DEVELOPMENT OF AN INFLATION SENSITIVE EXPOSURE BASE FOR HOSPITAL PROFESSIONAL LIABILITY INSURANCE

A review by Brian Scott

I am especially sympathetic to the search for the "Holy Grail" which will prevent the next malpractice crisis. Glenn Evans and Stan Miyao have used a very logical approach to selecting an exposure base which will respond to inflation but seemed to conclude, without analysis, that hospital revenue and inflation bear a direct relationship with hospital malpractice loss costs.

While I agree in general with their conclusions, I'll try to present some problems I see with the base and also comment on some problems I see with the paper.

It is very unlikely that the industry will be able to adopt a uniform exposure base. In fact, for this line, its becoming especially hard to identify the industry. Captives, self-insurance, and large deductibles, once used primarily as an answer to availability, are now used as ways of reducing costs. It is doubtful that any program that increases costs will be adopted at this time, as competition will probably prevent the introduction of a new base until a "crisis" exists. The final premium is going to be the benchmark and not the exposure or the rate level used in

the calculation. Further, adverse selection would be the inevitable result of a non-uniform exposure base.

If I understand Gross Patient Revenue, it represents the "bed rate" X number of days plus charges for miscellaneous expenses i.e., operating room, drugs, therapy etc. It would seem to meet all criteria for an inflation sensitive base. Despite the fact that there are states in which hospital rates are subject to regulatory control, G.P.R. would appear to be an improvement over the present exposure base and will reflect, to a degree, the current inflation.

In arriving at their recommendation, the authors cited the advantages and disadvantages of an inflation base. While I think they stretched their rate level example a little to help emphasize the point on rate increases, it is a valid and practical point that an inflation sensitive base would help camouflage final premium movement.

As for more equitable rating of hospitals, that is subject to debate. The assumption is that higher patient revenues reflect a higher malpractice exposure and that the higher costs are associated with "state of the art" techniques and reflect more risk. It would have added immensely to the paper if actual expe-

rience of such hospitals were compared to the less advanced institutions.

The surgical clinic example is a legitimate concern and obviously, our present exposure base does not properly measure the risk. I do not agree that these clinics will cause us to collect inadequate premiums on regular hospitals. I think the authors could have developed this point further.

The authors suggest that increased diagnostic testing and more frequent second opinions increase malpractice exposure and therefore should generate additional premium. I would expect just the opposite. These additional procedures would seem to be a logical extension of risk management and a way of reducing losses. In fact, this new base might discourage such practices and be self-defeating.

The disadvantages of this exposure base are few. The most obvious one, and one which will probably stop a conversion to a new base, is competition. It will take a significant selling job to convince Hospital Administrators that this base is in their best interest.

The testing portion of the paper, though well done, could have been improved had the authors included an analysis of those hospitals whose premium changed significantly with the new base. The characteristics of the hospitals and the factors that contributed to a 100% increase or a 60% decrease could give us some valuable insights into the exposure base itself.

The main question I have, that the paper left unanswered, is whether this new exposure base is a better predictor of claim costs. Again, a review of the claim history and characteristics of those hospitals whose new premium would be far different than before, along with a correlation of loss costs and exposure changes, would help answer the question.