occurrence" basis, as opposed to a "claims-made" basis. The traditional "occurrence" policy insures against liability arising from incidents occurring within the policy dates, regardless of when claims are made.⁴⁰ "Claims-made" policies, on the other hand, only insure against those claims brought within the coverage dates of the policy.⁴¹ Claims initiated after expiration of the policy, although based on acts occurring within policy dates, are excluded from coverage in claims-made policies. The advantage of "occurrence" provisions is, therefore, that an insured physician is protected for years after the possible commission of a negligent act.

C. Risk-Spreading Among Liability Insurance Companies

Before entering the malpractice or any liability insurance market, companies must consider how they will bear the risks. Within the insurance industry, companies spread the risks they carry by means of reinsurance contracts with other insurance companies. The need for reinsurance depends on the size of the primary carrier. Large companies who carry a full line of insurance find it less essential than smaller companies, who are more

230 Cal. App. 2d 788, 41 Cal. Rptr. 401 (1964); Note, *Liability Insurance—A Move To Limit the Excess Judgment Damages Award*, 42 *FORDHAM L. REV.* 439, 440 (1973). In *Crisci v. Security Ins. Co.*, 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967), the California Supreme Court altered the traditional "bad faith" standard of dishonest or fraudulent dealings to include unreasonableness of behavior. In *Crisci* the insurance company's refusal of a settlement agreeable to the insured constituted unreasonable behavior. The legal presumption in *Crisci* is further defined in *Garner v. American Mut. Liab. Ins. Co.*, 31 Cal. App. 3d 843, 107 Cal. Rptr. 604 (1973). In that case, the insurance company was held liable for a judgment greater than the policy limits because it failed to accept a reasonable settlement offer. In *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 510 P.2d 1032, 108 Cal. Rptr. 480 (1973), as in *Crisci*, the California Supreme Court recognized tort damages for emotional distress suffered by an insured because the insurer did not settle the claim in good faith.

³⁹1 LONG, *supra* note 22, § 12.08, at 12-11. See *Garner v. American Mut. Liab. Ins. Co.*, 31 Cal. App. 3d 843, 107 Cal. Rptr. 604 (1973).

⁴⁰Comment, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 *U.C.L.A.L. REV.* 925 (1975).

⁴¹*Id.*

specialized and who utilize reinsurance in order to compete with the larger companies.⁴² Relatively few insurance companies actively engage in reinsurance,⁴³ although the availability of reinsurance is of vital concern to issuers of malpractice policies. Thus, although established liability insurers at present have few difficulties in obtaining reinsurance, evidence indicates that formation of new companies is limited by a "thin" malpractice reinsurance market.⁴⁴

Another way in which established liability insurance companies spread risks is by writing umbrella policies which cover liabilities expressly excluded from or not mentioned in basic policies; they also write excess insurance which covers liability for damages exceeding those covered by other valid and collectible insurance. The purchase of an umbrella or excess policy is predicated on the existence of a primary malpractice policy with certain minimum limits.⁴⁵ If two companies are involved, one offering primary coverage and another selling other protection to the same insured, the financial risks are divided between them. At the same time, the physician is insured against the possibility that losses within the coverage period will be greater than the liability covered by the primary policy.

A third but less often utilized means of transferring risks consists of offering a deductible clause in the policy. Companies can afford to lower premium costs to insured parties and to provide insurance to high risk medical specialties if insurers know they will not be liable for certain minimum claim losses or for defense costs. To a degree, a deductible clause makes physicians self-insurers on some expenses.

III. THE ECONOMICS OF MALPRACTICE INSURANCE

A. *Rate Setting and Investment of Income*

The basic objective of an insurance company is to sell insurance at a competitive and profitable rate. This rate is determined by actuaries, who predict future losses and expenses that must be

⁴²HEW REPORT, *supra* note 18, at 39.

⁴³HEW APPENDIX, *supra* note 34, at 546 (while there are hundreds of companies engaged in primary casualty insurance, there are only two dozen companies in the United States mainly engaged in reinsurance).

⁴⁴*Id.* at 523, 547.

⁴⁵Malpractice policies are usually written with a given dollar limit per occurrence and an aggregate limit on all occurrences per policy year. *Id.* at 505. A typical policy has limits of \$100,000 per occurrence and \$300,000 per year. High-risk doctors may have difficulty obtaining umbrella coverage if their primary insurance covers less than \$200,000/\$600,000. *Malpractice Insurance Outlook: Brightening*, 48 MED. ECON. 103, 104 (1971).

paid from present premium income. Although the actuarial principles are similar for all lines of liability insurance,⁴⁶ rate setting in the malpractice area presents unique difficulties and demands a high degree of expertise.

Early rate structures failed to take into account the extended delay between an injury and the filing of a malpractice claim, and actuaries failed to anticipate a substantial increase in the number of malpractice suits.⁴⁷ Due to the nature of medical malpractice litigation, insurance companies must set aside large reserves to meet future claims,⁴⁸ and when the amount is underestimated, companies faced with excessive losses have been forced to withdraw from the market.⁴⁹ Dramatic changes over the last 10 years in the frequency and size of malpractice claims,⁵⁰ as well as inflation, have complicated the estimation. During an economic recession, the value of insurance reserves declines, making malpractice liability insurance less attractive to insurers,⁵¹ who rely on reserves for investment funds.

The malpractice insurance market is so small in proportion to the entire liability insurance business that it is difficult to formulate malpractice rate structures;⁵² therefore individual carriers have insufficient loss experience data to establish a valid rating base.⁵³ Actuaries take into account a physician's specialty, practice, geographical location, and the amount of requested coverage when determining his premium rate. Physicians in the most hazardous specialties pay much higher premiums than those in the lowest rate category. As claims payments and legal defense costs have risen, however, premium rates for all classes have in-

⁴⁶Insurers develop rates to produce sufficient premium volume to cover losses and administrative expenses and to provide a margin for contingencies and profit.

⁴⁷HEW APPENDIX, *supra* note 34, at 511; Brant, *Medical Malpractice Insurance: The Disease and How To Cure It*, 6 VALP. U.L. REV. 152, 163 (1972).

⁴⁸One company reported that malpractice insurance accounted for only 5% of its total premiums but for 10% of its reserves. Uhtoff, *Handwriting on the Wall*, 70 N.Y.J. MED. 1673 (1970).

⁴⁹Ribicoff, *supra* note 2, at 13; Sanders, *Money Well Spent*, 6 TRIAL, Feb.-Mar. 1970, at 16.

⁵⁰Three times as many malpractice suits were filed in the greater-Detroit circuit courts in 1974 as in 1970. N.Y. Times, Aug. 3, 1975, at 41, col. 5.

⁵¹Wall Street Journal, Jan. 20, 1975, at 1, col. 6.

⁵²The premium volume for medical professional liability insurance does not exceed 2.5% of the total property-liability insurance premium volume. HEW REPORT, *supra* note 18, at 41. Cf. HEW APPENDIX, *supra* note 34, at 511 (1%). Other government statistics indicate that only 0.3% of the billions of dollars garnered annually by fire and casualty underwriting represents medical professional liability insurance. Gibbs, *supra* note 12, at 29.

