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March 19, 2004

Commissioner Jose Montemayor
Chair, NAIC Property Casualty C Committee

Re: Draft Med Mal Report

Dear Commissioner Montemayor:

The Center for Economic Justice (CEJ) offers the following comments on the draft medical malpractice insurance report, released on March 8, 2004 and the draft executive summary, released on March 10, 2004. Because of the recent release of the report right before the NAIC meeting, we have had not had sufficient time to completely review the new 243-page report. Although we raise a number of concerns in this letter, there may be other issues we would raise given a reasonable amount of time to review.

First, the process to develop and adopt this med mal report has been, and remains, unreasonable and biased.

For both the winter 2003 meeting and this meeting, you issued a massive draft report – with major revisions in both instances – right before the meeting and then you sought to push it quickly through the committee with very limited discussion.

Even though comments on the December draft were submitted in January, you didn't issue this substantially-revised version until five days before today's meeting – and the executive summary just three days before the meeting. We are concerned, because of your push to adopt the draft report during this week's conference call and your mischaracterizations of the nature of necessary review, that you are more interested in getting out a product consistent with your personal views on "tort reform" than with getting out a solid NAIC product.

We found your complaints during the conference call about the NAIC taking a long time with this study while other studies have been issued to be unpersuasive. You are the one responsible for this report taking so long because of the repeated releases of biased draft reports and your repeated last minute releases with demands to adopt with limited review. The responsibility for any delay rests with you.

Second, the report – and the executive summary, in particular – remains strongly biased towards your so-called "tort reform" agenda. The report overemphasizes the role of increased claims and fails to give adequate consideration to other sources of problems for med mal insurers. Just as troubling, the report fails to present the available evidence on a particular issue and consistently presents information favorable to your "tort reform" agenda while ignoring the other relevant evidence.

For example, the report essentially discounts all causes of med mal insurance problems, other than increased claim costs. The significant role of greatly reduced investment income is completely discounted. And the discussion of investment income is – there's no other way to put it – simply terrible. First, the report claims that reduction in investment income cannot be a significant contributor to med mal insurer problems because a reduction in investment yields can only have a limited impact on insurer investment income. Yet, the report bases this conclusion on a hypothetical model of investment yields, but ignores the actual investment income data that show unequivocally the substantial impact of reduced investment income on med mal insurer revenues. We have previously provided you the following data, derived from the NAIC's *Profitability Report* for various years:

Investment Income per $1 of Earned Premium
Medical Malpractice Insurance, Countrywide, 1991-2002

Year	Investment Income
1991	$0.502
1992	$0.604
1993	$0.497
1994	$0.373
1995	$0.411
1996	$0.465
1997	$0.504
1998	$0.517
1999	$0.437
2000	$0.489
2001	$0.343
2002	$0.204

The average for the 1991-2000 period was $0.48 – meaning that med mal insurers earned 48 cents in investment income for every dollar of premium earned. By 2002, that amount dropped 28 cents to only 20 cents. Surely a reducing in revenue of 28 cents per dollar of premium is a significant factor affecting the revenue of med mal insurers.

We calculate that, if med mal insurers had achieved the same investment income in 2002 as during the 1991 through 2000 period, the countrywide return on net worth would have been 6.0% instead of -7.7%.

Our analysis is consistent with a study done by Ken Thorpe, the Robert W. Woodruff Professor and chair of the Department of Health Policy and Management, Rollins School of Public Health, Emory University, in Atlanta, Georgia and reported in "The Medical Malpractice 'Crisis': Recent And The Impact Of State Tort Reforms" in January 2004.

EXHIBIT 2
Trends In Medical Malpractice Financial Ratios, 1995–2002

Year	Broad combined ratio[a] (%)	Loss ratio[b] (%)	Investment insurance ratio[c] (%)	Net income[c] (%)
1995	126	95	49	23
1996	124	91	44	20
1997	124	91	45	21
1998	126	92	43	17
1999	122	91	34	12
2000	129	103	33	4
2001	141	113	31	–10
2002	129	111	18	–11

SOURCES: Senate Committee on Health, Education, Labor, and Pensions hearing, 11 February 2003; and Tillinghast-Towers
Perrin tabulations using the National Association of Insurance Commissioners filings of Physician Insurers Association of
America (PIAA) companies for 2002.

[a] Awards, settlements, and defense costs plus dividends, administrative costs, and corporate income taxes as a percentage of
premium.

[b] Awards, settlements, and defense costs as percentage of premium.

[c] As a percentage of premiums.

Professor Thorpe's analysis, above, shows that the combined ratio for 2002 was similar to that for the years 1995 through 2000. The difference in net income is attributable to the dramatic reduction in investment income between 2002 and previous years.

The draft NAIC report offers the following conclusion regarding the impact of investment income:

> Given the relatively small impact of investment income on the overall income of insurers, this study concludes that underwriting losses, not the declining stock market's impact on insurer investment income, was the major factor influencing the rate increases experienced by physicians and other health care providers. The U. S. General Accounting Office reached a similar conclusion in a report published in June 2003.

While underwriting losses were clearly a significant factor in rate increases, the report is incorrect to suggest that reduced investment income was not also a significant factor. And the report mischaracterizes the cited GAO report. The GAO report highlights state:

> Multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates in our sample states. However, GAO found that losses on medical malpractice claims — which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run.

