A REPORT TO THE LEGISLATIVE COUNCIL AND THE SENATE AND HOUSE COMMITTEES ON INSURANCE AND COMMERCE OF THE ARKANSAS GENERAL ASSEMBLY (AS REQUIRED BY ACT 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 1, 2006

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 are approved or disapproved within 60 days after the date of filing, Ark. Code Ann. §23-67-506(d). The Commissioner is required to use standards for rates promulgated in Ark. Code Ann. §23-67-502 in determining whether to approve or disapprove a filing. Ark. Code Ann. §23-67-502 requires that rates shall not be excessive, inadequate or unfairly discriminatory. However, the commissioner may approve an excessive rate if failure to approve the rate may tend to substantially lessen competition in the Arkansas malpractice insurance market, Ark. Code Ann. §23-67-506(e).

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 sixty (60) days prior to their proposed effective date for 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 <u>but</u> we cannot disapprove an overall rate <u>unless</u> it is actuarially "excessive, inadequate or unfairly discriminatory:"

- "<u>Excessive.</u>" A rate becomes excessive when the loss ratio (losses, including adjustment expenses and operating expenses, divided by premium paid) 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. "Unfair" discrimination basically means not treating similar risks the same in rates and coverages.

Overall base rates for an insurer are determined by the application of actuarial expertise to 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, taxes and fees, 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]

---

[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.

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

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

Seven (7) filings in the medical malpractice line of insurance were made with the Arkansas Insurance Department during this past reporting period:

- Five (5) became effective as filed;
- One (1) was disapproved as excessive; and
- One (1) was re-filed after being disapproved.

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*. Filings that trigger concerns about excessive or inadequate rates or contain significant increases are referred to an actuary. While 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 that 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 a limited number of companies actually writing new medical

malpractice liability policies. Currently, there are eight (8) companies with policyholders, an increase over the six (6) listed in the 2005 report. They are:

American Casualty of Reading, PA (nurses only) **(NEW)**
The Doctors Company, an Interinsurance Exchange
First Professionals Insurance Company
Medical Protective Company
Medical Assurance Company, Inc.
Podiatry Insurance Company of America (podiatrists only) **(NEW)**
Preferred Professional Insurance Company
State Volunteer Mutual Insurance Company

Continental Casualty is only renewing existing business.

Since August 1, 2005, the following rate actions have occurred:

COMPANY	EFFECTIVE DATE	OVERALL CHANGE	SPECIALTIES AFFECTED	DISPOSITION
Podiatry Ins. Co. of America	8/18/2005	5.0%	Podiatrists	Filed
Medical Protective Company	10/24/2005	0.0%	Physicians and Surgeons	Filed
AM Casualty of Reading, PA	11/14/2005	10.0%	Registered Nurses	Disapproved[3]
Medical Assurance Co., Inc.	2/27/2006	5.2%	Physicians and Surgeons	Approved[4]
Medical Assurance Co., Inc.	2/27/2006	-4.9%	Dental	Approved
AM Casualty of Reading, PA	3/28/2006	3.0%	Registered Nurses	Approved as Resubmitted
Medical Assurance Co., Inc.	6/8/2006	6.0%	Healthcare Facilities	Approved

Our review of recent rate filings has indicated that existing rates for the companies in question are approaching adequacy and that, other than the one filing disapproved as excessive, 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 Ark. Code Ann. §23-67-201 *et seq*. at the time of filing or was disapproved and re-filed, or amended to conform.

The aggregate loss and lost adjustment expense ("LAE") ratio for Arkansas for 2005 was 90.5%. The aggregate pure loss ratio[5] for the line was 57.13%. The aggregate LAE for the line was 24.23%. This is much better than in recent years. Act 649 of 2003 has only

[3] This filing was disapproved. The company revised it and resubmitted it. It was subsequently approved as resubmitted.
[4] The requirement that rate filings be approved or disapproved was effective January 1, 2006.
[5] "Pure loss ratio" is simply the ratio of losses incurred compared to premium earned. It does not contain LAE or other costs of operation or defense.

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 could be challenged in the courts and that uncertainty is taken into consideration by companies. The lower loss ratio is probably attributable to premium increases of the past few years driven by extremely high loss prior to 2004.

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	2005			2004		
Line of Insurance	Medical Malpractice	Commercial Multi Peril (Liability Portion)	Private Passenger Auto Liability	Medical Malpractice	Commercial Multi Peril (Liability Portion)	Private Passenger Auto Liability
Pure Loss Ratio	57.13%	34.02%	59.41%	69.16%	46.60%	62.91%
DCCE[6] Ratio	24.23%	10.48%	2.72%	28.47%	13.87%	2.70%
Pure plus DCCE	81.36%	44.50%	62.13%	97.63%	60.47%	65.61%

YEAR	2003			2002		
Line of Insurance	Medical Malpractice	Commercial Multi Peril (Liability Portion)	Private Passenger Auto Liability	Medical Malpractice	Commercial Multi Peril (Liability Portion)	Private Passenger Auto Liability
Pure Loss Ratio	101.47%	39.42%	63.17%	97.92%	54.20%	72.63%
DCCE Ratio	31.05%	12.28%	2.54%	39.69%	8.78%	2.00%
Pure plus DCCE	132.52%	51.70%	65.71%	137.61%	62.98%	74.63%

[6] "DCCE" is Defense and Cost Containment Expense." This number includes LAE, costs related to the defense of a claim and any other costs related to the containment of the loss. It does not contain expenses relating to general operating expenses, for sale of the product, or taxes.

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. In the year since the last report, the impact of the filings were for overall increases of 10% or less. Given the loss ratios for 2005, the market appears to be approaching or may even have achieved rate adequacy.

Loss ratios for the line remain high when compared to other liability lines, but continue to improve. Due to the specialized nature of litigation in this area, claims investigation, adjustment and defense costs are, on average, substantially higher than for other liability lines. It is still premature to draw any conclusions concerning the effect of Acts1007 and 649 of 2003. Current rates continue to predominately 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 in whole or part of Act 649 of 2003.

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 1, 2006.

cc: The Honorable Mike Huckabee, Governor
Tony Minicozzi, Executive Secretary, Arkansas Legislative Council
Carol Stapleton, Legislative Council Liaison, Bureau of Legislative Research
Lenita Blasingame, Chief Deputy Insurance Commissioner