⁵³HEW REPORT, *supra* note 18, at 44; HEW APPENDIX, *supra* note 34, at 529.

creased sharply.⁵⁴ Malpractice policy protection contains higher limits than in the past in order to protect adequately against rising claim amounts.⁵⁵ The higher limits alone, however, do not account for rates increasing as much as 949% for surgeons and 541% for other physicians in the 10 years from 1960 to 1970.⁵⁶ Insurance companies continue to insist that malpractice insurance is a poor business proposition.⁵⁷ One cogent argument supporting that contention is that increasing defense costs and claim losses⁵⁸ have di-

⁵⁴In New York, while premiums increased 332%, insurers' losses increased 375%. Uhtoff, *Medical Malpractice—The Insurance Scene*, 43 ST. JOHN'S L. REV. 578, 586 (1969).

⁵⁵In 1950 policy protection rarely exceeded \$100,000, while in 1972, 90 percent of practicing physicians had larger policies, the average protection being \$300,000. Brant, *Medical Malpractice Insurance: The Disease and How To Cure It*, 6 VALP. U.L. REV. 152, 158 (1972).

⁵⁶Between 1960 and 1970, premium rates rose 115% for dentists, 540.8% for physicians and 949.2% for surgeons. HEW REPORT, *supra* note 18, at 13. Other statistics add perspective to the HEW figures. For example, in New York between 1950 and 1967, the size of the average malpractice premium rose 170%, the consumer price index 36%, physicians' fees 81%, and hospital costs 246%. Uhtoff, *Medical Malpractice—The Insurance Scene*, 43 ST. JOHN'S L. REV. 578, 586 (1969). A more recent table shows the cost of a standard malpractice policy in Ohio in 1969 and 1974, with increases ranging from \$109 to \$475 for class 1 physicians (no surgery) and from \$1080 to \$3217 for class 5 physicians. Pohlman, *supra* note 9, at 656. Some specialists now pay as much as \$30,000 a year for liability protection. NEWSWEEK, June 9, 1975, at 60.

⁵⁷Smith, *supra* note 8, at 10. "Not one insurer has made money in writing medical insurance in recent years." Brant, *supra* note 55, at 6 (no authority given). See *Important Information on Professional Liability & Defense*, 69 N.Y.J. MED. 2427, 2428 (1969) (*Table: Malpractice Insurance Losses in New York*). See also Dornette, *supra* note 8, at 31 (table analyzing distribution of malpractice insurance premiums indicates significant loss).

⁵⁸Although statistics on defense costs are relatively scarce compared with the wealth of information on premium increases, it has been estimated that of malpractice insurance costs, 30% represents the amount recovered by the patient, while 15% goes to the patient's attorney, and 55% is consumed by defense attorney fees and defense investigation. Ribicoff, *supra* note 2, at 13. High defense costs are attributed to the complexity of malpractice litigation, which requires expert medical testimony, expensive diagnostic procedures, and experienced legal counsel, even if the claim is settled prior to trial. Brant, *supra* note 55, at 159. Despite 1972 HEW statistics indicating relatively few claims leading to large settlements or judgments (6.1% exceeding \$40,000), it was recognized that the number of large awards or settlements was increasing. HEW REPORT, *supra* note 18, at 10. A medical-legal authority states, however, that

[a]wards and settlements in six and seven figures are extremely rare.

In 1970, they accounted for only 3 percent of all payments to plaintiffs. Even in this group, the great bulk are within \$300,000.

Curran, *The Malpractice Insurance Crisis*, 293 NEW ENG. J. MED. 24, 25 (1975). Insurance industry sources reported the average malpractice settle-

minated the pool of potential investment capital. American Insurance Association statistics report that policies in force during 1966 generated \$13.6 million in premiums, but that by 1974, claims covered by 1966 policies had caused \$18.2 million in losses.⁵⁹

A number of noninsurers contend that the carriers' losses merely represent declining profits⁶⁰ because the insurance industry's concept of profit is underwriting profit, not net profit from the total funds invested, regardless of the source of the funds.⁶¹ Underwriting profit is calculated by subtracting incurred losses and expenses from the amount of earned premiums. This calculation does not include investment income, with the result that insurers can incur high loss premium income ratios yet still make a profit from returns on the investment of their reserves.⁶² The vagaries of economic and stock market trends have unquestionably had an impact on insurance company business planning. Fire and casualty insurers suffered sizeable stock market losses in 1974 and 1975.⁶³ The issuance of malpractice policies appears particularly vulnerable in such a situation, because most companies consider malpractice insurance a marginal venture. Whenever a company decides upon a curtailment of its activities, medical malpractice insurance is considered expendable.

ment in 1970 as \$5000, and in 1973 as \$8000, but noted that a \$1 million judgment is becoming less unusual, particularly in California. 33 CONG. Q. WEEKLY REP., April 5, 1975, at 709. Other authorities suggest that costs are actually increasing at a disproportionate rate, noting that the average cost per claim in New York rose from \$6,000 in 1965, to \$23,400 in 1975, and pointing to the fact that 13 of the judgments or settlements over \$1 million in New York history have occurred within the last 28 months. NEWSWEEK, June 9, 1975, at 59.

⁵⁹NEWSWEEK, June 9, 1975, at 63.

⁶⁰According to one physician, the formula "cost plus profit equals premium" has made insurance a powerful and successful venture. *Id.* An attorney expressed the opinion that if insurance companies were to make their books public, "we'd find their claims are spurious." *Id.* at 65. There is little official data backing up insurance company reports of unprofitability except that more claims are filed and paid. 33 CONG. Q. WEEKLY REP., April 5, 1975, at 709.

⁶¹King, *A Critique of the Report of HEW's Medical Malpractice Commission*, 2 J. LEGAL MED., Mar.-Apr. 1974, at 49, 51. Comment, *Insurance Ratemaking Problems: Administrative Discretion, Investment Income, and Prepaid Expenses*, 16 WAYNE L. REV. 95, 101 (1969).

⁶²HEW APPENDIX, *supra* note 34, at 522-23. *But see* 121 CONG. REC. 1288 (1975) (remarks of Representative Hastings). Employers Insurance of Wausau lost \$120 million over 25 years, even taking into account income earned from their reserves, and at least two other companies—California Insurance Exchange and Casualty Insurance Company of California—"went broke offering this type of coverage." *Id.*

⁶³Wall Street Journal, Aug. 11, 1975, at 4, col. 2.

B. Insurance Company Responses to Losses

Faced with substantial financial losses caused by actuarial and investment miscalculations, insurance companies have few alternatives. They may become increasingly selective about which physicians to insure,⁶⁴ tighten policy provisions governing the scope of their assumed risk,⁶⁵ continue to raise malpractice premium rates,⁶⁶ or withdraw from the malpractice market completely.⁶⁷

One company that was compelled to pursue the most drastic alternative, discontinuing its malpractice insurance line, was Argonaut Insurance Company, a subsidiary of Teledyne Corporation. Although the facts are in dispute, the Argonaut incident illustrates the insurers' predicament. The incident also reflects the reluctance of insurers, when justifying business decisions, to statistically separate losses resulting from general economic trends from losses attributable to the peculiarities of malpractice insurance.

