

**A REPORT TO THE LEGISLATIVE COUNCIL
AND
THE SENATE AND HOUSE INTERIM COMMITTEES
ON INSURANCE AND COMMERCE
OF
THE ARKANSAS GENERAL ASSEMBLY
(AS REQUIRED BY 1007 OF 2003)**



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Approved by: Mike Pickens, State Insurance Commissioner

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**REPORT TO THE LEGISLATURE ON ACT 1007 OF 2003
ANNUAL STUDY OF MEDICAL MALPRACTICE INSURANCE
MARKET IN ARKANSAS**

INTRODUCTION AND BACKGROUND MATERIAL

Act 1007 of 2003 requires the following:

(a) The Insurance Commissioner shall conduct an annual study of malpractice insurance rates in Arkansas and report the findings to the Legislative Council and the chairs of both the House and Senate Interim Committees on Insurance and Commerce.

(b) The study shall include:

- (1) Any findings regarding any changes in medical malpractice rates;*
- (2) Any other finding that is relevant to malpractice insurance rates; and*
- (3) Any recommendations in respect to any law relating to medical malpractice insurance.*

Arkansas has a “competitive rating law” for the medical malpractice line, Ark. Code Ann. § 23-67-201 et seq. Rates cannot be disapproved unless they are inadequate, excessive, or unfairly discriminatory, Ark. Code Ann. § 23-67-208.

There are two (2) common misconceptions about the function of the Legislature and Insurance Department regarding insurance rates. The first is the ability to control market exits of companies. There is no statutory authority to require any company to provide medical malpractice insurance coverage. The State cannot pass a law requiring any insurer to do business in Arkansas.

The second misconception concerns the Department’s oversight of rates. Medical malpractice rates must be filed at least twenty (20) days prior to their use in the State. We have broad authority to review how the rate is distributed among insureds according to factors that might predict future losses, but we cannot disapprove an overall rate unless it is actuarially “excessive, inadequate or unfairly discriminatory:

- “Excessive.” This occurs when the loss ratio (losses, loss adjustment expenses and operating expenses minus earned premiums and earned investment income) drops to a point that results in the insurance company earning an excessive amount of profit.
- “Inadequate.” A rate is inadequate if it will lead to solvency problems immediately or has the potential for long-term solvency implications in that it may not provide sufficient funds to pay future claims, the costs of adjusting those claims and operating the business.
- “Unfairly Discriminatory.” All insurance discriminates among various risks. There is “fair,” i.e., “legal” discrimination, and “unfair,” i.e., illegal discrimination. Cross-subsidies encourage risky behavior in some risk categories. Therefore, allocating the

premiums among risks tends to discourage risky behavior. This expression is commonly stated as treating similar risks the same in rates and coverages.

Overall base rates for an insurer are determined by the application of actuarial expertise that applies the standards set forth in the applicable state law¹. To this amount is added an expected amount for adjusting claims, selling, administration and defense.

An individual insured's rates are normally established by applying discounts and credits or surcharges/debits to a base rate. Under our law those discounts, credits or surcharges/debits must be such that they "...measure differences among risks that can be demonstrated to have a probability effect upon losses or expenses."²

Typical characteristics used to measure those differences may include:

- Specialty involved, including multiple practice characteristics
- Claims defense and history of paid claims and amount
- Exposures - number of patients
- Emergency room practice
- Length of practice
- Location of practice
- Risk management practices implementation
- Staff size and training
- Continuing education
- Board Certification

¹ **23-67-209. Rating criteria.**

(a) Due consideration must be given to past and prospective loss and expense experience within and outside this state, to catastrophe hazards and contingencies, to events or trends within and outside this state, to loadings for leveling rates over a period of time, to dividends or savings to be allowed or returned by insurers to their policyholders, members, or subscribers, and to all other relevant factors. All submissions for rate changes or supplementary rate changes must include this information with Arkansas experience shown as well as companywide experience for the past five (5) years for the class of business which this filing affects. The determination of the weighting of credibility assigned to Arkansas must be fully explained. If, within a particular class, the data is not sufficiently credible for Arkansas or companywide, and common classes are grouped together for rate-making purposes, all class codes utilized in developing credibility shall be shown as an exhibit in the filing, with Arkansas experience for each class affected shown separately. If significant trends within the state are utilized, a narrative describing the basis of the trend must be included.

(b) Risks may be classified in any reasonable way for the establishment of rates, except that no risks may be grouped by classifications based in whole or in part on race, color, creed, or national origin of the risk.

