

Center for Economic Justice Comments on December 3, 2003 Med Mal Draft Report

Page 6 “In some states the market problems are so pronounced that access by the public to essential health care services has been affected. This is particularly true for trauma services and high-risk medical specialties such as neurosurgeons, obstetrics and neonatal care.”

It is unclear what the support for this statement is. The GAO report, from August 2003, does not support this statement:

Actions taken by health care providers in response to rising malpractice premiums have contributed to localized health care access problems in the five states reviewed with reported problems. GAO confirmed instances in the five states of reduced access to hospital-based services affecting emergency surgery and newborn deliveries in scattered, often rural, areas where providers identified other long-standing factors that also affect the availability of services. Instances were not identified in the four states without reported problems. In the five states with reported problems, however, GAO also determined that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis. For example, although some physicians reported reducing certain services they consider to be high risk in terms of potential litigation, such as spinal surgeries and mammograms, GAO did not find access to these services widely affected, based on a review of Medicare data and contacts with providers that have reportedly been affected. Continuing to monitor the effect of providers’ responses to rising malpractice premiums on access to care will be essential, given the import and evolving nature of this issue.

Physicians reportedly practice defensive medicine in certain clinical situations, thereby contributing to health care costs; however, the overall prevalence and costs of such practices have not been reliably measured. Studies designed to measure physicians’ defensive medicine practices examined physician behavior in specific clinical situations, such as treating elderly Medicare patients with certain heart conditions. Given their limited scope, the study results cannot be generalized to estimate the extent and cost of defensive medicine practices across the health care system.

The January 8, 2004 report from the Congressional Budget Office also fails to support the claim that increased medical malpractice rates have affected the availability of health care:

Evidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise. But even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending.³ Advocates or opponents cite other possible effects

of limiting tort liability, such as reducing the extent to which physicians practice “defensive medicine” by conducting excessive procedures; preventing widespread problems of access to health care; or conversely, increasing medical injuries. However, evidence for those other effects is weak or inconclusive.

It appears that the support for the statements comes exclusively from a 2002 report by the U.S. Department of Health and Human Services. This report should be given less weight than the GAO and CBO reports for at least two reasons. First, current administration has a top political goal of pushing “tort reform,” with an emphasis on caps on non-economic damages in lawsuits. Since the GAP and CBO are non-partisan, their reports are not associated with pushing a particular political agenda. Second, the HHS report relies on anecdotes and statements by self-interested parties. Whereas the GAP and CBO reports look for actual changes in the health care marketplace, the HHS report is based on statements by doctors, who have a stated interest in caps on non-economic damages in med mal lawsuits. The GAO and CBO reports sought out actual evidence of the claims made in the HHS report and did not find such evidence. Based on the totality of the evidence, the above-cited statement in the draft report is unreasonable and unbalanced.

Page 6 states:

“Countrywide data has shown that medical malpractice insurance providers are finding it difficult to operate profitably. However, the financial results vary when one looks at individual state results.”

The most recent NAIC report on profitability by state by line shows that reduced investment income, along with higher loss ratios, is a major contributor to reduced med mal profitability. The table below shows countrywide med mal loss ratios, investment gains (including investment gain from insurance transactions and investment gain from surplus), and return on net worth from the countrywide IEE tables in the profitability reports.

The table shows that investment gain dropped dramatically in 2001 and then even more in 2002. A rough analysis shows that from 1991-2000, med mal investment income was about \$0.48 per dollar of premium. This was also the five-year average from 1996-2000. Had insurers achieved this average investment income in 2002, med mal insurers would have had \$0.28 more income per dollar of premium – a huge amount. If med mal insurers had achieved the 1996-2000 or 1991-2000 average investment income in 2002, we estimate the return on net worth would have been about 6% instead of -7.7%. We are certainly not arguing that changes in investment income are the only reason for poor profitability by med mal insurers in the past couple of years. We do argue that the tremendous decline in investment income changed a market downturn into a crisis. Consequently, we suggest that national economic factors are equally important, if not more so, than state factors in explaining the market performance of med mal insurers. The analysis of investment income also suggests that radical changes to the tort system

would likely be an overreaction to market problems caused in large part by changes in investment gains by med mal insurers.

