

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS  
INSURANCE ADMINISTRATION

In the Matter of: National Capital  
Reciprocal Insurance Company 1991  
Rate Filing

Order 92-7A

ORDER

This case arise under the authority of the District of Columbia Insurance Administration under Section 37-1704 of the D.C. Code, 1981 Edition, (as amended), to review, investigate and adjust insurance premium rates filed by insurance companies under Section 37-1703 of the D.C. Code, 1981 Edition, (as amended).

On March 29, 1991, former Superintendent of Insurance, Margurite C. Stokes, notified the National Reciprocal Insurance Company ("NCRIC") of her intention to order an adjustment to the 1991 program and filed rates, rules and policy forms submitted to the Insurance Administration on December 14, 1990. Upon NCRIC's request, a hearing was conducted on September 6 and 13, 1991. After due consideration of the administrative issues, the evidence and testimony introduced at the hearing I hereby make the following Findings of Fact.

FINDINGS OF FACT

I. PARTIES TO THIS ACTION AND JURISDICTIONAL INTEREST

1. The National Capital Reciprocal Insurance Company is a doctor owned reciprocal insurance company operating pursuant to a certificate of authority issued by the District of Columbia Insurance Administration. Since 1980, NCRIC has provided medical malpractice liability coverage to physicians in the District of Columbia. NCRIC's attorney-in-fact, National Capital Underwriters, Inc., ("NCUI"), administers and issues these insurance policies. NCUI makes annual filings with the Insurance Administration of the rates, rating plans, rules and classifications it uses or proposes to use in the District of Columbia. Mr. David K. Little is the President of NCUI.

2. NCRIC/NCUI is presently the major insurance company offering medical malpractice insurance to all medical specialties within the District of Columbia.
3. The Boards of Directors of NCRIC and NCUI are entirely composed of physicians, some of whom are obstetricians/gynecologists ("OB/GYN"). The NCRIC and NCUI underwriting committees are also entirely composed of physicians, some of whom are also OB/GYNs. According to Mr. Little's knowledge and belief, none of the OB/GYNs serving on these Boards of Directors or underwriting committees work with nurse-midwives. (Little, Tr., pp. 182-189).
4. For the past several years, NCRIC has offered vicarious liability coverage to its physician insureds for certain categories of non-physician health professionals employed by physicians in their practice. One such category is certified nurse-midwives. (1991 R.F., Little, Tr., pp. 179, 192).
5. On December 14, 1990, NCRIC/NCUI filed its 1991 program and rate filing with the District of Columbia Insurance Administration. As it pertains to vicarious liability coverage of physicians collaborating with nurse-midwives, this filing is currently under review by the Insurance Administration pursuant to Sections 35-1703 and 1704 of the D.C. Code, 1981 Edition, (as amended).
6. Drs. Safran and Horwitz, Chartered, an OB/GYN group practice located in the District of Columbia are Interveners as a NCRIC policyholder. (Jt. Cmts., Exhs. A-1 to A-3; Safran, Direct).
7. The Safran and Horwitz group practice consists of four physician members or partners, one physician employee, and three nurse-midwife employees. All members, partners or other employees are employed by the corporation. (Safran, Direct; Dutcher, Direct).
8. In 1990, in addition to the standard premiums charged Safran and Horwitz by NCRIC for coverage of the four member or partner physicians, the group practice also paid NCRIC a vicarious liability premium of \$305.00 for each of its nurse-midwife employees and a vicarious liability premium for its physician employee whose direct coverage was not purchased from NCRIC. The premium for corporate coverage was \$7,381.00. (Jt. Cmts., Exh. A-2; Safran, Direct).
9. In 1991, NCRIC did not assess a vicarious liability premium for the Safran and Horwitz physician employee, since her direct coverage was now purchased from NCRIC. The Safran and Horwitz

group practice purchased direct coverage from NCRIC for each of its member or partner physicians and the physician employee. The 1991 premium surcharge for vicarious liability coverage for these member or partner physicians collaborating with the three nurse-midwives was \$40,725 representing a cost of \$13,575.00 per nurse-midwife. This premium surcharge was equal to approximately 25% of the standard physician's rate for direct coverage. (Jt. Cmts., Exh. A-1; Safran, Direct; S & H Hearing Exh. K).

10. In the case of the Interveners Safran & Hortwitz, the premium surcharge for nurse midwife vicarious liability coverage represented a rate increase of over 4400% from 1990 to 1991. (Jt. Cmts.; Hunter, Tr., pp. 341-342; 358).
11. Under protest, Safran and Horwitz, paid the entire premium surcharge for nurse midwife vicarious liability, on or about January 24, 1991. On January 31, 1991, Safran and Hortwitz submitted a written request to NCRIC to revise its rating system with respect to the premium surcharge and refund the difference in payment. To date, NCRIC has not done so. (S & H Hearing Exh. M; Safran, Direct; Safran, Tr., p. 284).
12. The District of Columbia Chapter of the American College of Nurse Midwives ("ACNM") is an Intervener as a national professional organization which represents nurse midwives in the United States. ACNM is the only national organization which represents the education, practice, economics and professionalism of nurse-midwives, through certification of nurse mid-wives and accreditation of their educational programs. (Tirpak, Tr. p. 403).
13. It is ACNM's position that the 1991 filing submitted by NCRIC/NCUI to the Insurance Administration, if approved, could have a serious impact on access to midwives services and the ability of Certified Nurse Midwives ("CNM") to practice in the District of Columbia. (Dutcher, Tr., pp 286-287, 294-295; Tirpak, Tr. pp. 435-436; Bails, Tr., pp. 319-322; Doyne, Tr., pp. 299-300).

## II. BACKGROUND

14. On December 14, 1990, NCRIC/NCUI filed with the District of Columbia Insurance Administration its 1991 rate filing. This filing was supplemented on December 21, 1990 and again in March 1991. Generally, the filing requested an overall 2.7% decrease in the premium rates for direct physicians malpractice coverage. Milliman and Robertson, NCRIC's actuarial consultant

at the time, submitted an actuarial report with the 1991 rate filing. The 1991 rate filing contained actuarial data supporting premiums for direct coverage of physicians by specialty. (1991, R.F.)

15. The 1991 rate filing particularly contained a page headed "Physicians Vicarious Liability Premiums for Allied Health Professionals" which listed rates for vicarious liability premiums with respect to several categories of non-physician health professionals, including certified nurse-midwives. The rate filing specifically requested a premium surcharge in malpractice coverage for physicians who collaborate with CNMs. The premium surcharge is equivalent to 25% of the OB/GYN rate in direct coverage per CNM.
16. In the case of the Interveners, Drs. Safran & Horwitz, the premium surcharge amounted to a 4,400% increase of the prior \$305 premium charge per CNM for vicarious liability coverage in the prior year. The new filing also narrowed the extent of insurance risk by imposing specific limitations and conditions to the extent of vicarious liability coverage. The limitations and conditions require (a) that the CNM be insured with minimum coverage of \$1,000,000/\$3,000,000 (b) that liability exposure is limited to only births or deliveries which take place at facilities accredited by either the Joint Commission on Accreditation of Health Care Organizations ("JCAHCO") or the American Association for Ambulatory Health Care ("AAAHC"), and (c) that liability exposure is limited only to deliveries where the physician is actually present at the facility during the active phase of labor. Home births or births taking place at childbirth centers which are accredited by organizations other than JCAHCO or AAAHC or not specifically mentioned in the NCRIC policy endorsements, are excluded from coverage.
17. On January 31, 1991, the Interveners submitted to the Insurance Administration a statement titled "Joint Comments of Drs. Safran and Horwitz, Chartered, and of the D.C. Chapter of the American College of Nurse-Midwives Opposing Approval of the Rate Filing of The National Capital Reciprocal Insurance Company". The document requested the Insurance Administration to disapprove the portions of the rate filing pertaining to the premium surcharge for the vicarious liability of physicians collaborating with nurse-midwives. The Interveners base their arguments on the grounds that the proposed premium surcharge filing was not made in accordance with D.C. Code, Section 35-1703, 1981 Edition, (as amended), and that the rate, as filed, was excessive, inadequate and unfairly discriminatory.