(c) The expense provisions included in the rates to be used by any insurer shall reflect the operating methods of the insurer and its actual and anticipated expense experience.

(d) The rates may contain provisions for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration must be given to all investment income attributable to premiums and to the reserves associated with those premiums and to loss reserve funds.

² **23-67-210. Rating plans.**

(a) Rates may be modified to produce premiums for individual risks in accordance with filed rating plans which establish standards for measuring variations in hazards or expense provisions. Those standards may measure differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The modification shall apply to all risks under the same or substantially the same circumstances or conditions.

Another factor affecting availability for an individual seeking medical malpractice coverage is whether or not they meet the underwriting criteria of the insurer. Some underwriting concerns include:

- Professional sanctions
- Nursing home affiliation
- Willingness to implement risk management procedures
- Type of claims - severity and certainty of negligence conduct

FINDINGS

Ten (10) filings in the medical malpractice line of insurance have been made with the Arkansas Insurance Department since the passage of Act 1007. Each filing is subject to the normal rate review for excessive, inadequate or unfairly discriminatory levels, as well as the other statutory requirements set forth in Ark. Code Ann. § 23-67-201 et seq. Those that are questionable or contain significant increases are referred to an actuary. The companies provide actuarial justification as part of the filing. The Department's actuary may require additional supporting documentation as a part of his review.

There have been three impact statements filed pursuant to Bulletin 2-2003, which was promulgated as a result of the passage of Act 649 of 2003, which dealt with certain procedural and substantive issues in the State's tort system.

Arkansas still has very few companies actually writing new medical malpractice liability coverages. They are:

First Professional Insurance Company
Medical Protective
State Volunteer Mutual
Medical Assurance
Preferred Professionals Ins. Company

Continental Casualty is only renewing existing business.

Since the effective date of Act 1007 of 2003 the following rate actions have occurred:

2003

Company	Line of Business	Rate Action
The Doctors Company	Physicians, Surgeons, Ancillary Healthcare	+4%
Gulf Insurance Company	Chiropractors	+5%
Podiatry Insurance Co. of America	Podiatrists	+21%
PACO Assurance Co., Inc.	Chiropractors	+5%
Natl. Union Fires Ins. Co. of Pittsburgh	Psychiatrists	+12%
Medical Assurance Co., Inc.	Physicians, Surgeons, Ancillary Healthcare	+23.2%

Company	Line of Business	Rate Action
Continental Casualty	Hospital	+24.1%
Continental Casualty	Chiropractor	+0.3%
Cincinnati	Nursing Home	+106%

2004

Company	Line of Business	Rate Action
State Volunteer Mutual	Physicians and Surgeons	+13.6%
Medical Protective	Physicians and Surgeons	+22.6%
Preferred Professional Ins. Co.	Physicians and Surgeons	+100.0%

Recent rate filings have reflected that existing rates for the companies in question were inadequate and that the requested rate level change did not create statutorily excessive rate levels; nor did we find anything in the filings that resulted in unfair discrimination between similar risks. Each filing either complied with Ark. Code Ann. § 23-67-201 et seq. at the time of filing or was amended or re-submitted to conform.

Loss adjustment expenses and the cost of defense are still significantly higher in the medical malpractice line than in others. Nothing has changed in this respect in Arkansas. Year 2003 indicates that before loss adjustment expenses, the aggregate pure loss ratio for the line was 101.5%. When you add the expenses for adjusting claims and litigation of about 30% for the most recent year, the total loss ratio slightly exceeds 130%. This is much better than in immediate past years but still high. Act 649 of 2003 was in effect only about half of that year so it would still be premature to expect it to have had much of an impact on rates as almost all data submitted to justify the rate actions are based upon pre-act claims. Further, Act 649 is the subject of a challenge in court, and that uncertainty is taken into consideration by companies.

A significant portion of medical malpractice premiums is derived from the cost to investigate and defend claims (even when a claimant abandons a claim, loses in court or prevails). Due to the nature of the claim, expert witnesses are needed (which are other medical professionals) and highly specialized litigation counsel are often required. Sometimes the cost of defending a claim can equal or exceed the amount paid out. Providing a defense is both an obligation of the insurance company and a benefit to the insured medical provider.