⁶⁴In response to reduced surpluses caused by economic reverses in stock and bond markets, casualty insurance companies immediately began to change their "book of business" and stopped renewing the highest risk classes of medical liability insurance. Cast, *Indiana's Medical Liability Problem*, 68 J. IND. MED. ASS'N 21 (1975). See also Smith, *supra* note 8, at 10. The president of St. Paul Fire & Marine Insurance Company, which insured about 17% of the physicians in the U.S., claimed it did not have the capacity to take on any new malpractice policyholders except where the company was sponsored by a state medical society and would not renew existing policies except in states where insurance departments permitted the company an adequate rate for profitmaking. In Indiana, for example, St. Paul stopped renewing the two riskiest specialty classes. MED. WORLD NEWS, July 28, 1975, at 76.

⁶⁵Comment, *Risk Control in Professional Liability Insurance*, 1960 DUKE L.J. 106, 107.

⁶⁶Premium rates trigger intense reactions in the medical world.

Rate increases stem from fear of future losses, not from current experience, and companies tend to ask for all they think they can get to protect against future fiscal calamity.

10 HOSP. PRAC. 24 (1975). Massachusetts physicians have expressed concern that insurance carriers are attempting to collect higher premiums than are necessary to cover actual and projected losses in Massachusetts, which used to rank as one of the six lowest risk states. The physicians allege that the higher premiums are used to offset losses in investment portfolios and in other higher risk areas of operation. Gibbs, *supra* note 12, at 29.

⁶⁷Pacific Indemnity & Star Insurance Company unexpectedly withdrew from the malpractice field at the end of 1974. Los Angeles Times, Jan. 7, 1975, § I, at 1, col. 1. Earlier, in 1969, the Nettleship Company, a combine of insurance companies providing malpractice insurance in Southern California, "lost \$22 million . . . with the result that six companies ended participation with the combine." Jarrett, *Arizona's Medical Association Malpractice Insurance Plan*, 27 ARIZ. MED. 12 (1970).

In 1974, the insurer of the New York State Medical Society's program withdrew its insurance coverage, and Argonaut contracted to be the new carrier. According to one source, Argonaut believed it could succeed where Employers of Wausau had failed as Argonaut was new to the program and had doubled existing premium rates. Owing to the delay of several years between premium collections and payouts for claims, the company reasoned that it could collect a large reserve in premium income to invest before having to pay out much in claims.⁶⁸ The company also expected to allocate most of the business to reinsurers. However, Argonaut could not interest reinsurers and ended up holding the majority of the business.⁶⁹ When company statistics indicated heavy losses and Argonaut's requests for large rate increases met with resistance from the state insurance superintendent,⁷⁰ Teledyne insisted that Argonaut cease its malpractice insurance business when the group plan expired on June 30, 1975. It has not been established whether Teledyne handed down the ultimatum because of losses from Argonaut's stock market investments⁷¹ or, as Teledyne contends, because "actuarial projections of huge losses . . . threatened to make Argonaut insolvent."⁷² A third reason suggested by Argonaut's former president is that "Argonaut's ability to write medical liability policies was 'curtailed' by its parent company's withdrawal of a \$21 million tax credit last September [1974]."⁷³ Whatever the reason, the result was that New York, Florida, California, and four other states were adversely affected by Argonaut's withdrawal from the field.⁷⁴ A House Subcommittee on Public Health and Environment is examining Argonaut's loss projections to determine if they were highly inflated.⁷⁵

⁶⁸MED. WORLD NEWS, Feb. 24, 1975, at 22-23.

⁶⁹10 HOSP. PRAC. 24, 33 (1975).

⁷⁰Curran, *Malpractice Insurance*, 292 NEW ENG. J. MED. 1223, 1224 (1975). Argonaut received a 93.5% premium increase in June 1974, but its request for a 196.8% increase to continue coverage after January 10, 1975, was rejected. 16 MED. WORLD NEWS, July 28, 1975, at 76.

⁷¹MED. WORLD NEWS, Feb. 24, 1975, at 23.

⁷²*Id.*, July 14, 1975, at 23. For statistics on Argonaut's financial downfall, see Regier, *Insurer's Insecurity*, 3 J. LEGAL MED., Jan. 1975, at 32.

⁷³MED. WORLD NEWS, July 14, 1975, at 23.

⁷⁴*Id.*, July 28, 1975, at 76. Ironically, however, Argonaut still writes malpractice insurance in Hawaii and makes a profit there. *Id.*

⁷⁵*Id.*

IV. PUBLIC INTEREST AND STATE REGULATION OF INSURANCE

A. *The Responsibility of Insurance Companies*

Insurance companies attempt to exercise reasonable business sense in eliminating financial risks to curtail losses. It is argued, however, that insurers should not have independent power to take extreme actions. Insurance companies have been criticized as

woefully lacking in any recognition of the fact that their business must be geared to public interest. The industry has a duty to the public, a responsibility to the public and an accountability to the public. It cannot be given license to underwrite losses and then get out of the less profitable areas and concentrate on selling types of insurance where it collects premiums and pays out few losses.⁷⁶

Indeed, there are constant echoes of statements suggesting that insurance companies should assume greater responsibility in reducing malpractice insurance problems.⁷⁷

The insurance industry can utilize its resources beneficially by researching new techniques of risk selection, ratemaking, re-insurance and claims prevention, and establishing more refined statistical data collection systems on malpractice claims and costs. If insurers publicized information as to premiums collected, amounts of reserves, investment income, and ratios of premiums to claims payments, and reviewed their underwriting practices more stringently, the exercise of state regulatory powers to demand such information would be unnecessary.

B. *State Regulation of Insurance*

The business of insurance is affected with a public interest and is therefore subject to reasonable regulation by the state.⁷⁸ One explanation for the public interest aspect of insurance is that it has become such an important mechanism for shifting risks within our economic system that supervision is essential to assure

⁷⁶Low, *Malpractice Suit Citizen's Weapon*, Atlanta Journal, Mar. 4, 1975, at 15A.

⁷⁷See, e.g., Bernzweig, *Lawsuits: A Symptom Not a Cause*, 6 TRIAL, Feb.-Mar. 1970, at 14, 15.

⁷⁸California State Auto. Ass'n Inter-Ins. Bureau v. Maloney, 341 U.S. 105 (1951); Lewis v. Manufacturers Cas. Ins. Co., 107 F. Supp. 465 (W.D. La. 1952); Bouis v. Aetna Cas. & Sur. Co., 91 F. Supp. 954 (W.D. La. 1950); Department of Ins. v. Schoonover, 225 Ind. 187, 72 N.E.2d 747 (1947). Regulation of malpractice insurance might also be deemed appropriate in light of the state concern in licensing of physicians. See, e.g., IND. CODE §§ 25-22-1-1 to -11-2 (Burns 1974).

the solvency of insurers.⁷⁹ This interest in solvency requires some regulation of rates since the industry cannot effectively function in an atmosphere of unrestrained competition. For example, severe competition might lead to deceptive and unsound financial practices such as reducing premium rates below a level sufficient to cover losses.⁸⁰ The main reason for government regulation, therefore, is to protect the public from the effects of destructive competition and, at the same time, from the excesses resulting from collaborative activity.⁸¹

Historically, the regulation of insurance was viewed as a state concern and was not regulated by the Federal Government through commerce clause powers, even though policy contract transactions stretched across state lines.⁸² However, in 1944 the Supreme Court held in *United States v. South-Eastern Underwriters Association*⁸³ that the business of insurance involves interstate commerce subject to federal regulation. As a consequence, federal antitrust laws were made applicable to the regulation of insurance, thus prohibiting collaboration among companies for purposes of pooling loss statistics and fixing rates—actions the state laws had permitted. Confusion in the insurance industry and the state governments as to the application of the *South-Eastern Underwriters* decision led Congress in 1945 to pass the McCarran-Ferguson Act⁸⁴ to clarify federal intentions.

