

A Regulator Looks at Medical Malpractice Insurance Reform

SINCE ST. PAUL TRAVELERS, one of the largest commercial medical malpractice companies in the United States, decided to exit the marketplace, the debate about medical malpractice reform has been raging in state capitols throughout the country. Physicians, attorneys, insurance companies, consumer groups, and government officials have divergent opinions on what is causing the medical malpractice crisis, with each group having disparate viewpoints and statistics to support its position.

Physicians believe attorneys are encouraging patients to file suits; attorneys believe insurance companies are using actuarial reserving methodology to overcharge physicians for the medical malpractice insurance; and consumer groups believe insurance companies want to limit the awards and settlements to the injured party for medical errors caused by physicians. Although each group has a different point of view, all will agree on one fact: Medical malpractice premiums charged to physicians by insurance companies have increased dramatically since 2001.

The increase in medical malpractice premiums has affected physicians in all jurisdictions. However, the impact is greater in jurisdictions that haven't enacted any tort reform legislation. The District of Columbia and Delaware are the only two jurisdictions that haven't enacted tort reform. As a result, the average cost of medical malpractice insurance in those jurisdictions is higher than what physicians in neighboring states pay for the same amount of coverage. Both Virginia and Maryland have enacted tort reform legislation and have lower average premiums than the District of Columbia.

The higher insurance costs have caused some District physicians to consider relocating their practices outside the District to reduce their insurance premiums. In addition, physicians are looking at other methods to reduce medical malpractice premiums, such as scaling back the number of patients they serve or limiting the services they provide to patients. And in the extreme cases, some physicians have simply stopped practicing medicine altogether. Any sig-



nificant reduction in the number of practicing physicians in the District of Columbia, especially those providing primary care, will have an adverse effect on the District's health care delivery system.

Two Bills

Acknowledging that physicians are paying more for medical malpractice insurance coverage is easy. The more difficult and perplexing issues relate to the cause of the increase in medical malpractice premiums and the mechanism to stabilize or reduce these premiums quickly.

In December 2005, the Council of the District of Columbia held a hearing on two medical malpractice reform bills, the Health Care Reform Act of 2005 and the Medical Malpractice Reform Act of 2005. These bills have different approaches for addressing the high cost of medical malpractice insurance.

The Health Care Reform Act of 2005 focuses on establishing a cap of \$250,000 on non-economic damages for each claimant and establishes a payment schedule that limits contingency fees paid to attorneys. The bill also requires a claimant to provide a certificate of merit from a physician licensed to practice in the District of Columbia, saying that there is a reasonable probability that malpractice occurred.

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The Medical Malpractice Reform Act of 2005 requires individuals to file a 90-day notice of intent to submit before pursuing a suit alleging medical malpractice. The legislation also requires that current premium rates charged by medical malpractice insurance companies be made public, and that insurance companies and self-insurers that offer medical malpractice insurance disclose redacted information on claims, settlements, and judgments related to medical malpractice claims.

While the two legislative proposals may serve a public benefit, neither will have a direct correlation on the premium rates charged for medical malpractice coverage. Consequently, there won't be an immediate reduction in premium rates for physicians upon enactment of either of these two legislative initiatives. The simple reason is that premiums charged to physicians are based primarily on the losses

and expenses incurred by the insurance company.

More recently, in March 2006, the council held another hearing on the Medical Malpractice Insurance Reform Amendment Act of 2005. Although the D.C. Department of Insurance, Securities and Banking (DISB) agrees that it has a legal responsibility to deny medical malpractice insurance rates that are excessive or unreasonable, the agency disagrees with an amendment stating that the commissioner should not approve a rate increase sought by an insurer until he determines that the total capital of the insurer is no longer excessive.

Not a Perfunctory Exercise

There is a small correlation between total adjusted capital, which includes the company's capital and surplus balance of an insurance company, and the premium rate

being charged for insurance coverage in the District of Columbia. That is why DISB does not believe that the risk-based capital balance as determined by the commissioner is the best way to determine whether a company is charging excessive rates leading to overly high profits. The agency currently denies any premium rate requests that are determined to be unreasonably high based on the documentation submitted.

