

Anesthesiology
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Are Insurance Premiums Related to Use of Technology?

To the Editor:—Zeitlin and associates report that a reduction in premium was offered by the Joint Underwriting Association (JUA) in Massachusetts in rate year 1987, and that this beneficence came about through an incentive discount of 20% predicated on the use of monitors.¹ Much credit is due the Massachusetts Society of Anesthesiologists and their able counsel, Mr. Edward Brennan. The meaning and magnitude of this putative coup may be more apparent than real, however.

The discounted premium for 1987 was, indeed, less (by about 16%) than the total premium finally levied for 1986.* The offer of an incentive discount, however, was accompanied (in rate year 1987) by a walloping 140% retroactive increase in the 1986 premium. While the

This issue is also addressed by an editorial. Please see: Orkin FK: Practice standards: The Midas touch or the emperor's new clothes? ANESTHESIOLOGY 70:567-571, 1989.

* Because of retroactive premium levies in Massachusetts, assertions as to costs must be viewed with circumspection. Calculations herein are based on figures obtained from the JUA and the Massachusetts Medical Society for a 1 million/3 million occurrence policy: Premium for rate year 1987 (July 1, 1987, to June 30, 1988) = \$24,268; premium charged in rate year 1986 for 1986 = \$9,577; retroactive premium for 1986 levied in rate year 1987 = \$13,385; total premium for rate year 1986 = \$22,962; calculated premium for 1987 if discounted by 20% = \$19,414.

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In Reply:—Dr. Bruner seems to have two objections to our letter. First, that the discount offered by the Joint Underwriters Association of Massachusetts is just a commercial maneuver, that it is a "bait and switch" trick; and, second, that the outcome of anesthesia care is not necessarily improved by the routine use of oximetry and capnometry.

Our letter was intended to be archival and also to suggest to the readers of ANESTHESIOLOGY that perhaps they, too, could save money and, at the same time, do their patients some good. What has happened in Massachusetts since 1985 is the result of the coincidence of three events: the writing of standards of practice, the appearance of new and apparently valuable monitoring technology, and the desire of both anesthesiologists and executives of the insurance industry to control liability insurance rates.

Dr. Bruner's calculations mislead the reader. He has lumped together the basic coverage premiums, which indeed have been discounted, with retroactive payments. The latter are the unhappy result of the inability of the Insurance Commissioner to set final rates contemporaneously for the years 1983 to 1987. Our basic premiums have, in fact, decreased by 15% for claims made, and 20% for occurrence policies. For the coming year, we have been moved into a lower risk category on the basis of actuarial calculations. The net effect will be

proffered incentive discount may be a genuine expression of faith in the protective power of technology, the timing of the exercise is painfully reminiscent of the automobile salesman who offers a "generous" incentive rebate immediately after kiting the sticker price into the stratosphere.

To the best of my knowledge, no commercial or captive insurance company has—so far—offered a significant absolute reduction in premium based on the use of monitors.

Although early enamored of monitoring and technology, I observe that outcome in medicine has not been favorably affected by electronic monitoring save for dysrhythmia mortality following myocardial infarction (where the phenomenon monitored was directly and uniquely related to the cause of mortality). In the practice of anesthesia, as monitoring has increased, so have liability costs. (Employing the same "self-evident" reasoning practiced today, the risk management gurus of the 1970s trumpeted the need for oxygen analyzers. Analyzers came to be employed almost universally—and liability costs skyrocketed.)

It may be that (1) monitoring by technology, (2) outcome, and (3) liability costs are really independent variables.

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REFERENCE

1. Zeitlin GL, Cass WA, Gessner JS: Insurance incentives and the use of monitoring devices (letter). ANESTHESIOLOGY 69:441, 1988

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to reduce our basic premiums by a further 16.7%.* This result cannot fairly be compared to the activities of an unscrupulous automobile salesman.

Dr. Bruner has also ignored the other main requirement of the "Stipulation Regarding Discounts" that we observe the Standards for Basic Intraoperative Monitoring of the American Society of Anesthesiologists.† These standards emphasize the behavioral at least as much as the technological aspects of taking care of patients in the operating room. It should be noted that the adoption of the ASA Standards followed publication of the Standards for Patient Monitoring during Anesthesia at Harvard Medical School.¹ This was the result of much thought by his own colleagues.²

In our letter, we stated that the effect of the now widespread use of these monitoring devices on outcome of anesthesia care remains to

* Massachusetts Medical Society letter to members; JUA professional liability rates and related issues: Attachment B. 10 June 1988.

† American Society of Anesthesiologists Standards for Basic Intraoperative Monitoring. Anesthesia Patient Safety Foundation Newsletter 2:3, 1987.