The McCarran-Ferguson Act provides that no federal law shall impair any state law regulating insurance unless the federal law specifically relates to the business of insurance.⁸⁵ Federal antitrust laws, therefore, apply only to the extent that the insurance business is not regulated by state antitrust law.⁸⁶ Only a

⁷⁹Dineen, Gardner, & Proctor, *Insurance and Government*, in SYMPOSIUM ON INSURANCE AND GOVERNMENT, UNIVERSITY OF WISCONSIN, 1960, Vol. II, No. 1, at 12.

Since the insurance consumer purchases a policy with the expectation that claims made under it will be paid, the insurer bears a fiduciary responsibility to him which requires the insurer's continuing financial stability.

Note, *Insurance Regulation and Antitrust Exemptions: McCarran-Ferguson, the Boycott Exception, and the Public Interest*, 27 RUTGERS L. REV. 140, 156 (1973).

⁸⁰Dineen, Gardner, & Proctor, *supra* note 79, at 14.

⁸¹Comment, *Insurance Ratemaking Problems: Administrative Discretion, Investment Income, and Prepaid Expenses*, 16 WAYNE L. REV. 95, 97 (1969).

⁸²*United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 547-48 (1944).

⁸³322 U.S. 533 (1944).

⁸⁴Act. of Mar. 9, 1945, ch. 20, §§ 1-5, 59 Stat. 33-34 (codified at 15 U.S.C. §§ 1011-15 (1970)).

⁸⁵15 U.S.C. § 1012(b) (1970).

⁸⁶*Id.*

partial exemption from federal regulation is granted, however, because even if state laws regulate agreements to boycott, coerce or intimidate, the Sherman Act⁸⁷ still applies to such activities by insurance organizations.⁸⁸

The McCarran-Ferguson Act exemption has been further interpreted as applicable only when the insurance company is engaged in the "business of insurance."⁸⁹ That activity is narrowly defined as the relationship between insurer and insured, questions surrounding interpretation and enforcement of insurance policies, and other activities of companies closely related to their reliability as insurers.⁹⁰ Courts also have held that a state law must specifically regulate the insurance relationship if the insurance company is to claim a McCarran-Ferguson Act exemption from federal regulation.⁹¹ The degree to which restraints of trade will be permitted, in contravention of federal law, depends on the extent of state regulation and the unreasonableness of the restraint.⁹²

Exemption of the industry from federal antitrust laws generated a great deal of criticism when the McCarran-Ferguson Act first became effective in 1945. State antitrust laws had not been

⁸⁷*Id.* §§ 1-7.

⁸⁸*Id.* § 1013(b). In one interpretation, "the McCarran-Ferguson Act approves violations of federal antitrust laws so long as public regulation is provided." Comment, *Insurance Ratemaking Problems: Administrative Discretion, Investment Income, and Prepaid Expenses*, 16 WAYNE L. REV. 95, 100 (1969).

⁸⁹SEC v. National Sec., Inc., 393 U.S. 453 (1969).

⁹⁰*Id.*

⁹¹*Id.*; Hart v. Orion Ins. Co., 453 F.2d 1358 (10th Cir. 1971); Steingart v. Equitable Life Assurance Soc'y, 366 F. Supp. 790 (S.D.N.Y. 1973).

⁹²The common law rule that only unreasonable restraints of trade violate the law has been adopted by the Sherman Act, 15 U.S.C. §§ 1-7 (1970). The types of conduct held to violate the Sherman Act per se include price-fixing agreements, group boycotts, agreements to divide markets, and tie-in sales. E. KINTNER, AN ANTITRUST PRIMER 21 (2d ed. 1973). Indiana's statutes, for example, broadened regulation of trade practices in the insurance business in accordance with the McCarran Act, adopting Sherman Act terms concerning contracts to restrain commerce and prohibit monopolistic restraints. Indiana Code section 27-4-1-4(4) includes in the definition of unfair and deceptive acts and practices in business,

[e]ntering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

IND. CODE § 27-4-1-4(4) (Burns 1975). The statute also condemns excessive or inadequate charges for policy premiums and unfair discrimination in premium rates between policyholders of the same class dealing with essentially the same hazards. *Id.* § 27-4-1-4(7) (c).

effectively enforced in the past,⁹³ and it was argued that the size and power of the nationally organized insurance industry presented "the same difficulties for state control as . . . national railroads and giant manufacturing organizations."⁹⁴ This bleak projection has some basis in fact 30 years after the passage of the McCarran-Ferguson Act. One recent study of the Act has criticized states for having "failed to use their regulatory power effectively or to investigate and curtail anticompetitive practices in the industry."⁹⁵

Fears of monopolies and other antitrust activities have reappeared in recent months. The New York state legislature has formed a task force which in part will study antitrust implications in the simultaneous surfacing of the malpractice insurance crisis in many states across the country.⁹⁶

As fewer insurance companies sell malpractice insurance, a lack of competition may aggravate monopolistic tendencies. One study estimates that only ten companies sell 90% of the policy coverage.⁹⁷ The continuing surge in group insurance, particularly through state or county medical societies, also explains problems of rising rates and withdrawal of coverage affecting whole or large portions of states.⁹⁸ The growing reluctance of companies to write policies for physicians in high risk classifications, except through group plans, forces those physicians to join medical societies. At the same time, high participation in the group plan

⁹³C. EDWARDS, MAINTAINING COMPETITION—REQUISITES OF A GOVERNMENTAL POLICY 75 (1949).

⁹⁴*Id.*

⁹⁵Note, *Insurance Regulation and Antitrust Exemptions: McCarran-Ferguson, the Boycott Exception, and the Public Interest*, 27 RUTGERS L. REV. 140 n.2 (1973). Another study concluded that the existing administrative structure does not protect the public interest. Comment, *Insurance Rate-making Problems: Administrative Discretion, Investment Income, and Prepaid Expenses*, 16 WAYNE L. REV. 85, 133 (1969). Even earlier, a 1960 Senate report concluded that state regulation of the insurance industry was deficient in enforcing capital and surplus requirements and in scrutinizing underwriting and reserve activities, and that state departments were ineffective in dealing with mergers and liquidations. Evidence also indicated lax supervision of statutes governing restraint of trade, monopoly, and unfair trade practices. SENATE COMM. ON THE JUDICIARY, THE INSURANCE INDUSTRY, S. REP. No. 1834, 86th Cong., 2d Sess. 237-47 (1960).

⁹⁶Indianapolis News, May 30, 1975, at 3, col. 1.

⁹⁷*Moves Afoot To Shore Up Sagging Malpractice Coverage*, 10 HOSP. PRAC. 24, 25 (1975).