18. Additionally, the Insurance Administration received over one hundred letters and individual petitions from patients and citizens from the community expressing concerns for the impact this filing may or would have on the availability of midwifery services in the District.
19. On March 29, 1991, former Superintendent of Insurance, Margurite C. Stokes provided written notice to NCRIC/NCUI, that an investigation had been conducted and that it was the intent of the Insurance Administration to order an adjustment to the filed rates, rules and policy forms, effective January 1, 1991.

The specific inadequacies in the program filing were set forth in this document and the further statement that the proposed rates had not been shown to comply with Section 35-1703, of the D.C. Code, 1981 Edition, (as amended). This document also advised NCRIC/NCUI of their right to request a hearing prior to a final adjustment to the filed rates. NCRIC/NCUI requested a hearing in accordance with Superintendent Margurite Stokes's March 29, 1991 letter. Acting Superintendent Patrick E. Kelly then scheduled a pre-hearing conference on May 24, 1991.

20. On May 21, 1991, Drs. Safran & Horwitz, chartered, represented by Susan M. Jenkins, Esquire, and the D.C. Chapter of the American College of Nurse-Midwives, represented by Walt Auvil, Esquire, filed petitions for leave to formally intervene regarding the filed rate for a premium surcharge pertaining to the vicarious liability of physicians who collaborate with CNMS. On May 23, 1991, the petitions for leave to intervene were approved.
21. On May 24, 1991, a pre-hearing conference was held by Patrick E. Kelly, then Acting Superintendent of Insurance. The focus of the hearing was the alleged inadequacies in the filing related to the vicarious liability premium surcharge and the limitations and conditions establishing coverage exclusions related to supervision of nurse-midwives. The other aspects of the NCRIC/NCUI 1991 program filing were not disputed.
22. At the pre-hearing conference, then Acting Superintendent Patrick E. Kelly, established a schedule for resolving the inadequacy issues related to the filing. Pursuant to that schedule, NCRIC/NCUI, Safran & Horwitz, and ACNM, submitted comments and materials to the Insurance Administration on May 29, 1991, concerning the adequacy of the vicarious liability premium surcharge, limitations and conditions establishing coverage exclusions and other matters raised in former Superintendent Margurite Stokes's March 29, 1991 letter.

23. Pursuant to the materials submitted by the parties on March 29, 1991, the Insurance Administration staff recommended to then Acting Superintendent Patrick E. Kelly four adjustments to the proposed filing, each applicable to the nurse-midwives vicarious liability premium surcharge and the coverage exclusion issues.
24. On June 10, 1991, all parties (NCRIC/NCUI, Safran & Horwitz and ACNM), submitted written comments and legal arguments concerning the vicarious liability premium surcharge, limitations and conditions establishing exclusions and the four adjustment recommendations identified by the Insurance Administration staff.
25. Pursuant to the schedule established at the May 24, 1991, pre-hearing conference, then Acting Superintendent Patrick E. Kelly conducted a second pre-hearing conference on June 24, 1991. At this second pre-hearing conference, the parties could not reach an agreement on the inadequacies numbered 3, 10 and 11, of the March 29, 1991, letter from Margurite C. Stokes, and identified these three issues as the basis for the rate hearing. The three issues are:
  - (3) In relation to exhibit B of your December 21, 1990, letter, no applicable statements of policy by the American College of Obstetricians and Gynecologists have been provided. Also, no statistical justification, including the premium charges of other specific insurers, as to the amount of the premium charge for the supervision of nurse midwives indicating that the proposed surcharge is not excessive, inadequate, or unfairly discriminatory;
  - (10) No statistical support for the proposed changes to the premiums and reporting endorsement rates for physicians vicarious liability for allied health professionals, and for the direct coverage provided to allied health professionals, has been shown;
  - (11) No chart comparing the proposed premiums for NCRIC to other doctor-owned companies for direct coverage to allied health professionals has been provided.
26. On September 6 and 13, 1991, a rate hearing was conducted concerning the 1991 NCRIC/NCUI program filing. The hearing was conducted pursuant to Section 35-1704 of the D.C. Code, 1981 Edition, (as amended), which specifies the Superintendent of Insurance statutory obligation to review rate filings and to determine that rates are not excessive, inadequate or unfairly discriminatory, and in compliance with, Section 35-1703, of the D.C. Code, 1981 Edition, (as amended).

27. On October 10, 1991, all parties submitted legal briefs of the agreed issues, which included each party's closing statement, proposed findings of fact and proposed conclusions of law. On October 21, 1991, all parties submitted rebuttal briefs to the parties closing statements, proposed findings of fact and proposed conclusions of law.

III. **BACKGROUND INFORMATION ABOUT CERTIFIED NURSE MID-WIVES AND THEIR COLLABORATIVE RELATIONSHIP WITH OBSTETRICIANS AND GYNECOLOGISTS**

28. A certified nurse mid-wife is an individual educated in the two disciplines of nursing and mid-wifery and who is certified to practice mid-wifery based on the requirements established by the American College of Nurse Mid-wives. Nurse mid-wifery practice is the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally, and/or gynecologically, occurring within a health care system which provides for medical consultation, collaborative management, or referral and is in accordance with the applicable state statutes. (Tripak, Tr. p. 405).
29. Membership in the profession of Certified Nurse Mid-Wifery requires completion of a specialized graduate training program, successful completion of the ACNM examination and certification requirements, and then, licensure or certification in accordance with the pertinent state laws of each jurisdiction.
30. In the District of Columbia, a certified nurse mid-wife must be licensed as a nurse and certified as an Advanced Registered Nurse by the District of Columbia Board of Nursing. In order to practice nurse mid-wifery in the District of Columbia, CNMs must comply with the written professional standards of ACNM. To ensure continuing certification, CNMs are expected to also comply with ACNM standards concerning peer reviews on a regular basis. (D.C. Code, Sections 2-3301 to 3306, 1981 Edition, (as amended)).
31. CNMs are required by ACNM and by the District of Columbia licensure statute to enter into collaboration agreements with physicians in order to practice mid-wifery. Although the protocols and provisions of individual collaboration arrangements vary, the majority of arrangements followed in the District of Columbia do not establish or require direct physician supervision of the CNM care of the patient or physician attendance during labor and delivery. The collaborative arrangements required by District of Columbia law establishes referral and consultation patterns. Under District of Columbia law, CNMs are only required to have general collaboration, as opposed to the direct collaboration required of nurse anesthetists. (D.C. Code, Idem)

