

CEJ Comments on May 28 version of med mal report:

Page 6: “Committee asked . . . survey medical liability . . . The state of the economy and quality of medical services . . . outside the scope. . .

Not what you were asked to do. Charge was: Appoint a Market Conditions Working Group to monitor the availability and affordability, including all potential causes related thereto, of property and casualty insurance products and, for the most distressed lines of business, provide reports that contain market-monitoring information. Formulate solutions and propose regulatory responses for the most distressed lines of business.

Opening paragraph shows arbitrary, limited nature and limited value of study.

Page 6: AMA states in crisis

The AMA is an inappropriate source to cite here alone. The AMA represents the doctors who have a direct financial stake in certain outcomes and clearly has a partisan role in the debate. Further, the AMA claims that all but a few states are in crisis or deep trouble – making them seem like chicken little. Further, there is no discussion of how the AMA determines a state being in crisis and there is no citation.

Page 6 (and throughout report): Use of median insurer data by state

These are meaningless data for comparing states since the median data are greatly affected by the number of insurers and the number of med mal insurers is so small. Cross state comparisons should be based on per capita or per doctor premium/losses/claims. The use of median insurer data stuffs the report with irrelevant and uninformative info.

Page 6: One explanation voiced by lawyers and some consumer advocates . . . losses in equity portfolios . . .

No citation for this and not what CEJ or other consumer groups have said. We document the fact that investment income declined dramatically as a percentage of the premium dollar, which had a significant impact, along with increased claim costs, on rising premium rates. It is misleading to mischaracterize someone’s comment and then criticize the mischaracterization. The discussion of stocks versus bonds is a red herring and irrelevant.

Page 6: Research done . . . investment income decline, but underwriting losses most influential factor.

Discussion of investment income in this paragraph inconsistent with discussion of equities in prior paragraph. Further, it is unclear where the report discusses relationship between increased claims and availability of coverage.

Page 7: The second limitation is that the data provided to the NAIC is not sufficiently detailed to examine where, and to what extent, problems exist. Analysis of available data shows that, in broad terms, there is a market problem in medical malpractice. However, market problems are likely occurring within certain medical specialties and/or certain locales with greater severity. That limitation points to a need to develop a new statistical plan to collect such data to monitor market conditions in the future.

These statement are inconsistent with the sole executive summary recommendation being states should look at capping damage awards. Given the admission that you don't know where or to what extent problems exist, it is inappropriate to recommend a single solution that may or may not address the problems you cannot identify.

Page 7: It is generally recognized that the U.S. economy had an adverse effect on the medical liability market, at least in the initial crisis stage. Interest rates, the reinsurance market, and the decline in stock price in recent years played a role in putting upward pressure on medical liability premiums. While we recognize the economy has a bearing on the medical liability market, we also recognize that regulators and legislators cannot mandate economic conditions. Therefore, we necessarily restricted our study to those actions available to regulators and/or legislators at the state level.

It is important to identify how much of an impact the economy played in the med mal crisis because those factors indicate how much of the crisis was cyclical as opposed to structural. If the crisis was predominantly a result of cyclical causes, then regulators and legislators do have a role – don't use structural solutions for cyclical problems. And if the problems are primarily cyclical, then a cap on non-economic damages doesn't address the problems.

Page 7: One potential solution to the high cost of medical liability insurance would be to reduce a key underlying cause; adverse outcomes and medical results that sometime give rise to claims. However, though such a solution is highly desirable, it is not the province of insurance regulators or legislators. That part of the solution must necessarily be left to the medical institutions that govern the profession. A proposal for an ongoing process to reduce the rate of medical negligence could be suggested, but is outside the scope of this study.

This is another stunning paragraph. Insurers and regulators are active in loss prevention in every line of insurance, but here it is outside of the province of regulators and legislators? It is only outside the scope of this study because you want to focus on damage caps. The recent draft release by NCOIL on patient safety measures soundly refutes this paragraph.

Page 8: Moderate-premium states such as California were seen, upon analysis, to have legal environments that encouraged realistic verdicts and settlements.

It is unclear what realistic verdicts means. Further, the evidence on damage caps reducing rates is decidedly mixed. Texas is a glaring example.

Page 8: The Market Conditions Working Group suggests that states consider the efficacy of the experience in California and other states, in considering the enactment of measures to reduce the cost of awards and settlements without impairing the right of injured patients to recover the full amount of their economic losses and a reasonable compensatory amount for non-economic losses. Without question, these states have experienced consistently lower premium increases for all medical specialties through all types of economic conditions and regardless of the phase in the insurance cycle. Additionally, we are not aware of any decrease in the quality of care received, or in the public's ability to recover for medical negligence in those states.

These are outrageous and unsupported claims. If you cannot find evidence that consumers harmed by medical errors in California have a lower opportunity to recover for the medical negligence, you have not looked.

It is also remarkable that caps on damage awards is the only "solution" mentioned in the executive summary. This moves the paper away from something useful for states into be a political document that will be create division at the NAIC.

Page 9: Underwriting losses. . . GAO reached a similar conclusion.

This is a significant misrepresentation of the GAO study, which is entitled "Multiple Factors Have Contributed . . ." Further, the statements in the GAO study do track the claims made in this paragraph.

Page 15: Insurers are also subject to market pressures of which they have no control. When rates decrease in soft markets, an insurer that ignores the falling market rate or that is prohibited by regulators to match falling rates will lose the less risky policyholders to competitors and retain riskier policyholders not accepted by the competitor at the lower-priced coverage. The resulting book of business for the higher-priced insurer has a higher cost than before, causing the insurer to raise rates and subsequently lose additional lower-cost risks. This is a phenomenon of every business cycle; those who keep prices higher than the market face shrinking market share. The affect of adverse selection in the insurance business adds to this problem.

