CENTER FOR JUSTICE & DEMOCRACY
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September 17, 2007

Eric R. Dinallo, Superintendent
State Of New York
Insurance Department
One Commence Plaza
Albany, New York 12257

Dear Superintendent Dinallo:

The following information is submitted to the medical malpractice task force in answer to several questions raised in the workplan for September 19, 2007.

Financial Issues

Nationally, the property/casualty insurance industry and the medical malpractice industry, in particular, have been experiencing a soft market since 2004/2005. Profits are rising throughout the country, while at the same time rates have stabilized or are dropping. See, e.g., Americans for Insurance Reform, " Commercial Insurance Rates Continue to Fall While Insurer Profits Continue to Skyrocket to Record Levels, October 25, 2006; http://www.insurance-reform.org/AIRSoftMarketProfits.pdf. That the performance of some New York companies, like MLMIC, are so out-of-wack with the rest of the country is clearly due to unique problems in this state.

New York is the only state in the nation that provides doctors with $1 million in free coverage above the $1.3 million they currently pay for. Beyond this, however, New York law requires MMIP to decline no one, forcing it to insure the small number of objectively bad risks that cause most malpractice payouts in this state. (In New York, 7 percent of New York's doctors are responsible for 68 percent of malpractice payouts, according to Public Citizen's Health Research Group. "Just 7 Percent of New York's Doctors Are Responsible for Two-Thirds of Malpractice Payouts, Study Shows," March 10, 2003; *See* http://www.questionabledoctors.org/. See also, Public Citizen, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes,* January 2007.)

We also know that under the last Administration, the MMIA surplus was stolen for the state budget, and that the state contributed to MLMIC's poor performance by selling it MMIA's liabilities for an likely insufficient price just as the hard insurance market was taking hold nationally. MLMIC's results have been deteriorating since then. These are all real policy concerns for consumer groups, especially as certain interests suggest solving these problems on

the backs of the majority of good doctors who are already paying for the actions of a few bad ones, or even worse, patients who have been injured due to medical negligence.

We look forward to seeing data presented by medical malpractice insurance companies because currently public information has been sorely lacking. For example, MLMIC does not split out its results separately for the business it assumed from the MMIA and the business it initiated, so there is no way to compare the difference. Given the observation by many that MLMIC may have substantially underbid for the MMIA business and now is in trouble as a result, this data seems critical and we hope the Superintendent requests and releases them.

As to the current MMIP deficit, MMIP's actuaries say that it has a projected deficit of close to $500 million over a number of years. We note that the Center for Justice & Democracy has done work in the last few years with both Jay Angoff, former Missouri Insurance Commissioner, and J. Robert Hunter, Director of Insurance for the Consumer Federation of America, former Texas Insurance Commissioner and Federal Insurance Administrator under Ford and Carter, demonstrating that often estimates that actuaries make as to ultimate liabilities are often wildly exaggerated. In fact, this insurance department found such a phenomenon to be historically true in New York State. See New York Department of Insurance, *The Status of the Primary and Excess Medical Malpractice Market and the Future Need for the Medical Malpractice Insurance Association,* at 11 (1997).

We have found that only by looking at paid claims experience for several years back, examining such data as the carriers' Annual Statements filed under oath with state insurance departments, (and not rate filings which contain mostly estimates), does an accurate picture emerge. For example, on July 7, 2005, the Center for Justice & Democracy, along with the Alliance for Justice, Consumer Federation of America, Public Citizen, USAction and U.S. Public Interest Research Group, released *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, written by Angoff. The report examined data of leading A.M. Best-rated medical malpractice insurers. It found that contrary to what carriers were saying in their rate filings, claims payments of those carriers, as well as their incurred losses (the estimated future claims payments of those carriers), decreased in real terms over the prior five years.

Incurred losses in the medical malpractice insurance line are notoriously prone to swing up and down with the industry's investment/economic cycle. The proof that these swings are not real is that they do not manifest themselves in the paid data, even when reviewed over the long term to account for the long-tail lag between reserving and ultimate payment.

Indeed, in July 2007, NYPIRG, Center for Medical Consumers and Center for Justice & Democracy released an analysis of 30 years of New York insurance data, analyzed by J. Robert Hunter. The data clearly shows that when adjusted for medical inflation and the number of doctors, there has been no increase in the amounts medical malpractice insurers have paid out in claims in recent years, including all jury awards and settlements. "Groups React to NYS Insurance Department Med Mal Rate Hike, July 2, 2007, http://centerjd.org/NY%20Groups%20React%20to%20Insurance%20Department%20Rate%20Hike.pdf.