PRE-ACT RATE FILING HISTORY

From 1991 to 1999 filings in this line were practically nonexistent regarding rates. The following filings, were made by the industry in 1999 through 2002:

Year	Month	Company	Rate Action *	Product
1999	May	St. Paul	15%	Physicians and Surgeons
1999	July	St. Paul	10%	Hospital Professionals
1999	October	National Union Fire of Pittsburgh	3.59	Physicians and Surgeons
1999	December	Medical Protective	12%	Physicians and Surgeons
1999	December	State Volunteer Mutual	15%	Physicians and Surgeons
2000	May	Truck Insurance Exchange	Initial filing	Physicians and Surgeons.
2000	October	St. Paul	25%	Hospital Medical Professionals
2000	November	Medical Mutual of North Carolina	12%	Physicians and Surgeons
2001	January	St. Paul Fire and Marine	17.50%	Physicians and Surgeons
2001	February	Gulf Insurance Company	12%	Podiatrists
2001	May	St. Paul Fire and Marine	35%	Physicians and Surgeons
2001	May	State Volunteer Mutual	17.50%	Physicians and Surgeons
2001	July	Continental Casualty	26%	Physicians and Surgeons
2001	July	Doctors Company	14%	Physicians and Surgeons
2001	August	Professionals Advocate	25%	Physicians and Surgeons
2001	September	Reciprocal of America	26%	Hospital Professional Liability
2001	September	TIG	16.6	Physicians and Surgeons
2001	October	St. Paul Fire and Marine	44%	Hospital Professional Liability
2001	October	American Physicians Insurance Exchange	37%	Physicians, Surgeons, Dentists
2001	October	First Professionals Insurance Company	Initial filing	Physicians and Surgeons
2001	November	Medical Protective	50%	Physicians and Surgeons
2001	November	C.N.A.	26%	Physicians and Surgeons
2001	December	Reciprocal of America	25.70%	Hospital Physicians and Surgeons
2001	December	Granite State	30%	Healthcare Providers Professional Liability
2001	December	Truck Insurance Exchange (Farmers)	21.5	Physicians and Surgeons
2002	March	Medical Assurance	97.50%	Physicians and Surgeons
2002	April	Medical Protective	50%	Dentist and Oral Surgeons
2002	April	State Volunteer Mutual	22%	Physicians & Surgeons
2002	April	American Casualty of Reading, PA	12.60%	Nurse practitioner
2002	April	National Casualty Company	Initial filing	Dentists
2002	May	Medical Mutual Ins. Co. of North Carolina	50%	Physicians and Surgeons
2002	May	Hartford Fire	46%	Healthcare facilities
2002	August	ISO Loss Costs	21.80%	Hospital
2002	August	ISO Loss Costs	6.80%	Physicians and Surgeons
2002	August	The Doctors Company, An Interinsurance Exchange	33%	Psychiatry
2002	August	National Union Fire of Pittsburgh, PA	Initial filing	Psychiatry
2002	August	Medical Protective	21%	Physicians and Surgeons

* All were increases unless otherwise noted

Year	Month	Company	Rate Action*	Product
2002	October	Medical Protective	9.50%	Dentists
2002	October	The Doctors Company, An Interinsurance Exchange	26.90%	Physicians and Surgeons & Ancillary Healthcare Providers
2002	November	State Volunteer Mutual	22%	Physicians and Surgeons

CONCLUSION

Since the passage of Acts 1007 and 649 of 2003, the number of filings for companies actively writing insurance in the medical malpractice market has slowed although those filings are for net increases. None of the filings were subject to disapproval as excessive, inadequate or unfairly discriminatory and otherwise complied with Arkansas statutory requirements.

Loss ratios for the line are still greatly in excess of 100% but lower than in the past. Due to the specialized nature of litigation in this area, adjustment and defense costs are, on average, higher than for most other lines of insurance.

RECOMMENDATIONS

It is premature to draw any conclusions concerning the effect of Acts 1007 and 649 of 2003. Current rates reflect claims and litigation to the effective dates of the Acts. Moreover, the medical malpractice market can still be adversely affected by a judicial repeal of Act 649 of 2003.

Any significant repeal of all or a portion of Act 649 of 2003 by the passage of what is being called "insurance reform" during the 2005 legislative session will make Arkansas less attractive to those remaining companies providing medical malpractice coverage to Arkansas's medical community. The loss of even one more medical malpractice insurer will result in significant declines in both availability and affordability of coverage for the medical community.

Prepared November 1, 2004.

cc: The Honorable Mike Huckabee, Governor
Ms. Carol Stapleton, Legislative Liaison, Bureau of Legislative Research
Ms. Lenita Blasingame, Deputy Commissioner, AID

* All were increases unless otherwise noted