Do regulators really want to be saying that insurers have no choice but to misprice their products, that they have no control over charging an appropriate rate?

Page 21: Because of these limitations, there is no way to determine what portions of losses are driven by actual medical expense or by payment for non-economic/punitive damages on an aggregate basis. The data are also not useful to the medical profession and others to discover root causes of adverse events for risk management, claim prevention, or patient safety purposes.

How then can the exec summary feature caps on non-econ damages as the best solution for all states?

Page 27: Insurer losses have been the driving force of medical liability rate increases over the past several years. However, there is debate about why costs are increasing. On the one hand, some argue that one cause of increased losses has been an increase in economic costs; those costs the insurer pays in medical care, lost wages, etc. On the other hand, some argue that the driving force of loss increases has been an increase in non-economic damages; those damages insurers pay to compensate for pain and suffering, loss of companionship, punitive damages, etc. To provide meaningful analyses on the impact of economic and non-economic damages on insurer losses, the authors recommend the NAIC study an appropriate methodology for reporting specific types of loss costs and include the collection of this data by state by specialty in a statistical plan.

Again, contradiction between text and executive summary recommendation

Page 23: Discussion of losses, median insurer losses.

A comparison of median insurer losses with median insurer premiums greatly understates the severity of problems in the med mal market and demonstrates why the use of median insurer data is inappropriate. The comparison of median insurer losses with number of insurers is equally irrelevant.

Page 28: Defense Costs

Again, median insurer data and number of insurers are irrelevant. Of course we would expect the median to grow as the number of insurers declines. The study misses the boat on defense costs – why are med mal defense costs so high relative to claims compared to any other line of insurance and doesn't this present an opportunity for major cost savings?

Page 32: Investment Income

The data on investment income are not replicable – there is no source document or exhibit. The data are inconsistent with several other data sources published by the NAIC that show over a \$1 billion reduction in investment income over a two or three year period. The statement that the GAO reached a similar conclusion is demonstrably incorrect.

Additional Comments:

- Page 9 – “Anecdotal evidence provided to the NAIC suggests that in some states the market problems are so pronounced that access by the public to essential health care services has been affected.” - This is directly contrary to the findings of the GAO, the report cites to the GAO reports it likes, while ignoring the ones that contradict the report’s findings. Why is the NAIC relying upon anecdotal evidence when a GAO study indicates otherwise?
- Page 10 – “Medical liability insurers spend substantial funds investigating and defending claims where there is a adverse patient outcome not resulting from negligence.” - There is no source cited (not surprising because I doubt there is any data to back this up).
- Page 14 – Last paragraph suggests that an insurer that does not slash prices when competitors do will be left with the higher risk customer, forcing further rate hikes. The point should be that regulators should be willing and capable to put their foot down to halt such destructive cycles. All this paragraph really seems to do is justify poor planning/bad business practices.
- Page 15 – Role of Reserving. The report doesn’t actually say much about whether overreserving and/or underreserving helped lead to the current ‘crisis.’ It notes that reserving can be a factor in pricing premiums, but curiously doesn’t address whether it’s a current problem. (For example, it could be that overreserving in prior years, like St. Paul did, of funds that were later released to surplus – generating huge profits that made the line look attractive and immensely profitable, which then can lead to underreserving as insurers decide to reserve less and realize higher profits immediately).
- Page 17 – third paragraph. Coning report cites “aggressive reserve takedowns” as a cause of the market problems. The NAIC report doesn’t address this issue (as noted in the previous bullet).
- Bottom 18 – Top 19. The report discusses a 1973 federal report that recommended state regulators collect better medical malpractice data so more meaningful studies could be done. Today, that’s still a recommendation. Though the topic was raised by in 1973, the NAIC did nothing about – and lo and behold more malpractice cycles and “crises” occurred. Yet, despite this long history of inadequacy of data, rather than focusing on data collection, the NAIC is leading headfirst into tort reform proposals (and considering better data collection second).
- Page 29 “A modest percentage of invested assets were held in the stock market.” Some of the charts cut from prior versions of the report showed that stock market investments, while less than bonds, had increased greatly since 1992.
- Page 53 – Bad Faith section. Despite the fact there is no data, the report nevertheless comments negatively on Bad Faith suits. Highlights a problem with caps, they destroy an insurer’s incentive to settle legitimate claims quickly. If there’s not bad faith, they have nothing to lose by dragging a suit out or denying claims as a matter of course.
- Page 62 – “Further, evaluation of changed in insurer reserving practices was beyond the scope of the study.” Report doesn’t explain why. Conning identified “aggressive

reserve takedowns” as a major cause of the medmal problems, so why would the NAIC ignore the impact of industry reserving changes.

NOTE – THE FOLLOWING TABLES WERE CUT FROM THE REPORT [THEY CAN BE FOUND IN THE MAY 5, REDLINED VERSION] - These charts shed more light on important things.

- Table 19 – shows that stock investments by medmal insurers more than doubled from 1991-2002, going from 10.7 billion to 25.8 billion (hitting a peak of 34.4 billion in 2000).
- Similarly, Table 22 showed that percentage of common stocks held in 1991 (1.29%) more than quadrupled to 5.43% by 2002 (after peaking at 9.9% in 1999).
- Table 26 – Shows that even though most of the investments held by insurers were bonds, companies still suffered from market declines in the bond markets. Bond Income dropped from \$4.3 billion in 2000 to \$3.66 billion in 2003).
- Table 28 showed a similar decline for Cash and Short Term investments