The insurance regulatory agency is responsible for analyzing and approving the premium rates charged by insurance companies, reviewing and examining the financial statements of these companies, and verifying their compliance with other insurance laws and regulations. The cost drivers of any medical malpractice insurance premium rate increases are the actual and anticipated losses incurred, the expenses incurred to operate the company, and the need to earn a profit.

Insurance rates are filed and reviewed by actuaries in the state insurance regulatory agencies for compliance with actuarial standards. Those filings generally include actual losses incurred by the company and the anticipated losses for the future period with an inflation factor.

The process for reviewing and approving rates is not a perfunctory exercise but a comprehensive review of rating documentation in accordance with principles detailed by the American Academy of Actuaries. Although the processes for reviewing and analyzing rate filings are virtually the same among regulatory agencies, states have enacted different methods of approving rate filings.

There are four different methods for approving rate filings: "file and use," "use and file," "competitive," and "prior approval." Each method has its own procedures for approving any rate increase. A jurisdiction's decision to include factors other than actuarially sound principles in the rate analysis process, even when the analysis performed suggests a rate increase is warranted, could have an adverse financial effect on the company. This process may cause other companies to evaluate whether they would continue to write

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business in a market where they're restricted from charging sufficient premiums.

Consumer groups have argued that only paid claims should not be included in the premium rate filing calculations, since they're the actual losses of the company. The proposal to exclude expected future payments on existing claims from the rate filings is based on a lack of understanding of both the nature of malpractice claim payments and actuarial principles and practices.

Medical malpractice insurance policies are sold primarily on a claim-made basis, which requires claims for a contract period to be paid if they're reported to the company during that period only. Because of investigation and litigation, it may take several years after a claim has been filed before any payment may be made. To exclude these payments from the rate-making process would definitely lead to insolvencies in the medical malpractice marketplace, and subsequently increase the medical malpractice premiums in the companies that continue to provide coverage.

Real reductions to the cost of medical malpractice claims can be brought about by enacting reforms that will limit the recovery associated in medical malpractice cases. Jury awards and civil settlements are based on three major components: (1) lost wages

and opportunity; (2) medical costs; and (3) pain and suffering.

The first two components are characterized as economic damages. The third component represents non-economic damages. Insurance companies can reasonably estimate their economic damage costs based on trends and previous payments to insureds.

On the other hand, it's very difficult to estimate the amount of pain or suffering damages that a jury might award. If those variable damages were capped, however, a company could more accurately predict future losses. That would reduce and stabilize the company's future insurance rates.

Also, the establishment of caps on non-economic damages reduces the number of people who meet the financial threshold for an attorney to take the case on a contingency basis.

For example, two individuals who experienced the same medical negligence and suffered the same injury may not get an attorney willing to accept the engagement if a cap is placed on non-economic damages. This was documented in a *Wall Street Journal* article published in 2005, on the effects of the California Medical Injury Compensation Reform Act.

The article found that attorneys were less willing to represent clients who had alleged injuries from medical negligence if these clients didn't have substantial economic damages. Thus, an individual with an income of \$100,000 would receive representation where it was difficult for an individual with an income of \$20,000 to get representation.

Conclusion

One of the primary objectives of insurance regulators is to monitor and maintain the financial solvency of insurance companies. When an insurance insolvency occurs or an insurance company with a significant market share decides for financial reasons to discontinue writing a particular line of business, these events have a detrimental impact on the community.

We all recognize physicians are human and medical errors will occur. Enacting laws that require patient-safety initiatives, and establish alternative dispute-resolution requirements may reduce the cost of settling cases. But those types of initiatives alone will take a long time to translate into lower insurance company costs and reduced rates. Rather, any medical malpractice reform, to be effective, must have restrictions on non-economic damages, such as pain and suffering, and limits on attorney fees.

Our agency will continue to work with all parties involved to make available any documentation that we have collected, which will offer a better understanding of the cost of medical malpractice insurance. I hope we can develop a solution to this problem before physicians take drastic measures similar to the measures taken by physicians in New Jersey, Pennsylvania, and other states with high medical malpractice costs.

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