- 32 Pursuant to ACNM professional practice standards and District of Columbia law, the CNM is required to involve a physician in a patient's care when he/she judges that a patient should be referred to a physician for a consultation, and possibly treatment, or when the CNM engages in collegial consultations. (D.C. Code, Idem)
33. The nature of certified nurse mid-wifery practice in accordance with District of Columbia law and the ACNM standards involves the independent management of health care and responsibility by the CNM for prenatal, labor and delivery, and postpartum care of essentially healthy, low-risk women. (D.C. Code, Idem)  
There are two key aspects to CNM practice: (1) CNM responsibility for the screening of patients, and consultation and/or referral out to the collaborating physician of patients who have health problems or are otherwise "high risk"; and, (2) the consultation between physicians and CNM's must occur according to collaborative relationships developed pursuant to District of Columbia law to suit the needs of the particular professionals and practice situations involved.
34. There are a variety of CNM practices in the District of Columbia. CNM practices can and do occur in the settings of owned and managed private offices and in hospitals, or CNMs working for a community service organization.
35. Patients choosing CNM provided care generally fall into two groups. The one group can be described as educated women who, based on their knowledge and preference, prefer and choose CNM care over physician care. The second group are those who lack medical insurance, have language or cultural barriers, or for a variety of other reasons find CNM provided care to be a reasonable access to high quality prenatal care. (Affidavits of Marion McCartney and Kate Schwob, DCC/ACNM Pre-Hearing Submission, Attachment No. 5).
36. CNM care is a distinctive segment of the spectrum of health care services available to women. Such services are reimbursed by Medicare, Medicaid, Campus, and broad array of private health insurance packages. (DCC/ACNM Pre-Hearing Submission, Attachment No. 6).
37. There has been clear and consistent growth of CNM practice in the District of Columbia over the past several years as the practice of nurse mid-wifery has come to be gradually understood and respected by health care consumers and physicians. This growth is also attributable to the impressive record of CNM statistical success. (Curtis, Tr. pp. 308-309).

38. CNM practice is an important and effective tool for delivering good prenatal and obstetrical services. A senior study consultant at the Institute of Medicine, and an authority in the field of maternal and infant care, testified emphatically to the need to encourage and not to discourage CNM practice in the District of Columbia to help combat the high infant mortality rate. (Brown, generally, tr. pp. 154-160).

#### IV. NCRIC/NCUI RATE FILING AND RATE MAKING PROCESS

39. When NCRIC/NCUI seeks to adjust its rates upward or downward, its outstanding practice has been to submit an actuarial report along with its proposed rates. An actuarial report prepared by Milliman and Robertson was filed with the 1991 rate filing. Although the report contained actuarial data statistically justifying or supporting premiums rates for direct coverage of physicians by specialty, there was no actuarial report with regard to the proposed premium surcharge rates for vicarious liability for physicians who collaborate with CNMs. (Little, Tr., pp. 235-236; Bickerstaff, Tr., pp. 127-128, 235-236; 1991 R.F.)
40. Dr. Charles Epps testified as a founder of NCRIC and Chairman of the NCUI Board of Director, and as a participant in the decision making process concerning the vicarious liability premium surcharge rate. Dr. Epps opined in his testimony that all rates prepared by NCRIC/NCUI were the result of a detailed analysis of the actuaries, supported by some basis. He further stated that this analysis is reported to the Board. However, the record otherwise establishes that there was no detailed analysis by actuaries supporting the vicarious liability premium surcharge rate. NCRIC/NCUI claims that it does not have any relevant data nor was there ever an actuarial report to the NCUI or NCRIC Boards on vicarious liability rates for CNMs. (Epps, Tr., pp. 56-63).
41. Historically, NCRIC/NCUI has never filed a rate in one year and then filed a rate the next year for the same coverage which was 4,400% higher. (Little Tr., p. 180).
42. Mr. David R. Bickerstaff, a Consulting Actuary for NCRIC/NCUI, testified that making a rate filing involves a two-step process. The first step is to establish for a state or jurisdiction an overall average rate level using the exclusive loss and claim experience for that state or jurisdiction. The second step in the process is to allocate the average rate among the various rating categories. In this process, primary physicians are classified into eight rating categories. The

rates for these classes are allocated based not only on the District of Columbia data but on a country wide data compiled and updated occasionally recognizing the experience of other physician owned insurance companies. The data base takes the relative low cost of various physician specialties all over the country and computes the relationships applied in the various states. (Bickerstaff, Tr., pp. 90-91; (122-124).

43. NCRIC/NCUI rates for ancillary health professionals, including the rates for direct and vicarious liability of CNM, were not made in accordance with the two step process cited by Mr. Bickerstaff, nor on any actuarial data basis. The vicarious liability premium surcharge rates were established by NCUI solely on the basis of underwriting judgment.
44. Both Mr. Bickerstaff and Mr. Little testified that underwriting judgment was the only basis for establishing the premium surcharge rate due to the absence of "hard" or "credible" data. However, the record further indicates that NCRIC/NCUI did not make a reasonable effort to obtain other data to support or elaborate or develop its judgment. For example, NCRIC/NCUI made no effort to contact the American College of Obstetricians and Gynecologists ("ACOG"), the ACNM, local hospitals with active nurse mid-wifery practice, non-physicians owned insurance companies insuring OB/GYNs, insurance companies providing direct coverage for CNMs, or the Physician Insurance Association of American ("PIAA"), the national trade association of such companies, regarding the vicarious liability exposure to physicians collaborating with nurse mid-wives. (Bickerstaff pp. 90-93, 99-100, 118-119, Little pp. 205-213).
45. NCRIC/NCUI only effort to collect supporting data was an informal survey of some physician owned companies and the advice of Mr. Bickerstaff whose knowledge is based on his experience as actuarial consultant for other physician owned insurance companies.
46. Mr. Little testified that NCRIC conducted an informal telephone survey among other physicians owned companies. Reliance on this survey appears to be highly questionable because of the wide variance in the results and the manner in which the survey was taken and the data recorded. Of 33 companies reportedly contacted, only 4 companies actually imposed a 25% surcharge similar to the one proposed by NCRIC/NCUI. However, it appears that the nature of the risk and the limitations for this coverage is different among the four companies. One of the companies reported the surcharge as including direct coverage for the CNM with the same limit as

the physician. Another company responded as being in the process of reviewing their policy. Of the other 29 companies surveyed, three companies reported imposing a surcharge of 10% or less. Seven companies reported no surcharge, and the remaining nineteen companies either did not offered vicarious liability coverage or did not insured OB/GYNs.

47. The results of the informal survey are also questionable due the manner in which the data was gathered. There was no record as to how the information was gathered, who the person was providing the information or their official capacity, or the specific coverage these companies were offering. There is no information in the record to establish whether these companies were asked how and when they established their rates or the information or data was being used to develop or justify the rates. There was also no information in the record to establish whether the companies responding as imposing a premium surcharge rate were actually insuring any OB/GYNs collaborating with CNMs and for how long, and whether there had been any claims made under this category. Finally, of the insurers who imposed premium surcharge for this particular category, the survey did not specify the extent of the coverage and whether there were any restrictions, limitations, conditions or exclusions similar to those imposed by NCRIC/NCUI which would impact the extent of the risk in relation to the amount of the premium charged.
48. Mr. Bickerstaff testified on direct that he was consulted and participated in the premium surcharge rate making decision. He stated that the basis for his advice or judgment was derived from whatever data is available from the seven or eight doctor owned companies for which he consults. However, there was no evidence introduced in the record to established that these companies had any data regarding nurse-midwives or vicarious liability of OB/GYNs collaborating with nurse mid-wives. Furthermore, on cross examination Mr. Bickerstaff stated he had no knowledge of the proposed or actual vicarious liability surcharges of several of his doctor owned clients. Mr. Bickerstaff was also not aware that one of his clients, Louisiana Physician's Reciprocal, had proposed a premium surcharge on surgeons who work with nurse anesthetics which was later withdrawn. He was similarly unaware of the status of premium surcharges by two other clients, a Texas insurer, TMLT, and the Illinois company, ISMIE.
49. Mr. Bickerstaff's other doctor owned clients appear to have acted inconsistently from each other and from NCRIC/NCUI. Based on the record, there appears to be no consensus or consistent judgment among Mr. Bickerstaff's clients.