⁹⁸In 1970, an HEW study of the malpractice insurance market predicted: Within the foreseeable future, it is possible that group plans may so totally dominate the market that insurance carriers will cease selling policies to individual hospitals or practitioners.

HEW APPENDIX, *supra* note 34, at 494.

discourages writers of individual policies from entering the state.⁹⁹ Some "good risk" physicians who might be offered better insurance rates outside the group plan then find such policies unavailable.

Advantages to the insurance industry of physician group insurance plans include economies of scale in marketing and administration, risk spreading, and more reliable data on loss experience.¹⁰⁰ Although group plans might involve potential monopolistic tendencies, in that even slightly anticompetitive activities have a broader impact on malpractice insurance as fewer companies dominate larger market segments, the tendencies could be controlled by legislative action. Class action litigation would not be necessary if states regulate the insurance industry to protect the public against monopolistic activities and the resulting harmful practices.

C. *The State Insurance Commissioner*

Via their regulatory powers, states have created special departments to deal exclusively with the insurance business. The Department of Insurance in Indiana, for example, has charge of the "organization, supervision, regulation, examination, rehabilitation, liquidation, and/or conservation"¹⁰¹ of insurance companies. If an insurance company conducts its business in an unlawful, unsafe or unauthorized manner, allows its capital or surplus funds to fall below a certain level, or fails or refuses to comply with any order, rule or regulation of the department, the insurance commissioner can direct correction of the problem by written order to the insurance company's board of directors.¹⁰² If that effort fails, he may enjoin or compel the act.¹⁰³ Other powers of the Indiana insurance commissioner, which are representative of those granted by statutes in other states,¹⁰⁴ include authority to revoke a company's license to do business in the state,¹⁰⁵ to compel forfeitures,¹⁰⁶ to issue cease and desist orders,¹⁰⁷ and to seize company assets.¹⁰⁸ The regulation of rates is the prime consideration

⁹⁹*Id.* at 514.

¹⁰⁰*Id.* at 521.

¹⁰¹IND. CODE § 27-1-1-1 (Burns 1975).

¹⁰²*Id.* § 27-1-3-19.

¹⁰³*Id.*

¹⁰⁴*E.g.*, CAL. INS. CODE § 1065.1 (1972); N.Y. INS. LAW § 127 (McKinney 1966).

¹⁰⁵IND. CODE § 27-1-3-10 (Burns 1975).

¹⁰⁶*Id.* § 27-4-1-12.

¹⁰⁷*Id.* §§ 27-4-1-6 to -9, & -12.

¹⁰⁸*Id.* §§ 27-1-4-1 & -4. See Pfennigstorf, *The Enforcement of Insurance Laws*, 1969 WIS. L. REV. 1026, 1032-67 (discussion of insurance commissioners' powers).

here, and the Indiana law, in language typical of statutes in other states, proposes to

promote the public welfare by empowering the commissioner of insurance to regulate insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory, and to encourage reasonable competition among insurance companies . . . and to permit and regulate, but not require, cooperative action among insurers, as to rates, rating systems, rating plans and practices¹⁰⁹

As in other states,¹¹⁰ insurers in Indiana must either file rating schedules or plans with the commissioner or belong to a licensed rating organization that does.¹¹¹ The commissioner is empowered to make any rules and regulations he deems necessary to exercise his enumerated powers.¹¹²

There is some question as to whether insurance commissioners are using their powers effectively to regulate industry activity. Problems generated by group insurance programs, for instance, could be limited if insurance commissioners adopt plans providing six months of insurance coverage in the event of the carrier's bankruptcy,¹¹³ requiring substantial advance notice of cancellation,¹¹⁴ and allowing public hearings for physicians denied coverage by the group.¹¹⁵ Although state insurance commissioners cannot absolutely compel the issuance of medical malpractice policies,¹¹⁶ commissioners apparently can condition the sale of other types of insurance on assumption of part of the malpractice busi-

¹⁰⁹IND. CODE § 27-1-22-1 (Burns 1975).

¹¹⁰See Donovan, *Regulation of Insurance Under the McCarran Act*, 15 LAW & CONTEMP. PROB. 473, 485-86 (1950).

¹¹¹IND. CODE § 27-1-22-4 (Burns 1975).

¹¹²*Id.* § 27-1-3-7.

¹¹³HEW APPENDIX, *supra* note 34, at 553. See IND. CODE §§ 27-6-8-2 to -18 (Burns 1975) (dealing with the contingency of a company's bankruptcy).

¹¹⁴HEW APPENDIX, *supra* note 34, at 553.

¹¹⁵*Id.* at 555.

¹¹⁶In *St. Paul Fire & Marine Ins. Co. v. Insurance Comm'r*, 339 A.2d 291 (Md. Ct. App. 1975), the Maryland Court of Appeals struck down an attempt by the insurance commissioner to order St. Paul Fire & Marine Insurance Company to continue writing insurance for its physician-policyholders. The court held that the insurer's withdrawal from the malpractice field was not prevented by a Maryland statute, MD. ANN. CODE art. 48A, § 234A (1972), providing that an insurer could not cancel or refuse to underwrite a particular insurance risk for arbitrary, capricious or unfairly discriminatory reasons. See also Curran, *The Malpractice Insurance Crisis*, 293 NEW ENG. J. MED. 24 (1975).

ness.¹¹⁷ They may require supporting data from insurance companies proposing premium rate increases and refuse to permit unjustified rates. That commissioners often have not done so in the past¹¹⁸ is further reason to encourage new exercise of their powers.

In numerous ways, insurance commissioners could take an active role in insurance supervision. Recently the Texas legislature gave the state insurance board control over medical liability rates,¹¹⁹ an extension of the power of most commissioners to review and approve but not fix rates.¹²⁰ The board immediately exercised that control by freezing premium rates.¹²¹ In another illustration of the potentialities, the Pennsylvania insurance commissioner settled a suit by the state medical society against Argonaut Insurance Company. The commissioner approved a 206% rate increase for Argonaut but added provisos that the company underwrite the state's physicians for four years and that premiums be justified by claims experience.¹²² In the past, insurance commissioners have shied away from mandating insurance company efforts to solve the malpractice insurance crisis, relying instead on state legislative actions. Conceivably, within their broadly enumerated powers, commissioners could find authority for requiring companies authorized by law to sell all types of liability insurance to set up an assigned risk pool to cover all physicians who otherwise could not obtain insurance.¹²³ Such a plan would be analogous to automobile liability assigned risk programs for drivers who cannot find insurance in the free market. Alternatively, states could legislate on an emergency basis that any insurance company withdrawing from the malpractice business would be barred from writing other insurance business in the state. The danger, however, of attempting to force insurers to cover malpractice risks is that companies will opt to leave the state rather than risk subjecting their businesses to what they view as imminent financial distress. On the positive side, a broad and equitable apportionment of risks among insurers might prove economically reasonable, if not necessarily profit-generating.

¹¹⁷JUAs have not yet been attacked on constitutional grounds. Curran, *supra* note 116, at 24.

¹¹⁸States are criticized for not exercising "their police powers in impounding for careful expert scrutiny the purported losses and requests for rate increases of any professional liability insurance company . . ." Gibbs, *supra* note 12, at 32.