Year	Loss and Loss Adj. Expense	Investment Gain on Insurance Transaction per \$1 of Premium	Earned Premium to Net Worth Ratio	Investment Gain on Net Worth	Investment Gain on Net Worth per \$1 of Premium	Total Invest Gain per \$1 of Premium	RONW
1991	83.5%	37.5%				50.2%	18.6%
1992	100.5%	46.6%				60.4%	16.2%
1993	88.2%	36.8%				49.7%	16.0%
1994	87.3%	27.2%				37.3%	12.9%
1995	88.0%	28.5%	57.0%	7.2%	12.6%	41.1%	13.3%
1996	88.3%	31.5%	43.3%	6.5%	15.0%	46.5%	12.2%
1997	83.4%	30.3%	39.3%	7.9%	20.1%	50.4%	12.1%
1998	91.4%	31.5%	37.2%	7.5%	20.2%	51.7%	10.2%
1999	104.4%	26.1%	37.4%	6.6%	17.6%	43.7%	5.0%
2000	109.4%	30.9%	41.1%	7.4%	18.0%	48.9%	5.7%
2001	131.0%	22.1%	47.7%	5.8%	12.2%	34.3%	-4.8%
2002	122.9%	13.4%	60.0%	4.2%	7.0%	20.4%	-7.7%

The table below summarizes key factors from the above table and calculates results for 2001 and 2002 if average (1996-2000) investment gains had been achieved.

Year	LLAE	Inv. Gain						
1991	84%	0.502						
1992	101%	0.604						
1993	88%	0.497						
1994	87%	0.373						
1995	88%	0.411						
1996	88%	0.465						
1997	83%	0.504						
1998	91%	0.517						
1999	104%	0.437						
2000	109%	0.489	0.480	0.482				
2001	131%	0.343			0.140	(0.189)	(0.049)	-2.3%
2002	123%	0.204			0.278	(0.179)	0.099	6.0%
					Add.			
					Inv.		Profit on	
			Avg.	Avg.	Gain if	Actual	Insur.	RONW
			Inv.	Inv.	Avg.	Profit	Trans. if	if Avg.
			Gain	Gain	Inv.	on Insur.	Avg.	Inv.
			1991-00	1996-00	Gain	Trans.	Inv.	Gain

Page 6 states:

“Since the late 1990s, there have been substantial rate increases for medical malpractice insurance in many states, while rates remained stable in others. These rapid increases led to complaints from the medical community about the affordability of coverage. This, coupled with the inability of physicians to pass these costs to patients because of managed care arrangements, has led to evidence that physicians have curtailed their practice in certain states or certain medical specialties to avoid these spiraling costs.”

The AMA labeled the vast majority of states as “in crisis” or “showing problem signs.” Even today, the AMA identifies only six (6) states as “doing okay.” This suggests a national problem as opposed to a problem more susceptible to individual state solutions. The distinction is important because the language of the draft – problems in certain states which are amendable to state-based solutions – leads to very particular types of solutions – namely the limits on med mal awards favored by certain regulators as the solution to med mal problems. In fact, the problems seem to have as much to do with insurer underwriting practices and changes in investment income as with differences in tort laws among states.

The claim of “evidence that physicians have curtailed their practice” is not supported by the GAO and CBO studies, cited above.

Page 10 states:

“Thus, a common claim that rising medical liability insurance rates are attributable to recoupment of prior losses is inaccurate.”

The phrase “in theory” should be added to this statement. In fact, “cash flow underwriting” has been a common practice of many insurers, including med mal insurers, over the years. And while regulators, in theory, will prevent med mal insurers from trying to recoup past losses in current rates, it is unclear if regulators are always successful. As you note later in the paper, a number of states have use and file laws for med mal rates while a minority of states have prior approval.

Page 26 refers to a chart of median insurer premium written, which we understand to be the amount of premium written by the middle insurer (in terms of premium). We find the charts and discussion on median insurer premium to have little value and suggest their deletion. We see no relevant information imparted by an analysis of median insurer premium. The discussion of major variances by state in the draft show how little meaning this statistic has. And what is the value of median incurred loss? Or a correlation statistic based upon ten points between median incurred loss and number of insurers. It is axiomatic that fewer insurers, all other things equal, will mean more premium and more losses per insurer. The statistics on median premium and median losses have no probative value.

Figure 6 on page 35 shows expense ratio, loss ratio and combined ratio. We suggest showing investment gain (total) as a percentage of premium also. Investment gain is very significant and is very close to loss ratio is several years. By adding investment gain to this chart, the impact of massively lower investment gains in 2001 and 2002 becomes evident.

Page 41 gives an example of the role of investment income in insurer profitability and uses 8% as the amount of investment income. This is quite misleading for medical malpractice. A more accurate representation would be to use the difference between 48 cents (the 1991-2000 and 1996-2000 med mal average) and 20 cents (the 2002 investment gain).

Page 42 states:

“Given the relatively small impact of investment income on the overall income of insurers, this study concludes that underwriting losses, not a declining stock market, were the major factor influencing the rate increases experienced by physicians and health care providers.”

This statement errs by extending the role of investment income overall for insurers to the impact of reduced investment gains for med mal insurers. The actual data, as reported in the NAIC profitability report, show a huge impact – 28 cents per dollar of premium – of reduced investment income for med mal insurers.

The discussion of investment income should be revised to reflect the actual data described above and to explain the major impact of reduced investment income on med mal insurer profitability.