According to a chart prepared by NCRIC/NCUI based on information contained in the informal telephone physician-insurer survey, the Minnesota reciprocal insurer does not imposed a vicarious liability premium surcharge on physicians who work with nurse-midwives. Rather, it adds a CNM employee as an additional insured to the physician's policy with shared limits for a premium equal to 25% of the OB/GYN premium. Also, neither the New Jersey nor the Louisiana companies charge any additional premium for vicarious liability coverage of OB/GYNs who work with CNMs. One of the two Texas companies excludes both OB/GYNs and CNMs from coverage, while the other does not cover CNMs on OB/GYNs policies. (S & H Exhibit X; 1991 NCRIC survey results).

V. BASIS FOR NCRIC/NCUI UNDERWRITING JUDGMENT

50. According to Mr. Bickerstaff's testimony, the premium surcharge rate in question was the product of the combined judgment of NCRIC/NCUI Board members, his input, and that of the Underwriting Committees. In the final analysis, the surcharge rate was based upon the judgment of the physicians, who are members of these Boards and the Underwriting Committees. (Bickerstaff, Tr., pp. 103-107).
51. According to the record, OB/GYNs on the Underwriting Committees and on the NCRIC and NCUI Boards do not have experience working with nurse mid-wives. Mr. Little compared their knowledge and experience regarding nurse-midwives to that of Dr. Fraga. (Little, Tr., pp. 183-184, 219-220).
52. Dr. Vivian Fraga, M.D., is an OB/GYN practicing medicine in the District of Columbia. She testified on behalf of NCRIC/NCUI as to the nature of the relationship between nurse mid-wives and physicians. However, Dr. Fraga's knowledge and experience with nurse mid-wifery practices and the protocols and the practices between nurse mid-wives and physicians has been limited. According to her testimony, Dr. Fraga has never established a collaborative relationship with a specific nurse mid-wife and was not familiar with the various protocols and the collaborative relationships between nurse mid-wives and physicians. Her only experience of any type with nurse mid-wives was during her residency at D.C. General Hospital. Dr. Fraga admitted that her residency experience was not a true collaboration. On cross examination, Dr. Fraga conceded that she was not an expert in nurse mid-wifery and that she was not basing her opinions on any statistical analysis. (Fraga, Tr., pp. 75-87).

53. Mr. David Little, President of NCUI, testified that he was the person who actually made the decision to recommend the 25% premium surcharge to the NCRIC and NCUI Boards. Mr. Little testified there was no data or claims loss experience upon which the surcharge or coverage limitations and conditions were premised. He defended the surcharge decisions on the basis of underwriting judgment and, in part, input from the Underwriting Committees. (Little, tr., pp. 226, 182).
54. There are two OB/GYNs on the Underwriting Committees and on NCRIC/NCUI's Boards. Neither has or has had a collaborative relationships with a CNM. (Little, Tr., pp. 183-189).
55. The Underwriting Committees, in conjunction with Mr. Little, recommended the proposed 1991 premium surcharge rate to the NCRIC and NCUI's Boards as a package. (Little tr., p. 182).
56. At the rate hearing, upon advise and instructions of counsel, Mr. Little would not provide testimony on cross examination concerning the opinions or identify the OB/GYNs on the Underwriting Committees or to give any explanation of how the Committees arrived at their underwriting judgment. Mr. Lee T. Ellis, Attorney for NCRIC/NCUI stated that "How we got there it is irrelevant." (Little, tr., pp. 184-188).
57. Mr. Little testified that an important factor in deciding the 25% premium surcharge was the NCRIC/NCUI experience with the vicarious liability premium for physicians supervising certified nurse anesthetic ("CRNA"). However, the record demonstrates substantial differences between CNMs and CRNAs. First, the CNM-OB/GYN relationship is collaborative based on clearly defined protocols identifying the respective areas of control and responsibilities. By contrast, the CRNA-physician relationship is, in fact, supervisory. CRNAs are required by law to practice under the direct supervision of the physician. Second, there is a substantial difference in the nature of the practices. CRNAs have no limitations as to the type of patient they can care for and, by law, they can care for the same patients as the anesthesiologist, regardless of the condition. On the other hand, CNMs are limited by protocols when a patient will no longer be low risk. (Little, Tr., pp. 199-205; Bickerstaff, Tr., p. 170).
58. On cross-examination, Mr. Little testified there is a track record of loss experience with anesthesiologists upon which to base the insurance ratings. However, there is no evidence on the record to demonstrate any losses concerning vicarious liability arising from the practice of nurse mid-wifery.

59. Mr. Little further testified not being sure of the nature of the relationship between physician and CNM required by NCRIC/NCUI in its filing. Mr. Little appeared to believe that NCRIC/NCUI's restrictions were equivalent to direct supervision requiring the physician to be present in the room during the active phase of labor. In fact, the filing only requires the physician be present at the facility. (Little, Tr., pp. 250-258)
60. Both Dr. Epps and Mr. Little testified that another factor considered in the premium surcharge was the absence of tort reform legislation in the District of Columbia. Nonetheless, there was no evidence on the record demonstrating any relationship between a lack of tort reform and the vicarious liability of physicians collaborating with nurse mid-wives. Dr. Epps admitted not being an expert on tort reform. (Epps, Tr., p. 65).
61. Mr. Robert J. Hunter, an actuary, testified as an expert witness on behalf of Interveners. Mr. Hunter was of the opinion that NCRIC's lack of tort reform claim was questionable for several reasons. First, NCRIC's reduction of overall rates for its physician insureds by 2.7% in 1991 demonstrates that, in the aggregate, the lack of tort reform does not have an impact on rates. Mr. Hunter also stated that in his experience he had never encountered the argument that the impact of tort reform could be unique to just one physician classification. Mr. Hunter noted that St. Paul Fire and Marine Insurance Company considered tort reform in Florida to have had zero impact on rates. Finally, Mr. Hunter argued, that it simply does not make sense that an increase of over 4,400% in one classification is needed because of lack of tort reform when rates overall are going down 2.7%. According to Mr. Hunter, the lack of tort reform with respect to jury verdicts could be considered as a factor to justify increasing coverage limits, but would have no impact on basic rate-making.

#### VI. UNDERWRITING JUDGMENT AS A RATE MAKING TOOL

62. The District of Columbia Code allows underwriting judgment as one of the factors to be considered in setting insurance rates. (D.C. Code, Section 35-1703 (b), 1981 Edition, (as amended)). This provision recognizes that sometimes it is necessary for companies to establish new classifications and rates for perceived risk based solely on underwriting judgment. This approach is recognized by the actuarial profession as being appropriate for actuaries to make references without specific demonstration. (Actuarial practice #12; Bickerstaff, Hunter Tr).