¹¹⁹TEX. INS. CODE art. 5.82 (Cum. Supp. 1975-76).

¹²⁰*E.g.*, N.Y. INS. LAW § 184 (McKinney 1966).

¹²¹American Medical News, Aug. 4, 1975, at 10, col. 1.

¹²²MED. WORLD NEWS, July 14, 1975, at 23.

¹²³121 CONG. REC. 306 (1975) (remarks of Senator Nelson).

An insurance commissioner's powers, therefore, are presently more preventive and punitive than affirmative. If a state legislature were to provide the commissioner with express statutory authority to initiate programs and rules regarding malpractice insurance, however, he would feel supported in taking more positive actions to regulate insurers.

D. *New State Legislation*

In the first half of 1975, most states either passed emergency bills which dealt with malpractice insurance availability, or established a commission to study the problem.¹²⁴ Such legislation was generally directed towards the stabilization of insurance premiums and the attraction of malpractice insurers into a state. Whether these acts will eliminate the dangers of monopoly, deceptive rate-making, and coercive activity by insurance companies remains to be seen. Noteworthy changes in the new acts include restrictions on statutes of limitations, often eliminating the rule that the statute does not begin to run until discovery of an injury, dollar "caps" on total recoveries available to injured plaintiffs, and arbitration panels.¹²⁵ Certainly, all of those changes meet insurance industry suggestions to ease ratemaking problems in that the "long tail" on claims is replaced by a set time period within which claims must be brought, clear limits on insured physicians' liability eliminate guesswork as to inflation of future awards, and arbitration panels can save defense expenses and settle "nuisance value" cases.¹²⁶

One point that cannot be ignored in reviewing the new legislation is that insurance companies made no commitments to main-

¹²⁴Curran, *Malpractice Crisis: The Flood of Legislation*, 293 NEW ENG. J. MED. 1182 (1975).

¹²⁵MED. WORLD NEWS, July 28, 1975, at 80 (chart of malpractice laws by state as of mid-July 1975). The Indiana act, IND. CODE §§ 16-9.5-1-1 to -9-10 (Burns Supp. 1975), provides for the following: A two year statute of limitations running from the date of the occurrence, *id.* §§ 16-9.5-3-1, -2; a \$100,000 limit on physician-insurer liability, *id.* § 16-9.5-2-2(b), with an excess insurance fund covering liability up to the maximum recoverable of \$500,000, *id.* § 16-9.5-2-2(a); and arbitration, in the form of a mandatory, non-binding screening panel, preliminary to court suit, *id.* §§ 16-9.5-9-1 to -10. Several states have statutes similar to Indiana's. See ch. 75-9, §§ 1-17, [1975] Laws of Fla. 13 (to be codified in scattered sections of FLA. STAT.); ch. 796, §§ 1-27, [1975] Ore. Laws 2306 (to be codified in scattered sections of ORE. REV. STAT.); Act of Aug. 4, 1975, No. 817, §§ 1-3, [1975] LA. SESS. LAW SERV. No. 4, at 1382 (West 1975), to be codified as LA. REV. STAT. §§ 40:1299.41-47.

¹²⁶Indisputably, physicians gain tremendous advantages from having their liability limited by time and amount and reviewed prior to trial or settlement. On the other hand, there are obvious disadvantages to plaintiff-patients and questions as to the constitutionality of limiting redress for injury resulting from malpractice.

tain reasonable premium rates and no guarantees to insure physicians in high risk classes.¹²⁷ The Indiana medical malpractice law,¹²⁸ as one example, offers unique solutions to the malpractice insurance problem, but the law's inherent weakness lies in the absence of means to enforce the continued availability of insurance.¹²⁹ Therefore, other facets of the the new laws attract particular interest as they affect the insurance domain: joint underwriting associations or risk pools, malpractice insurance funds, and physicians' self-insurance companies.¹³⁰

The National Association of Insurance Commissioners urged authorization of joint underwriting associations (JUAs), or mandatory risk-sharing pools, as a temporary solution to the problem of unavailability of insurance.¹³¹ Several state legislatures followed the advice.¹³² A typical JUA plan requires all companies writing personal liability insurance in a state to participate in the malpractice insurance business.¹³³ Most laws provide for the plan to be temporary or operational at the insurance commissioner's option.¹³⁴ JUAs provide primary coverage for physicians or reinsurance of policy liability over a certain amount. They might cover only those physicians otherwise unable to obtain insurance

¹²⁷One reason for the reluctance of insurers to speak to the issue of rates might be that the Indiana act is not retroactively effective; section 7 of chapter 1 explicitly excludes application to any act of malpractice occurring before July 1, 1975. IND. CODE § 16-9.5-1-7 (Burns Supp. 1975).

¹²⁸*Id.* §§ 16-9.5-1-1 to -9-10.

¹²⁹*Id.* § 16-9.5-7-1.

¹³⁰By mid-July 1975, there were at least seven states establishing joint underwriting associations by new laws. Ch. 75-9, § 2, [1975] Laws of Fla. 15, *to be codified as* FLA. STAT. § 627.352; IDAHO CODE §§ 41-4101 to -4114 (Cum. Supp. 1975); Act of Sept. 12, 1975, Pub. Act 79-962, [1975] ILL. LEGIS. SERV. No. 6, at 1619-26 (West 1975), *to be codified as* ILL. REV. STAT. ch. 73, §§ 1065.201-.221; MD. ANN. CODE art. 48A, §§ 504-18 (Cum. Supp. 1975); ch. 296, [1975] Nev. Sess. Laws 398-400 (Nevada Essential Insurance Association); WIS. STAT. ANN. § 619.01 (Spec. Pamphlet 1975).

At least two states established physician-supported insurance funds. IND. CODE §§ 16-9.5-4-1 to -3 (Burns Supp. 1975); Act of May 12, 1975, Pub. Act 43, [1975] MICH. LEGIS. SERV. No. 1, at 89-94 (West 1975), *to be codified as* MICH. COMP. LAWS §§ 500.2500-.2517.

Five states authorized the formation of physicians' self-insurance companies. MD. ANN. CODE art. 48, §§ 548-65 (Cum. Supp. 1975); MO. REV. STAT. §§ 383.010-.040 (Vernon Cum. Supp. 1976); N.Y. INS. LAW §§ 681-95 (McKinney Supp. 1975-76); N.D. CENT. CODE §§ 26-40-01 to -15 (Supp. 1975); ch. 796, § 12, [1975] Ore. Laws 2313-14, *to be codified as* ORE. REV. STAT. § 731-504.

¹³¹MED. WORLD NEWS, July 28, 1975, at 76. The American Insurance Association also supported JUAs. *Id.*, Mar. 25, 1975, at 25.

¹³²*Id.*, July 28, 1975, at 80.

¹³³*E.g.*, IDAHO CODE § 41-4103(1) (Cum. Supp. 1975).

¹³⁴*E.g.*, *id.* § 41-4103(3).

or they may be the exclusive writers of malpractice policies. Reserve funds for such plans are accumulated either from surcharges on JUA policies or assessments of all state physicians, according to the scope of the program.

