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

ANNUAL STUDY OF MEDICAL MALPRACTICE INSURANCE MARKET IN ARKANSAS

Prepared by: William R. Lacy, Property & Casualty Division Director
Arkansas Insurance Department

Approved by: Julie Benafield Bowman, State Insurance Commissioner

Date Submitted: August 22, 2005

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, A.C.A. 23-67-201 *et seq*. Rates cannot be disapproved unless they are inadequate, excessive, or unfairly discriminatory, A.C.A. 23-67-208.

There are two common misconceptions about the role of the legislature and insurance department regarding insurance rates. The first misconception is that either entity has the ability to control market exits of companies. There is no statutory authority to compel any company to provide medical malpractice insurance coverage; furthermore, any law requiring any insurer to do business in Arkansas would be disruptive to the entire marketplace, even spilling over into other lines of insurance.

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." A rate becomes excessive when the loss ratio (losses = loss adjustment expenses and operating expenses, minus earned premiums and earned investment income) drops to a point which 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. "Unfair" discrimination basically means not treating similar risks the same in rates and coverages.

Overall base rates for a insurer are determined by the application of actuarial expertise that applies the standards set forth in the applicable state law.[1] To this amount is added an expected amount for adjusting claims, distribution or sales expenses, administration and defense costs.

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 probable 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 of payment
- Exposures - number of patients
- Emergency room practice
- Length of time in practice
- Location of practice
- Implementation of risk management practices
- 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.

The most basic 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 negligent conduct

FINDINGS

Six filings in the medical malpractice line of insurance have been made with the Arkansas Insurance Department during this past reporting period. 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 A.C.A. 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.

Impact statements regarding the affect of Act 649 of 2003 are filed pursuant to Bulletin 2-2003 which was promulgated as a result of the passage of the Act 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. Currently, there are six companies with policyholders, an increase over the five listed in the 2004 report. They are:

First Professional Insurance Company
Medical Protective
State Volunteer Mutual
Medical Assurance
Preferred Professionals Insurance Company
The Doctors Company, an Interinsurance Exchange

Continental Casualty is only renewing existing business.

Since the August 1, 2004, the following rate actions have occurred:

COMPANY	EFFECTIVE DATE	OVERALL CHANGE	SPECIALTIES AFFECTED
FPIC	10/04	20%	Physicians/Surgeons/Allied Healthcare Professionals
Medical Assurance, Inc.	1/05	+19.3%	Hospital Professionals
State Volunteer Insurance Company	4/20/05	+5.5%	Physicians/Surgeons
Continental Casualty Company	5/16/05	+25.9%	Hospital Professionals
Continental Casualty Company	7/22/05	+ 4.1%	Allied Heathcare Professionals
Continental Casualty Company	7/22/05	+ 6.5%	Physicians/Surgeons

Our review of recent rate filings has indicated that existing rates for the companies in question are approaching adequacy and that the requested rate level change did not create statutorily excessive rate levels. We did not find anything in the filings that resulted in unfair discrimination between similar risks. Each filing either complied with A.C.A. 23-67-201 *et seq*. at the time of filing or was amended or re-submitted to conform.

The aggregate loss and lost adjustment expense ("LAE") ratio for Arkansas for 2004 was 97.63%. The aggregate pure loss ratio for the line was 69.16%. The aggregate LAE for the line was 27.47%. This is much better than in recent years. Act 649 of 2003 has only been in effect since March 25, 2003, so it would still be premature to expect it to have had a significant impact on rates, as almost all data submitted to justify the rate actions are based upon pre-act claims or extremely young reserving data for long tail claims. Further, Act 649 is the subject of a challenge in court and that uncertainty is taken into consideration by companies. The lower loss ratio is probably attributable to premium increases of the past few years.

Loss adjustment expenses and the cost of defense are still significantly higher in the medical malpractice line than in other lines of insurance. 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 is often required. Sometimes the cost of defending a claim can equal or exceed the amount paid in judgments or settlements. Providing a defense is both an obligation of the insurance company and a benefit to the insured medical provider. The following table presents a comparison of medical malpractice loss and expense ratios as compared to commercial liability coverage and private passenger auto liability coverage.

Year	2004			2003			2002		
Line of Insurance	Medical Malpractice	Commercial Multiple Peril (Liability Portion)	Private Passenger Auto Liability	Medical Malpractice	Commercial Multiple Peril (Liability Portion)	Private Passenger Auto Liability	Medical Malpractice	Commercial Multiple Peril (Liability Portion)	Private Passenger Auto Liability
Pure Loss Ratio	69.16%	46.60%	62.91%	101.47%	39.42%	63.17%	97.92%	54.20%	72.63%
LAE Ratio	28.47%	13.87%	2.70%	31.05%	12.28%	2.54%	39.69%	8.78%	2.00%
Pure Plus LAE	97.63%	60.47%	65.61%	132.52%	51.70%	65.71%	137.61%	62.98%	74.63%

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 overall increases. None of the filings were subject to disapproval as excessive, inadequate or unfairly discriminatory and otherwise complied with Arkansas statutory requirements. Given the loss ratios for 2004, the market appears to be approaching rate adequacy.

Loss ratios for the line are still high, but much 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 as reflected by the above chart.

RECOMMENDATIONS

It is premature to draw any conclusions concerning the effect of Acts 1007 and 649 of 2003. Current rates reflect claims and litigation prior 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 in a future legislative session will make Arkansas less attractive to those remaining companies providing medical malpractice coverage to Arkansas' 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 August 22, 2005.

cc: The Honorable Mike Huckabee, Governor
Ms. Lenita Blasingame, Chief Deputy Insurance Commissioner