63. Mr. Hunter testified that, in his opinion, while some degree of judgment might be acceptable or necessary in developing insurance rates, actuarial science tries to eliminate as much judgment as possible. Moreover, once an actuarial or underwriting judgment is made, the usual and proper course would be to establish a statistical collection process to confirm the judgment with statistical analysis. NCRIC has presented no such evidence on the record to support its underwriting judgment. (Hunter, Tr., pp. 341-342).
64. Mr. Hunter further testified that, once an unsupported new classification judgment is made, as NCRIC/NCUI did in establishing the current \$305.00 per CNM rate, it is proper actuarial practice that that judgment and the rate should remain unchanged until the statistical data has been collected to support a change. Mr. Hunter considers it very unusual for a judgment to be made about a particular risk in one year and then for that judgment to be changed one year later without any new statistical evidence to justify the change. According to Mr. Hunter, prior to 1991, NCRIC/NCUI made the judgment that the vicarious liability risk for this classification justified a premium of \$305.00. In 1991, NCRIC exercised a new judgment that this same risk required a premium which was 4,400% higher. Yet, there was no statistical evidence to justify that change in judgment. Mr. Hunter testified that, in his opinion, either the prior judgment or this year's judgment must be wrong. NCRIC/NCUI has not provided statistical justification for either rate. (Hunter, Tr., pp. 341-343 Little, Tr., p. 179).
65. Mr. Hunter categorized as "shocking" a change of this magnitude (4,400% increase), based solely upon underwriting judgment. Dr. Epps categorized as "dramatic" a 200% increase in medical malpractice rates over a period of 10 years. (Hunter, Tr., pp. 342-343, Epps. Tr., p. 58).
66. The 1991 rate filing, in addition to applying a premium surcharge for the vicarious liability of physicians collaborating with CNMs, also imposed limitations and conditions which narrowed the extent of the risk and the liability exposure by: (a) excluding coverage of births taking place at home or at accredited facilities by organizations other than the ones specifically stated by NCRIC/NCUI in the coverage endorsement; (b) excluding births that take place while the physician is not present at the facility during the active phase of labor; (c) by requiring that the CNMs have direct coverage with minimums of \$1,000,000/\$3,000,000. (Bickerstaff, Tr., pp. 141-144).

67. The 1991 proposed rate filing also contains a page headed "Direct Coverage for Allied Health Professionals", which proposed rates for direct coverage of various categories of non-physician health professionals including certified nurse mid-wives. These rates were also based on underwriting judgment. The proposed rate for the CNM direct coverage is about four times lower than the proposed rate for the physician for his vicarious liability coverage arising out of his relationship with the CNM.
68. According to Mr. Hunter, the discrepancy between rates which NCRIC/NCUI proposed to charge for direct coverage of nurse mid-wives and for vicarious liability of the physician for nurse mid-wives' alleged negligence is inconsistent. There is no evidence that the risk is as much as four times greater for the person with vicarious liability than the person actually performing the procedure. The insurer has a fairly heavy burden to justify such an assignment of the relative risks. (Hunter, Tr., pp. 391-392).
69. The 25% premium surcharge for the vicarious liability for physicians is an actual claims made policy, which means that the policy will only cover actual claims that are filed during the coverage periods. The proposed rate for CNM's direct coverage is an occurrence basis policy, which means that the policy will cover any claim in which the triggering event occurred during the policy period. Usually, occurrence basis policies are more expensive during the first few years of the policy than actual claims made policies because the insurance company exposure continues beyond the actual policy period.
70. NCRIC/NCUI charges physician a 25% percent surcharge for vicarious liability of physician employees not insured by NCRIC/NCUI for direct coverage. The vicarious liability premium of the physician employer is approximately 75% less than the physician employee direct coverage premium.

#### VII. VICARIOUS LIABILITY ISSUE

71. Mr. Little testifies that the entire 25% premium surcharge was actually allocated towards vicarious liability. (Little, Tr. p. 235).
72. For purpose of vicarious liability it is Mr. Little conclusion that it doesn't make a difference whether the CNM is an employee of the collaborating physician or an independent contractor collaborating with a physician in accordance with their protocol. This factor was not considered by NCRIC/NCUI when formulating the vicarious liability rate. (Little, tr., pp. 241-242).

73. Mr. Little's conclusion appears to contradict the opinion of Mr. Bickerstaff, who conceded that the type of relationship between the physician and the CNM might impact whether there is a vicarious liability or the risk of vicarious liability, and the opinion of Dr. Epps, who admitted that an independent contractor relationship between a physician and nurse mid-wife does not carry the same risk of vicarious liability as an employment relationship might. The propose premium surcharge rate does not differentiate between the two relationships. (Bickerstaff, Tr., p. 112; Epps, tr., p. 70).
74. Mr. Little testified that, although the policy requires that the CNM have \$1,000,000/\$3,000,000 direct coverage, the surcharge rate did not take into consideration the possibility that the company may recover through a counter claim or subrogation against the CNM direct coverage. This appears to contradict his other testimony when he stated that it was imperative that the nurse mid-wife have separate coverage so that the company was not automatically the deep pocket, and to afford the company the chance of mitigating their losses (Little, Tr., pp., 245, 266).

#### VIII. ISSUE OF FAIRNESS OF THE RATE

75. Mr. Bickerstaff stated that the data regarding an OB/GYN's vicarious liability for collaboration with a CNM is commingle with all other claims against OB/GYNs all of which are reflected or charged to the five-digit statistical code which represents OB/GYNs. (Bickerstaff, Tr., pp. 116-117).
76. The 1991 rate filing contains actuarial data which support premiums for direct coverage of physicians by specialty. The data are derived from three sources: D.C. claims experience, the Milliman and Robertson data base (i.e., the seven or eight Bickerstaff clients), and the Insurance Service Office (ISO). NCRIC/NCUI relies on all these data sources in setting rates for direct coverage of all physicians, grouped by specialty into classifications. One of these classifications is that for OB/GYNs; the OB/GYN classification is number 80153. (1991 R.F.; Hunter, Tr., pp. 344-345; Bickerstaff, Tr., pp. 122-124).
77. With respect to classification 80153, there are data from ISO, from Milliman and Robertson, and from D.C. regarding exposure of that particular class. Based on these data, NCRIC/NCUI has arrived at a weighted differential for this class, of 4.55. (1991 R.F.; Hunter, Tr., pp. 345-346)

78. NCRIC/NCUI claims the reason that no data exist regarding vicarious liability of OB/GYNs for the negligence of nurse-midwives is because data are collected and maintained in relation to each specialty class without distinguishing whether a claim is for direct or vicarious liability. Thus, according to NCRIC/NCUI and its actuary, all claims against OB/GYNs whether based on the physician's own negligence or vicarious liability are grouped together simply as claims against the OB/GYN class. (Little, Direct; Bickerstaff, Direct; Epps, Direct; Little, Tr., 236, 265; Bickerstaff, Tr., pp. 116 - 118; Hunter, Tr., pp. 378-379).
79. The ISO, Milliman and Robertson, and D.C. data upon which NCRIC/NCUI relied to derive a weighted differential of 4.55 for OB/GYNs are the sort of data which reflect only claims against OB/GYNs by class and do not distinguish whether a claim is direct or for vicarious liability. (Hunter, Tr., pp. 345-346).
80. NCRIC/NCUI's premium for direct coverage of OB/GYNs is based upon the 4.55 weighted differential contained in the 1991 rate filing, which in turn is based upon the ISO, Milliman and Robertson, and D.C. data regarding all claims against OB/GYNs. (Hunter, Tr., pp. 344-346).
81. The premium charged by NCRIC/NCUI for direct coverage of OB/GYNs is therefore based upon data which already includes vicarious liability claims, if any, against OB/GYNs for alleged negligence of CNMs. Thus, the OB/GYN premium for direct coverage already reflects the risk or exposure which might result from employment of or collaboration with nurse mid-wives. (Hunter, Tr., pp. 344-346).
82. In the expert opinion of Mr. Hunter for NCRIC/NCUI to charge an additional premium of any amount for vicarious liability to physicians who collaborate with nurse mid-wives would constitute double dipping. This is because vicarious liability claims which are not presently be differentiated from all other claims against OB/GYNs are already accounted for within the primary classification, based upon all claims against OB/GYNs. The vicarious liability surcharge appears redundant in that it charges for the vicarious liability which is already included and charged for within the primary classification. (Hunter, Tr., pp. 345-346).