A second approach involves malpractice insurance fund plans such as those in Indiana¹³⁵ and Michigan.¹³⁶ These plans, which also offer insurance for physicians who cannot purchase protection elsewhere, are supported by premiums and assessments on physicians. They are administered by a risk manager under the authority of the department of insurance, rather than by an organization of all liability insurance companies. A third innovation is exemplified by Maryland's plan,¹³⁷ which authorizes a \$300 tax charge on every doctor in the state for creation of a physicians' mutual liability company to handle medical malpractice insurance.¹³⁸ Any licensed physician may become a member upon payment of the tax.¹³⁹ The company will be governed by an eleven-member board, of which not more than five may be physicians.¹⁴⁰

The main criticism that can be directed at these three programs is that, while they have dealt with the present availability of insurance, they do not guarantee reasonable rates. In fact, all require surcharges or special reserve fund charges in addition to regular premiums.¹⁴¹

Compromises form the basis of this body of legislation—compromises on the part of physicians, on the part of insurance companies, and on the part of insurance commissioners. Given the uniqueness of the predicament, no one can postulate with certainty the correctness of any one solution. Possibly, a combination of proposals addressed to the ratesetting and availability aspects of the malpractice insurance dilemma might be implemented without much difficulty.

V. A PROPOSAL

Notwithstanding the wealth of no-fault proposals,¹⁴² arbitra-

¹³⁵IND. CODE §§ 16-9.5-1-1 to -9-10 (Burns Supp. 1975).

¹³⁶MICH. COMP. LAWS ANN. §§ 500.2500-2517 (West Supp. 1975).

¹³⁷MD. ANN. CODE art. 48A, §§ 548-56 (Cum. Supp. 1975).

¹³⁸*Id.* § 552(b).

¹³⁹*Id.* § 552(e).

¹⁴⁰The physician members of the company will elect the board. *Id.* § 551.

¹⁴¹American Medical News, Aug. 4, 1975, at 10, col. 1. In the case of the Maryland physicians' self-insurance company, rates are expected to increase 100%. *Id.*

¹⁴²See, e.g., Carlson, *Conceptualization of a No-Fault Compensation System for Medical Injuries*, 7 LAW & SOC. REV. 329 (1973); Havighurst & Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 1974 INS. L.J. 69; Keeton, *Compensa-*

tion plans,¹⁴³ and federal insurance bills,¹⁴⁴ a system combining several other proposals might alleviate the need for drastic revisions in the present manner of dealing with medical malpractice cases. The traditional system requiring a determination of negligence in order to hold a physician liable for damages could be preserved, and responsibility for insurance supervision could remain with state governments. A data collection system for rate-making, adoption of claims-made policies, creation of physicians' self-insurance companies, and government-sponsored reinsurance comprise the four elements of this proposal.

The first requirement, a data collection system for malpractice insurance statistics, would be supervised and utilized by insurance commissioners to compare rates and rating practices among companies.¹⁴⁵ Commissioners could then determine the extent of insurance availability and the reasonableness of rates without resort to medical society or insurance industry statistics. Companies could forecast losses and set rates more accurately than in the past with the aid of accurate data. In particular, newly-established physicians' companies would have at hand the factual information that has previously eluded insurers to ease their financial stabilization in the insurance business. Insurance commissioners could apply appropriate pressures to keep companies in line with rates and penalize rate deviations or attempts to manipulate the market. However, those profit-oriented tendencies would be anticipated only to a limited degree with physicians' self-insurance companies, whose major concern would be coverage.

The next suggested action is more drastic: adoption of claims-made insurance policies in place of the occurrence policies now commonly offered. This step would eliminate the difficulties accompanying the current situation of having an indefinite number of claims incurred but not yet reported. In a claims-made policy, the insurer agrees to assume liability for acts of malpractice occurring during the policy term only to the extent that a claim is

tion for Medical Accidents, 121 U. PA. L. REV. 590 (1973); O'Connell, *No-Fault Insurance for Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21 (1975).

¹⁴³See, e.g., S. 482, 94th Cong., 1st Sess. (1975). This legislation is entitled the National Medical Insurance and Arbitration Act. It would make federal insurance available only to states with programs for initial arbitration of malpractice claims. The bill sets forth procedures for initiation of arbitration, appointment of the arbitration panel, hearing procedures, law governing the panel's decision, and proceedings subsequent to the panel's decision.

¹⁴⁴See, e.g., S. 482, 94th Cong., 1st Sess. (1975); S. 215, 94th Cong., 1st Sess. (1975).

¹⁴⁵See HEW REPORT, *supra* note 18, at 38 (stressing the need for such a reporting system).

made within the policy period.¹⁴⁶ Coverage under an occurrence policy, on the other hand, extends to any acts of malpractice occurring during the policy period, regardless of when claims are made.¹⁴⁷ Since an insurer's retrospective and prospective liability are limited under the claims-made policy, he can predict losses, determine rates, and set aside reserves with a higher degree of accuracy.

Physicians have voiced strong objections to claims-made policies, largely because the physicians would be forced to purchase coverage even after they discontinued practicing in order to be protected.¹⁴⁸ Since the policy only covers claims or suits brought in the specific period of the policy, a retired physician would still need an insurance policy in case a patient brought a claim within the statute of limitations but after the physician's last year of practice. That expense must be weighed against the elimination of inflated premium charges, and presumably the premium could be reduced each year as the possibility of a claim declined. One final charge could cover all remaining exposure to liability after a predetermined period.¹⁴⁹ Alternatively, state insurance departments could form risk pools for coverage of retired physicians or the estates of deceased physicians.¹⁵⁰ Claims-made policies are also criticized for offering no more than a short-term reduction in malpractice insurance costs if other malpractice litigation expenses continue to rise. Nevertheless, coverage at a reasonably calculated though increasing rate could be assured, and at least one company actively championing the claims-made concept predicts a lowered rate.¹⁵¹ Another argument insists that there is no need for claims-made policies following passage of statutes, such as Indiana's, which reduce statutes of limitation to two or three years¹⁵² and strictly limit recoverable damages.¹⁵³ In response to that point, a caveat applies. If those statutes do not operate retro-

¹⁴⁶Comment, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A.L. REV. 925 (1975).

¹⁴⁷*Id.*

¹⁴⁸Lanzone, *Products Liability and Professional Liability No-Fault: A Defense Lawyer's View*, 47 N.Y. ST. B.J. 185, 216 (1975).

¹⁴⁹St. Paul's claims-made plan offers "reporting" coverage for retired physicians or deceased physicians' estates in a three-year installment plan. MED. WORLD NEWS, July 14, 1975, at 78.

¹⁵⁰Lanzone, *supra* note 148, at 216.

¹⁵¹St. Paul plans a five-year premium rate increase per physician, with the coverage "maturing" in the fifth year, and predicts that the mature claims-made rate will be less than the occurrence rate would be at that time. MED. WORLD NEWS, July 14, 1975, at 78.

¹⁵²IND. CODE § 16-9.5-3-1 (Burns Supp. 1975).

¹⁵³*Id.* § 16-9.5-2-2.

actively, as Indiana's does not,¹⁵⁴ acts of malpractice occurring prior to the effective date of the statute are not covered. In those cases, the previous laws allowing open-ended awards and extended statutes of limitation would apply. Thus, insurers would need the definite terms available in claims-made policies.