> In addition, factors other than losses can affect premium rates in the short run, exacerbating cycles within the medical malpractice market. For example, high investment income or adjustments to account for lower than expected losses may legitimately permit insurers to price insurance below the expected cost of paying claims. However, because of the long lag between collecting premiums and paying claims, underlying losses may be increasing while insurers are holding premium rates down, requiring large premium rate hikes when the increasing trend in losses is recognized. While these factors may explain some events in the medical malpractice market, GAO could not fully analyze the composition and causes of losses at the insurer level owing to a lack of comprehensive data.

The GAO report did find reduced investment income to be a significant factor affecting rising med mal premiums. And the GAO report's analysis of investment income also relied upon a hypothetical analysis of investment yields instead of actual data – the data we and Professor Thorpe used. We would hope that insurance experts – insurance regulators – would demonstrate their knowledge of insurance ratemaking by referencing their own data and assist the GAO in this regard.

We don't claim that reduced investment income was the sole cause of the problems for many insurers, but we do argue that the radically reduced investment income turned a surge in claims into a crisis for many insurers and doctors.

The reason that an accurate assessment of the causes of the problems is critical is because this analysis drives the solutions. The paper's focus on increased claims leads to its preoccupation with the tort reform agenda proffered by insurers and doctors. An assessment of the causes that included lower investment income as a contribution would place emphasis on tort reform among the possible responses.

We also find the analysis of increased claims to be lacking. The report simply explains that claim costs have risen, but provides no analysis of the causes or analysis of whether claims costs have risen uniformly or is driven by increases in specific medical specializations. There is no analysis of how much of claims cost are attributable to the non-economic damages that you so desperately want to cap. There is no analysis of whether a cap on non-economic damages lowers claims primarily by reducing payouts or by eliminating med mal litigation because consumers can no longer attract attorneys for their cases.

Further, we disagree with the basic premise that caps on non-economic damages is a reasonable approach to addressing medical malpractice claims. Any cap on claim payouts can reduce premiums. Why not put a cap on non-economic damages for people killed or maimed by a drunk driver? That would reduce claim payouts and lower auto insurance rates. Of course, that would be terrible public policy. It penalizes low income consumers who have little economic damages and it reduces the penalty and disincentive for drunk driving.

We find the lack of substantive discussion in the report of the potential problems with caps on damages to consumers injured by medical errors to be a major omission.

And if we are going to limit the damages a consumer can receive because of medical error, why aren't we combining that cap with a cap on doctors' income and insurer executive compensation?

The focus on "tort reform" is why the report is so bad. Instead of the regulators demonstrating insurance experience and coming up with responses within the insurance mechanism, the report trumpets the tort reform agenda of insurers and doctors.

The executive summary contains a number of unsupported or inaccurate assertions.

The number of insurers offering this [med mal] coverage diminished and the cost of the coverage rose to the point that many health care providers' ability to purchase it has been tested.

We do not know what "ability to purchase has been tested" means. Another GAO report found no evidence that increased med mal premiums had caused a reduction in health care services.

There are many reports of providers establishing plans of self-insurance or doing without vital liability coverage entirely.

It is unclear why establishing plans of self-insurance is evidence of a crisis or even a market problem. Many commercial enterprises are turning to alternatives to traditional insurance to save money, promote loss prevention or provide other advantages over traditional insurance.

The American Medical Association (AMA) indicates that 19 states are currently experiencing a crisis in their medical liability insurance markets.

The AMA labels all but 6 states as in crisis or showing problem signs. It is clear that the AMA has a political agenda to enact limitations on med mal lawsuits. Does the committee endorse the AMA's view of crisis?

There has been considerable speculation and a number of studies concerning the causes of the latest crisis of availability and affordability of medical malpractice coverage. One explanation voiced by personal injury lawyers and some consumer advocates has been that rising insurance rates compensated for losses in equity portfolios during the bear market that began in 2000. However, data published in Best's Aggregates and Averages indicates that stocks accounted for only 12 percent of the invested assets of companies specializing in medical malpractice insurance while bonds were approximately 80 percent.

Consumer groups have not argued about the composition of the insurers portfolios – we have pointed out the dramatic reduction in investment gains for med mal insurers. The report does a disservice to readers by discussing portfolio composition instead of reporting the actual reduction in investment gains.

Research done for the accompanying report of the NAIC's Market Conditions Working Group further indicates underwriting losses, not declining stocks continue as the major factor influencing the rate increases experienced by physicians and other health care providers. The U. S. General Accounting Office reached a similar conclusion in a report published in June 2003.

We discussed these statements above. The suggestion that reduced investment income has not been a major factor in rising med mal premiums is incorrect and is not the conclusion of the GAO report. Further, another GAO report reached conclusions that there was no evidence to support the claims that rising med mal premiums had reduced access to health care, but those GAO findings are not reported.

Low-premium states such as California were seen, upon analysis, to have legal environments that encouraged realistic verdicts and settlements.

What does "realistic" mean? As discussed above, there is no analysis of the impact of damage caps on consumers' ability to bring a case for medical error or altered incentives for safe practice by doctors.

The problems with the med mal report and its executive summary can be summarized by asking, why are insurance regulators featuring "tort reform" as the centerpiece of a report on medical malpractice insurance? Where is the emphasis on loss prevention? The proposed "solutions" simply eliminate opportunity for many consumers to bring an action in the event of medical malpractice and do nothing to address the actual malpractice. It's like eliminating replacement cost coverage on roofs and requiring actual cash value – the damage caused by hail to roofs is the same but the cost has simply been shifted to consumers. We suggest that a report by insurance regulators should feature discussion of ways to reduce the actual incidence of claims and not simply shift costs to consumers as a way to lower premiums.

Sincerely,

Birny Birnbaum
Executive Director