We also know that insurers historically have increased reserves as a way to justify price increases. We do not know if this is happening among any of the med mal carriers in New York, but it is important to determine if it is because historically, this kind of activity can degenerate into a "liability insurance crisis." For example, we know that nationally, there was a large jump in med mal loss reserves in 2001, at the beginning of the most recent hard market in the country. According to a June 24, 2002, *Wall Street Journal* front page investigative news story, St. Paul Insurance Co., which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the 1980s, so it "released" $1.1 billion in reserves, which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market and started slashing prices to attract customers.

From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, generating supply and demand problems for doctors in many states. The head of a leading medical malpractice insurer described problems in the med mal insurance market at that time: "I don't like to hear insurance-company executives say it's the tort system – it's self-inflicted." Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis," *Wall Street Journal*, June 24, 2002.

As one insurance industry insider also put it in 2001, "The [medical malpractice insurance] market is in chaos.... Throughout the 1990s ... insurers were ... driven by a desire to accumulate large amounts of capital with which to turn into investment income. Regardless of the level of ... tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money." Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!," International Risk Mgmt. Institute (Sept. 2001), http://www.irmi.com/expert/articles/kolodkin001.asp

Notably, for 15 years, between 1988 and 2002, MLMIC not only sought no net rate increase but frequently issued dividends to its policyholders. During the last few years, the insurance department has generally approved single digit increases.

Claims experience – No Increase; Few Sue

Each year medical negligence in New York hospitals results in at least 27,000 injuries and 7,000 deaths. Yet eight times as many patients are injured as ever file a claim; 16 times as many suffer injuries as receive any compensation. Institute of Medicine, *To Err is Human: Building a Safer Health System*, (1999); Harvard Medical Practice Study (1990). At the highest level, the estimated number of medical injuries nationally is more than one million per year; approximately 85,000 malpractice suits are filed annually. "With about ten times as many injuries as malpractice claims, the only conclusion possible is that injured patients rarely file lawsuits." David A. Hyman and Charles Silver, "Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid," 59 Vand. L. Rev. 1085, 1089 (May 2006) (citing Brian Ostrom, Neal Kauder & Neil LaFontain, Examining the Work of State Courts (2003) at 23).

What's more, New York data from the National Center for State Courts (NCSC), shows that between 1997 to 2001, New York medical malpractice filings dropped 3 percent, while the

average among all 17 states examined was a 5 percent increase before adjusting for population growth. National Center for State Courts, *Examining the Work of State Courts, 2002: A National Perspective from the Court Statistics Project* (Brian J. Ostrom et al. eds., 2003).

As noted above, Hunter's studies, using decades of paid loss and written premium data, are consistent with this finding, both in New York and nationally. See, both "Groups React to NYS Insurance Department Med Mal Rate Hike, July 2, 2007, http://centerjd.org/NY%20Groups%20React%20to%20Insurance%20Department%20Rate%20Hike.pdf; and "Medical Malpractice Insurance: Stable Losses, Unstable Rates 2007," Americans for Insurance Reform, http://www.insurance-reform.org/StableLosses2007.pdf. Other studies by Hunter examine Loss Adjustment Expenses (including things like defense costs) and reach comparable conclusions. See, e.g. Hunter, "Measured Costs," Americans for Insurance Reform, July 2005, http://www.insurance-reform.org/issues/measured_costs.pdf.

Many other studies have demonstrated a disconnect between claims and rising premiums. A study by law professors at the University of Texas, Columbia University and the University of Illinois based on closed claim data compiled by the Texas Department of Insurance since 1988 concluded that "the rapid changes in insurance premiums that sparked the crisis appear to reflect insurance market dynamics, largely disconnected from claim outcomes." Black, Silver, Hyman, and Sage, "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002," Journal of Empirical Legal Studies (2005).

Similarly, an econometric analysis of the malpractice market by two Dartmouth economists found that "past and present malpractice payments do not seem to be the driving force behind increases in premiums," and that premium growth may be affected by many factors beyond increases in claims payments, such as industry competition and the insurance underwriting cycle. Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, "The Effect of Malpractice Liability on the Delivery of Health Care," at 14 and 20 (Aug. 2004). *See also,* Amitabh Chandra, Shantanu Nundy, Seth A. Seabury, "The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank," *Health Affairs*, May 31, 2005. The study analyzed National Practitioner Data Bank data on payments, as well as data on premiums, physicians, and treatments.

Insurers always try to blame the legal system for price jumps, as if lawyers miraculously engineer big awards to occur precisely as the cycle turns, i.e., engineering large awards in the mid-1970s, stopping for a decade, engineering large awards again in the mid-1980s, stopping for 17-20 years, and suddenly engineering large awards again. This is ludicrous, as the data confirms.