#### IX. DISCRIMINATORY ASPECTS OF THE PROPOSED RATE

83. NCRIC does not base the premiums it charges to OB/GYNs for direct coverage upon the volume of deliveries of the OB/GYN's practice. (Bickerstaff, Tr., p. 133).

84. Part of NCRIC/NCUI's collective judgment in assessing the proposed premium surcharge for vicarious liability was its assumption that an OB/GYN volume of deliveries would increase if the OB/GYN collaborated with a CNM. According to Mr. Bickerstaff, this assumption was the "inherent risk" factor which underlies this rate increase. (Bickerstaff, Tr., pp. 107, 119-120, 133-138).
85. Mr. Bickerstaff testified that he assumed that OB/GYNs who work with nurse midwives would probably have a greater volume of deliveries than those who do not. He further claimed, this would justify the premium surcharge. He termed this an "inherent risk" factor and stated that this formed a basis for NCRIC/NCUI's judgment to impose this surcharge. Mr. Bickerstaff admitted that neither he nor NCRIC/NCUI has any data to support this assumption and did not test it empirically. He also admitted that NCRIC/NCUI does not base its rates for OB/GYN direct coverage upon the physician's volume of deliveries, but has only now begun to consider it a factor regarding the premium surcharge, but not for the direct coverage rate. (Bickerstaff, Tr., pp. 133-138).
86. Mr. Hunter testified it would be inappropriate for NCRIC/NCUI to make the assumption that OB/GYNs who work with nurse mid-wives have a greater volume of deliveries. Without testing this assumption, it would be unfairly discriminatory to base a secondary classification, like the nurse mid-wives surcharge, on this assumption when it is not a factor in determining the rate for the primary classification (direct coverage for the OB/GYN). Such assumptions are testable, but NCRIC/NCUI did not do so. (Hunter, Tr., pp. 353-355).
87. Mr. Bickerstaff conceded that it is possible that an OB/GYN who collaborates with a CNM could have fewer, not more deliveries than an OB/GYN who does not. He has no data one way or the other. (Bickerstaff, Tr. pp. 133-135).
88. It was not the intention of Drs. Safran and Hortwitz, Chartered, to increase the number of deliveries they do by employing nurse mid-wives, and the number has not increased appreciably. The practice, which consists of five physicians and three nurse-midwives, delivers approximately 600 babies per year. (Safran, Tr, p. 279).
89. Another discriminatory aspect of the rate file is the fact that the vicarious liability premium does not categorize or differentiate between the different types of CNMs physician relationships. There are a variety of CNM practices in the

District of Columbia. Practices occur in the setting of CNM owned and managed private offices, as employees of a hospital, employees of a particular physician practice or as independent contractor of a community service organization. The nature of the physician/nurse relationship should logically have an impact in the determination as to whether vicarious liability exist and the judgment applied in assessing the exposure of the risk.

Based on the forgoing finding of facts I make the following conclusions of law.

### CONCLUSION OF LAW

#### I. STATUTORY FRAMEWORK

The statutory authority governing the NCRIC/NCUI application and the regulatory review of the proposed premium surcharge rate for OB/GYN medical malpractice insurance coverage are Sections 35-1703 and 1704 of the D.C. Code, 1981 Edition, (as amended). The pertinent provisions of these Sections are as follows:

#### Section 35-1703:

- (a) "Rates for insurance within the scope of this chapter shall not be excessive, inadequate, or unfairly discriminatory.
- (b) Due consideration shall be given to past and prospective loss experience within and outside the District, to physical hazards, to safety and loss prevention factors, to underwriting practice and judgment, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies; to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members, or subscribers; to past and prospective expenses both country-wide and those specially applicable to the District; to whether classification rates exist generally for the risks under consideration; to the rarity or peculiar characteristics of the risks; and to all other relevant factors within and outside the District. Due consideration shall be given to the net investment income (including the realized capital gains) on all cash and invested assets held against all unearned premium reserves and loss reserves of any nature."

Section 35-1704:

- (b) "Whenever it shall be made to appear to the Superintendent, either from his own information or from complaint of any party alleging to be aggrieved thereby, that there are reasonable grounds to believe that the rates on any or on all risks or classes of risks or kinds of insurance within the scope of this chapter are not in accordance with the terms of this chapter, it shall be his duty, and he shall have the full power and authority, to investigate the necessity for an adjustment of any or all such rates.
- (c) After such an investigation of any such rates, the Superintendent shall, before ordering any appropriate adjustment thereof, hold a hearing upon not less than 10 days written notice specifying the matters to be considered at such hearing, to every company and rating organization which filed such rates, provided the Superintendent need not hold such hearing in the event he is advised by every such company and rating organization that they do not desire such hearing. If after such hearing the Superintendent determines that any or all of such rates are excessive or inadequate, he shall order appropriate adjustment thereof. Pending such investigation and order of the Superintendent rates shall be deemed to have been made in accordance with the terms of this chapter . . ."
- (d) "In determining the necessity for an adjustment of rates, the Superintendent shall be bound by all of the provisions of Section 35-1703.
- (e) The Superintendent is further empowered to investigate and to order removed at such time and in such manner as he shall specify any unfair discrimination existing between individual risks or classes of risks."

Section 35-1703 establishes the guidelines and other factors that insurers are required to follow in formulating insurance rates. Section 35-1704 establishes the duty and authority of the Superintendent of Insurance to review rate filings, investigate such rates and to propose appropriate adjustments thereof.

II. THE NCRIC/NCUI PROPOSED RATE FILING, AS IT PERTAINS TO VICARIOUS LIABILITY PREMIUM SURCHARGE FOR PHYSICIANS COLLABORATING WITH NURSE-MIDWIVES, CAN NOT BE APPROVED BECAUSE THE COMPANY FAILED TO DEMONSTRATE THAT THE PROPOSED RATES WERE MADE WITH DUE CONSIDERATION OF THE GUIDELINES AND OTHER FACTORS SET FORTH IN SECTION 35-1703 OF THE D.C. CODE.

The insurer must bear the burden of demonstrating both the need and reasoning behind a rate increase. *Geico vs. Montgomery*, 465 A. 2d

813 (D.C. 1983). In order to do this, the insurer must demonstrate that the formulation of the rate increase was made with due consideration of guidelines and other factors established by Section 35-1703. Section 35-1703 imposes a statutory obligation upon the insurer to formulate rates which shall not be excessive, inadequate, or unfairly discriminatory and to give due consideration to all factors, where appropriate, outlined in the statute. This Section, at the very least, imposes upon the insurer the burden to demonstrate that due consideration was given to the guidelines and other factors outlined by Section 35-1703, and that the insurer makes a reasonable effort to give due consideration to these statutory standards.