Claims-made policies have aroused controversy wherever insurance companies have attempted to obtain approval of them; Indiana, among other states, has not been receptive.¹⁵⁵ Although new to medical malpractice insurance, claims-made provisions have increasingly been used by insurers of architects, engineers, lawyers, brokers, and accountants,¹⁵⁶ and the validity of those professional liability insurance contracts has been litigated.¹⁵⁷ The benefits of such policies have been well recognized. In thirty-one of the forty-four states in which St. Paul Fire & Marine Insurance Company filed requests for claims-made policies, the requests have been approved.¹⁵⁸ The approach of the California legislature seems the most reasonable. A 1975 statute¹⁵⁹ permits claims-made policies to be issued, subject to the conditions that the fact that coverage is limited to liability for claims made against the in-

¹⁵⁴*Id.* § 16-9.5-1-7.

¹⁵⁵Interview with Lawrence G. Kaseff, Deputy Commissioner, Patients Compensation Authority, Indiana Department of Insurance, in Indianapolis, Ind., August 29, 1975. Mr. Kaseff confirmed the fact that the Indiana insurance commissioner had rejected the claim-made policy form submitted by St. Paul and predicted that the commissioner would not approve the forms in the future.

¹⁵⁶Comment, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A.L. REV. 925, 926 (1975).

¹⁵⁷For examples of courts striking down claims-made policies, see *J.G. Link & Co. v. Continental Cas. Co.*, 470 F.2d 1133 (9th Cir. 1972), *cert. denied*, 414 U.S. 829 (1973) (ambiguous claims-made provision in architect's policy construed in favor of insured); *Gyler v. Mission Ins. Co.*, 10 Cal. 3d 216, 514 P.2d 1219, 110 Cal. Rptr. 139 (1973) (attorney's claims-made policy held ambiguous); *Jones v. Continental Cas. Co.*, 123 N.J. Super. 353, 303 A.2d 91 (Ch. 1973) (professional engineer claims-made policy held invalid as contrary to public policy in limiting coverage). Cases in which courts upheld claims-made policies include *Cornell, Howland, Hayes & Merryfield, Inc. v. Continental Cas. Co.*, 465 F.2d 22 (9th Cir. 1972) (court relied on plain language of policy to deny recovery to engineer-policyholders); *Livingston Parish School Bd. v. Firemen's Fund Am. Ins. Co.*, 282 So. 2d 478 (La. 1973) (engineer's claim to reasonable expectations of coverage held defeated by unambiguous provisions clearly limiting protection); *J.M. Brown Constr. Co. v. D & M Mechanical Contractors, Inc.*, 222 So.2d 93 (La. Ct. App. 1969) (court found forthright statement on face of broker's policy as to coverage was clear).

¹⁵⁸*American Medical News*, July 21, 1975, at 10, col. 2.

¹⁵⁹CAL. INS. CODE § 11580.01 (West Supp. 1975).

sured while the policy is in force be conspicuously recited on the application and on the front page of the policy.¹⁶⁰

Approval of claims-made policies by state insurance commissioners would facilitate implementation of the next step in this suggested plan, which is establishment of physician-owned insurance companies. The idea has been tried and found workable. For example, in 1957 a group of Colorado physicians reduced their insurance costs by forming their own insurance company, Empire Casualty Company,¹⁶¹ and in 1971 the entirely doctor-owned and doctor-run company insured 55% of the private physicians in the state.¹⁶² The financial uncertainties which plague self-insurance companies as well as other insurers would be minimized by the first two steps of this plan since companies could begin operations with a surer footing in ratemaking and investment planning. The obvious advantages to physicians and to general liability insurers of having physicians develop their own companies range from lifting a financial burden from the established general insurers to providing an opportunity for the specialized company to develop expertise in malpractice insurance writing and defense. General liability insurers would no longer feel pressured to compensate for malpractice insurance losses by raising rates of other insurance lines, and the cooperative companies could concern themselves more with coverage than with profitmaking.

In setting up an insurance business, two hurdles are raising the initial capital required by state law to prove financial solvency and obtaining reinsurance. Assessments of all medical society members and initial surcharges of insured physicians can be used to build capital and reserves. Physician-owned insurance companies in New York, Maryland, Michigan, and Northern California are presently implementing those procedures.¹⁶³ Under most state laws, companies must restrict their coverage to some percentage of their reserves if they do not have reinsurance.¹⁶⁴ This critical requirement could be met either by a state-operated JUA which would function exclusively for the purpose of offering reinsurance to physician-owned companies, or by a federal re-

¹⁶⁰See Comment, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A.L. REV. 925 (1975), for a critical study of the validity of claims-made policies, concluding with an endorsement of the California statute. See Trout, *Malpractice Insurance: Claims-Made Policies Pose a New Dilemma*, 3 J. LEGAL MED. 33 (1975), for a similar analysis.

¹⁶¹Tucker, *New Answer to High Malpractice Rates*, 35 MED. ECON. 71 (1958).

¹⁶²*Malpractice Insurance Outlook: Brightening*, 48 MED. ECON. 103, 104 (1971).

¹⁶³See American Medical News, July 28, 1975, at 1, col. 2.

¹⁶⁴See, e.g., IND. CODE § 27-1-13-6 (Burns 1975).

insurance program. Under one proposed federal program, companies could make payments into a federal reinsurance fund, which would cover all payments beyond the first \$25,000 of each claim.¹⁶⁵ Under acts such as Indiana's,¹⁶⁶ which limit recovery amounts for malpractice injuries, the need for reinsurance would diminish as fewer suits are brought under past laws.

By incorporating these four steps into one system, states could continue their regulation of the insurance industry with limited federal interference. Within carefully delineated bounds, a private insurance system could operate efficiently and competitively.

VI. SUMMARY

Maintenance of insurance availability at reasonable rates will not solve the malpractice problem, nor is it intended to do so. As long as physicians commit acts of malpractice and are held liable for resulting injuries, however, medical malpractice insurance will remain a necessity. This Note approaches the malpractice crisis from the viewpoint of insurance, showing the need for professional liability insurance under the existing system of laws and examining the causes and effects of the malpractice insurance crisis. Various economic factors stimulated drastic and far-reaching responses from insurance companies regarding malpractice insurance. Unfortunately, many state insurance departments did not react so quickly. What this Note has attempted to demonstrate is that state governments have been deemed the appropriate entities to control the business of insurance and that states have an obligation to fulfill that role. Insurance companies, in turn, have a responsibility to the public and should exercise that duty in the course of business.

New state laws clarify these powers and responsibilities; nevertheless changes in attitudes, as well as laws, are needed. The proposal set forth in this Note does not demand a major overhaul of approaches to malpractice insurance, but in essence the proposal does require that insurance commissioners exercise long dormant powers and actively police the industry. The crisis in malpractice insurance availability warrants affirmative efforts by physicians, insurers, and insurance departments to assure continued coverage at reasonable rates.

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¹⁶⁵S. 188, 94th Cong., 1st Sess. (1975), entitled the Federal Medical Malpractice Insurance Act. Requirements of arbitration and uniform rates as they appeared in that bill would not be endorsed as necessary to this proposed solution. *See also* H.R. 2804, 94th Cong., 1st Sess. (1975).

¹⁶⁶IND. CODE §§ 16-9.5-1-1 to -9-10 (Burns Supp. 1975).