Medical Errors – Large and Costly

While we do not have data showing the impact of medical errors on the financial condition of med mal insurance companies, we do know that the total national costs of negligence in hospitals (lost income, lost household production, disability and health care costs) are estimated to be between $17 billion and $29 billion each year, of which health care costs represent over one-half. Moreover, these figures vastly underestimate the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk, and direct hospital costs

are only a fraction of the total costs. Institute of Medicine, *To Err is Human: Building a Safer Health System*, 1999.

Defensive Medicine and the Costs of Litigation

Studies consistently show that only a very small portion of health care costs result from defensive medicine. Even before the widespread onset of managed care in this country, the congressional Office of Technology Assessment (OTA) found that less than 8 percent of all diagnostic procedures were likely to be caused primarily by liability concerns. OTA found that most physicians who "order aggressive diagnostic procedures . . . do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability." The effects of "tort reform" on defensive medicine "are likely to be small." U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice*, OTA-H--6O2 (1994).

According to a Congressional Budget Office study, "some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients.... CBO believes that savings from reducing defensive medicine would be very small." CBO also found that limiting tort liability would have no significant impact on health care spending. Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice* 1, 6 (Jan. 8, 2004).

The Annenberg Center's web site, "factcheck.org," has repeatedly challenged President Bush and the insurance industry's use of bogus statistics to make the argument that medical malpractice limits would save health care costs based on considerations like defensive medicine. See, e.g., "Two nonpartisan agencies of Congress have examined the question. In 2004 the Congressional Budget Office found 'no evidence that restrictions on tort liability reduce medical spending.' And in 1999 the Governmental Accountability Office evaluated the study and said that the evidence presented was too narrow for estimating the overall costs of defensive medicine." "Insurance Industry Ad Makes Fishy Claim About Lawyers; Lobby groups fight like animals over health care costs - implausible statistics vs. fact-free stereotypes," April 19, 2005.

What's more, it has been repeatedly shown that malpractice claims and premiums each represent only a tiny percentage of overall health care costs. The CBO found that "Malpractice costs account for less than 2 percent of [health care] spending," and that all the provisions of the federal medical malpractice bill, including a $250,000 cap on non-economic damages, "would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small." Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice* 1, 6 (Jan. 8, 2004).

Total medical malpractice payouts, for injuries and deaths caused by medical negligence in the nation, have recently hovered between $5 billion and $6 billion annually. This is less than half of what Americans pay for dog and cat food each year, which the Pet Food Institute puts at $13 to $14 billion annually over the past few years. *See*, http://www.petfoodinstitute.org/reference_pet_data.cfm; "Medical Malpractice Insurance: Stable Losses, Unstable Rates 2007," Americans for Insurance Reform, http://www.insurance-reform.org/StableLosses2007.pdf.

Recommendations

Of all med mal issues facing the state, only the potential MMIP deficit is an issue that could eventually become a "crisis," even though it is not necessary to create a fund today that will cover the entire deficit right now. That said, here are some possible recommendations:

Require that MMIP be allowed to turn down objectively bad risks and require generally that risks with poorer experience pay more than good risks. In New York, MMIP must insure any doctor who insurers refuse to insure voluntarily. MMIP can decline no one, no matter how bad the risk. In terms of both contributing to the deficit and reducing medical errors, this is terrible policy. MMIP should be allowed to turn down bad risks based on an objective definition of good practice, i.e., doctors with clean records based on their specialty or location. If turned down, "surplus lines" carriers--carriers who are not licensed in the state but are licensed in other states – should be authorized to write medical malpractice coverage, in whatever way the state determines. Such a change would improve the results of the MMIP, would stop good doctors from paying for the small number of bad ones, and would make proper use of the insurance function to help weed out doctors with poor experience.

Further, all medical malpractice insurers should be required to use claims history as a rating factor, and give that factor significant weight. Auto insurers use an individual's driving record as a rating factor; workers compensation insurers use the employer's loss experience as a rating factor. Malpractice insurers should do the same. In addition, medical malpractice insurers should be required to offer all "good" doctors– *i.e.,* all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors – the lowest rate.

Surcharge the P/C companies. If the MMIP deficit were spread across this industry, each insurer would need to pay a surcharge of only approximately 1 – 2 percent of premium to pay off the deficit, and less if spread over a number of years. The surcharge would be even less if the health insurance/managed care industry were included. However, this requires policyholders to pay for a problem they did not create so from a policy perspective, there are drawbacks to this approach. However, it could most easily resolve the current potential crisis.

Others have recommended conducting a competitive bidding process whereby the carriers agree to assume the current liabilities of the MMIP.

We hope this was helpful. Please do not hesitate to contact us with any questions.

Very sincerely,

Joanne Doroshow
Executive Director