A review of the record in these proceedings does not establish that NCRIC/NCUI gave due consideration to the guidelines and other factors outlined by Section 35-1703 in establishing a basis for the proposed rate filing for the vicarious liability rate increase, or that a demonstrable effort was made to either use or give consideration other data to support the proposed rate filing.

According to NCRIC/NCUI, the only factor considered in formulating the vicarious liability rate increase was underwriting judgment. It is the company's position that no other factors could be considered due to the lack of other credible or reliable information.

However, a review of the record indicates that NCRIC/NCUI did not make a demonstrable effort to obtain any other data or information to support its claim that underwriting judgment alone should be the sole basis for the proposed rate filing. The company appears to have simply assumed as unreliable any other possible data or information available without making an effort to obtain and review such data. Assuming, per arguendo, that NCRIC/NCUI was correct regarding the reliability of any other data or information, at the very least, this resource would have been useful to the company in formulating a better judgment, when judgment alone is the only factor considered, or provided relevant support for its rate making conclusion.

By setting forth several factors and guidelines, Section 35-1703 recognizes underwriting judgment as one of the factors to be considered in formulating insurance rates. However, underwriting judgment is only one of several factors the insurer must consider in supporting a rate filing. The insurer's statutory burden of proof requires a demonstration that these factors were evaluated and considered in formulating a proposed rate, or at the very least that, a reasonable effort was made to consider all the factors outlined in the statute and not just one. The record in this hearing does not establish that NCRIC/NCUI adequately met its burden of proof.

III. NCRIC/NCUI'S UNDERWRITING JUDGMENT WAS NOT ADEQUATELY SUPPORTED BY RELEVANT EXPERIENCE OR SUFFICIENTLY RELIABLE ASSUMPTIONS TO ESTABLISH A CREDIBLE BASIS FOR THE PROPOSED PREMIUM SURCHARGE.

The Insurance Administration recognizes that when formulating rates for new risk categories there may be situations, when underwriting judgment may be the major factor in formulating a rate. In those situations an insurer must, at the very least, demonstrate that a good faith effort was made to obtain relevant data and information to minimize the reliability on judgment solely. On the other hand, the Insurance Administration has a duty to carefully scrutinize the basis of such judgment in order to assure that the proposed rate is reasonably based on reliable assumptions and the relevant data, knowledge and experience that support the need and reasoning for the proposed rate. This duty is particularly relevant when parties alleging to be aggrieved by the proposed rate present evidence that an insurer's rate has not been established in accordance with statutory standards.

According to NCRIC/NCUI, the only sources of information and experience relied upon by the company to formulate the proposed rate increase were; an informal survey of 33 physicians owned companies; the advice of their actuary consultant, Mr. David A. Bickerstaff; and the knowledge and experience of the physicians serving on the Boards and Underwriting Committees of NCRIC and NCUI.

The Informal Survey - Mr. Little testified, that the company conducted an informal telephone survey which reportedly contacted 33 physician owned companies to inquire about their practices regarding physicians collaborating with CNMs. Reliance on this survey appears to be highly questionable, because of the wide variance in the results and the manner in which the survey was taken and the data recorded. The record is unclear whether this survey was conducted prior to NCRIC/NCUI filing the proposed rate or after the Insurance Administration requested the company to provide additional information regarding the practices of other physicians owned companies.

Of 33 companies reportedly contacted, only 4 companies actually levied a 25% premium surcharge and among these four companies the survey appears to indicate that there are substantial differences in the nature and extent of the risk covered by the surcharge. In one of these companies the premium surcharge included not only the vicarious liability of the physician, but also direct coverage for the CNM with the same liability limit as the physician.

Another company reported being in the process of reviewing their surcharge policy. Of the other 29 companies, three companies surveyed reported a surcharge of 10% or less. Seven companies

reported no surcharge at all and the remaining nineteen companies either did not extend vicarious liability coverage or did not insured OB/GYN's.

The recordkeeping and basis for the "informal telephone" survey raises reasonable doubts about its reliability and completeness. No record was kept as to how the information was gathered, the name of the contact person providing the information, or their official capacity, or the specific coverage offered by companies which allegedly imposed a premium surcharge. There was no information in the record to establish whether these companies were surveyed as to when and how they established their rates or the existence of any information or data to support their premium surcharge rates. There was no evidence showing whether the companies imposing a premium surcharge were actually insuring any OB/GYN's collaborating with CNM's, or for how long, and whether any vicarious liability claims has been made. Finally, of the insurers imposing a premium surcharge for vicarious liability, the survey did not address whether there were any coverage limitations, conditions, restrictions, or exclusions similar to the ones required by the NCRIC/NCUI filing which directly impacted the extent of risk in relation to the amount of the premium surcharge.

THE ADVICE OF MR. BICKERSTAFF - Mr. Bickerstaff is NCRIC/NCUI actuarial consultant and expert witness. He testified that his advice was not actuarially supported because there was no data available to conduct an actuarial analysis. Instead, he stated that his advice was based solely on his knowledge and experience as an actuarial consultant to seven or eight other physicians owned insurance companies. However, in reviewing Mr. Bickerstaff's testimony, regarding the knowledge and experience of his clients, he professed to have no knowledge of either proposed or actual vicarious liability premium surcharges imposed by these clients. Mr. Bickerstaff was also unaware of recent efforts by some of his client companies to impose a premium surcharge or that one filings was later withdrawn. The record further establishes that there is no consistent policy among his clients regarding a premium surcharge for vicarious liability of physicians collaborating with nurse mid-wives. Such evidence could have possibly supported a considered opinion by Mr. Bickerstaff of what should consist of a fair value for this risk category.

THE EXPERIENCE OF PHYSICIANS MEMBERS OF NCRIC/NCUI'S BOARDS OF DIRECTORS AND UNDERWRITING COMMITTEES - A review of the record establishes that the input or advice these physicians could have provided was limited with regard to the risk classification involved herein. Of the OB/GYNs on the Underwriting Committees and on NCRIC/NCUI's Boards none appear to have worked in a direct collaborative relationship with a CNM. There was no evidence to

establish that any of them possessed any experience or specialize knowledge concerning the extent of the risk and the nature of the collaborative relationship with CNMs to be help quantify the risk exposure necessary to justify the premium surcharge rate.

In addition to the aforementioned bases to support the premium surcharge, the record shows that NCRIC/NCUI considered two other factors in proposing the premium surcharge for CNM vicarious liability; the lack of tort reform in the District of Columbia and NCRIC/NCUI own experience with the vicarious liability premium for physicians supervising certified nurse anesthetics (CRNA).

THE LACK OF TORT OF REFORM - The evidence presented by NCRIC/NCUI on the record and at the hearing did not sufficiently establish a relationship between the lack of tort reform and the vicarious liability of a physician collaborating with nurse mid-wives. Moreover, this assertion appears to be inconsistent with its rate filing. NCRIC/NCUI reduced rates overall for its physicians insured by 2.7% while at the same time dramatically the premium rate for the vicarious liability of physicians collaborating with nurse mid-wives. It appears wholly inconsistent to argue that the lack of tort reform has such an impact as to justify a substantially higher rate increase in just one classification, when the overall rates for other medical malpractice classifications are decreased by 2.7%.

NCRIC/NCUI OWN EXPERIENCE WITH THE VICARIOUS LIABILITY PREMIUM FOR PHYSICIANS SUPERVISING CRNA'S - The Insurance Administration accepts the position that in some instances an analogy to the experience of other risk categories is relevant and appropriate in formulating rates for similar risk categories. However, in this case, the CRNA analogy is not appropriate. The record indicates that there are substantial differences in the nature of the nurse-physician supervisory relationship as between CNMs and CRNAs, the type of procedures that each nurse specialist can practice and the type and condition of the patients that they can care for. These differences appear to be substantial in determining the possible vicarious liability exposure of the physician as well as the extent and amount of claims that may arise as a result of this relationship.

Therefore, the CRNA analogy was not considered relevant support for the NCRIC/NCUI position.

In conclusion, the evidence on the record discloses that NCRIC/NCUI did not obtain credible other data or information or apply relevant actuarial experience that may have assisted the company in reasonably exercising underwriting judgment. NCRIC/NCUI relied totally on a highly questionable informal telephone survey and the underwriting judgment, alone, of its actuarial consultant and its underwriting committees and Boards of Directors. Based on the record this Administration cannot approve a rate increase of this

magnitude founded solely on underwriting judgment. Insufficient evidence has been presented relating to any events, information or experience to support the premium surcharge rate.

IV. THE INSURANCE ADMINISTRATION IS UNABLE TO DETERMINE A SPECIFIC RATE BECAUSE OF NCRIC/NCUI'S INCONSISTENCY IN APPLYING UNDERWRITING JUDGMENTS AND THE LACK OF CONSENSUS AMONG THE INDUSTRY CONCERNING A SURCHARGE FOR THIS RISK CATEGORY.

Even if the Insurance Administration were to have found that underwriting judgment were the only factor that could have been considered to determine the proposed increase herein, and assumed further that the judgment was fairly developed, this Administration would be unable to determine what would constitute an adequate rate. Not only was there inconsistency by NCRIC/NCUI in evaluating the possible value of this risk, but also a lack of a consensus among the surveyed insurance companies as to whether this risk category is necessary and what should be an adequate premium amount and limitations and conditions as to coverage.

According to a prior 1990 NCRIC/NCUI filing for nurse mid-wife coverage, the company exercised underwriting judgment on the value of this risk. When the company decided to create this risk classification, it determined that the value of the risk was \$305 per CNM. In the 1991 filing, NCRIC/NCUI exercised underwriting judgment again, even though by their own admission there have been no additional information suggesting the need for a change. Solely on the basis of underwriting judgment did NCRIC/NCUI determine that the value of the risk should be increased by the equivalent of twenty five (25%) percent of the physician primary rate.

Moverover, in the same filing, NCRIC/NCUI proposed a new rate for the CNM's own primary coverage. This rate, according to NCRIC/NCUI, was also based on judgment. This rate is approximately seventy-five (75%) less than the rate for the physician who is the person that may be vicariously liable for the negligence of the CNM. It appears wholly inconsistent to charge the person that may be vicariously liable a substantially higher rate than the person who may actually perform the negligence act, and therefore, be primary liable.

Finally, after reviewing the evidence on the record concerning the custom and practices of other insurers regarding this risk category, we found there was no consistency. Infact, the majority of the companies did not impose a surcharge for this risk. Therefore, NCRIC/NCUI did not establish a demonstrable consensus within the insurance industry regarding the need and justification for this particular risk.

V. THE PREMIUM SURCHARGE IS EXCESSIVE AND CONSTITUTES AN OVERCHARGE BECAUSE THE RISK IT PURPORTS TO INSURE AGAINST HAS ALREADY BEEN ACCOUNTED FOR IN THE PRIMARY CLASSIFICATION UPON WHICH IT IS BASED.

NCRIC/NCUI has steadfastly claimed that the reason it lacked the information necessary to quantify the risk of vicarious liability of OB/GYNs who collaborate with nurse mid-wives is that national statistical and actuarial data does not distinguish between claims based on the physician's own negligence or claims based on the vicarious liability for the negligence of another. All claims are coded and collected on the basis of a five-digit code which denotes "OB/GYN". Accepting these facts as correct, any vicarious liability which might result from collaboration with a nurse mid-wife is already reflected in the data upon which direct coverage rates are based. Since this data is used to determine the weighted differential upon which direct coverage rates are based for physician, then any vicarious liability for which the physician may be at risk is already accounted for in the basic premium he or she is paying for his or her own direct coverage. Applying a premium surcharge against physicians who work with a nurse mid-wife results in a dual payment for the same risk. Mr. Hunter, Intervener's actuarial expert witness, termed this practice "double dipping" and concluded this would result in excessive and discriminatory rates.

VI. THE RATE INCREASE IS UNFAIRLY DISCRIMINATORY TO THE EXTENT IT ASSUMES AS ONE OF ITS FACTORS A HIGHER VOLUME OF PRACTICE.

NCRIC's/NCUI's witnesses, including Mr. Bickerstaff, alluded to what they termed an "inherent risk" incurred by a physician's collaboration with a nurse mid-wife. Upon further questioning, it was developed that this "inherent risk" factor is NCRIC's/NCUI's assumption that such collaboration translates into a higher volume of practice for such physicians, that is, they would be responsible for a greater number of deliveries. NCRIC/NCUI did not present any support for this assumption. However, the record did disclose that NCRIC/NCUI does not base its rates for direct coverage for OB/GYNs on the volume of practice. Thus, it is entirely possible that a particular physician/nurse mid-wife team may together deliver fewer babies than a physician who practices alone, a point which Mr. Bickerstaff conceded.

Since it appeared that this line of reasoning was a factor in formulating NCRIC's underwriting judgment, the premium surcharge rate is unfairly discriminatory.

VII. THE ROLE OF THE INSURANCE ADMINISTRATION THROUGHOUT THESE PROCEEDING WAS TO CONDUCT AN INVESTIGATION OF THE PROPOSED PREMIUM SURCHARGE RATE AND NOT THAT IF A PARTY ADVOCATING A PARTICULAR POSITION.

During the hearing, NCRIC/NCUI asserted that the Insurance Administration failed to comply with its statutory obligation by

failing to present direct evidence intended to demonstrate that the rate increase in question is either excessive, inadequate or unfairly discriminatory. We strongly disagree with this assertion. The Insurance Administration's role throughout these proceedings has been to conduct an investigation and make Findings of Fact and Conclusions of Law based on the record of this hearing. The Insurance Administration's role in this hearing process is not to advocate a particular position.

Under the D.C. Code, the Insurance Administration has a statutory obligation to review rate filings, to conduct an investigation whenever the Superintendent believes or has information to believe that the proposed rates are either excessive, inadequate or unfairly discriminatory, to inform the insurer of the result of our investigation, to offer the insurer the right to a hearing before issuing a decision. Under Geico vs. Montgomery, infra, the Insurance Administration is required to render a decision based on factually supported reasons. Based on the record of this hearing, the Insurance Administration has fully complied with these required statutory duties.

#### DECISION

Based upon the documents contained in the official records and the above Findings of Fact and Conclusions of Law, it is the decision of the Superintendent of Insurance that:

1. The rates, rules and policy forms submitted by NCRIC/NCUI, as it 1991 program filing as it pertains to the vicarious liability premium surcharge for physicians collaborating with nurse mid-wives, are hereby rejected.
2. NCRIC/NCUI should immediately reimburse any party who may have been subjected to this rate increase to the extent that the new rate exceeded the 1990 premium.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of this Administration this 7th day of February, 1992.



Robert M. Willis  
Robert M. Willis  
Superintendent of Insurance