Consumer Federation of America

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BEFORE THE
NEW YORK STATE DEPARTMENT OF HEALTH MEDICAID REDESIGN TEAM:
MEDICAL MALPRACTICE REFORM WORKING GROUP
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Good morning.

I apologize for not being there with you this morning but I cannot travel right now because my wife is ill.

I am Bob Hunter, Director of Insurance for the Consumer Federation of America, a federation of about 300 pro-consumer groups. I am an actuary. I have served as Federal Insurance Administrator under Presidents Ford and Carter and as Texas Insurance Commissioner. I have been researching medical malpractice insurance for almost 40 years.

If you look at the first slide captioned "Insurance Economic Cycle" you see the history of profits in the property/casualty insurance industry since 1967. It shows a cyclical pattern. There were three cycle bottoms in 1975, 1985, and 2001 (1992 was not a cycle bottom, that was simply the impact of Hurricane Andrew). Following each bottom there was what we now call a "hard market" where rates skyrocket for 2 to 3 years. This is followed by a "soft market" where rates are stable and even, in commercial insurance, decline. The cycle is particularly acute for long-tailed lines, where it takes a long time for claims to settle, like medical malpractice.

Huge med mal rate increases in the three hard market times have led to doctors marching on capitals calling for tort reform, because their insurers tell them it is exploding claims that cause these periodic rate jumps.

In 1975, doctors asking for national tort reform barraged the Ford White House. I was asked to study the cause for the sudden rate crisis.

Data were not available. Indeed, med mal was such a quiet line of insurance; data were not even broken out in insurer annual reports to the states.

Working with the National Association of Insurance Commissioners we undertook 2 things:

- To help track the situation in the future, NAIC ordered data to be broken out for med mal in the reports and
- To help understand the situation, we collected data in a special call and also undertook a multi-year retrospective closed claim study.

I was able to advise the White House that what we found was confusing because no real explosion of claims was apparent. What we found was that paid claims were rising slowly and steadily, by about inflation but that incurred claims were exploding not because of payments but because of huge jumps in insurer reserves for claims, the amounts they estimated they would pay out in the future. The jumps were particularly sharp for Incurred But Not Reported or IBNR reserves that insurers put up to guess what they might pay out in the future on claims they don't even know about yet. President Ford refused to back national med mal tort reform under these questionable circumstances.

And he was proven right. In future hard markets in the mid 1980s and in the early to mid 2000s we saw the same thing, huge jumps in reserves followed by huge rate increases but never followed by huge jumps in paid claims, which remain near inflation trends. Soft markets saw stable to dropping med mal rates and releases to surplus of the excessive reserves built up unnecessarily during the hard market years. The periodic crises in med mal are caused by insurer economics and manipulation of reserves. Hard market high reserves show false bad profit numbers justifying rate increases and inflaming the doctors while paid claims remain stable.

I have been working on the NY med mal issue over many years and produced reports in 2007 and earlier this year. Let's take a look at slide 2, "New York Med Mal History"

This is a chart of NY med mal data from my MARCH 2011 REPORT

- The earliest data available in 1975, the data I negotiated with the NAIC at the time. Using data from1975 to 2008, inflation-adjusted claims payouts per doctor in NYS, the lower red line, rose from 1975 to 1988 ($4,500 to $15,200) but fell since (to $10,000 in 2008). So. Med mal paid claims in NY did increase at a rate over inflation from 1975 to 1989 but has been flat to down since.
- Inflation-adjusted premiums, the top blue line, rose, in 2008 dollars, from $16,500 in 1975 to a whopping $34,200 in 1988 at the end of the mid-1980s hard market, but fell back to $16,700 by 2008, unchanged in real terms over more than three decades.
- Loss ratios, the percentage of premium in claims, including reserves, were in the 60%-70% range from 2001 to 2008, profitable for the carriers especially for a long-tailed line like malpractice. Later data after 2008 should be gathered and reviewed. Fragmentary evidence indicates continued

improvement in MM insurer profitability in NY and nationally since 2008 as excess reserves are released.

POINTS FROM MY DECEMBER 2007 REPORT

- NY State took $691 million from MMIA reserves between 1992 and 1997. (The state dissolved MMIA in 2001, and replaced it with MMIP, the pool in which all med mal insurers participate) As far as I know, the state has still not refunded this money.
- MMIP deficit was said to be $1.5 to $2 billion in 2007 but we said this was calculated by use of unknown data and assumptions (explain IBNR) and we questioned if the reserves were excessive. We understand that today this deficit is in the $470 million range, but data on how this figure was calculated remains unavailable. All we are sure of is the unreliability of the figures over time.
- My inflation-adjusted data showed per doctor premiums and losses in a fashion similar to the 2011 report we discussed a couple of minutes ago.
- We recommended in 2007 that there was no need for quick action as, even if the deficit was real, because of the large cash available in reserves - $8 billion. We were right. A rate freeze for 2 years, only two small increases of 5% since and the situation has eased and stabilized)
- The reserve levels and their rapid build-up in the early 2000s raised questions. The reserves seemed to be a classic end-of-cycle hard-market build-up.
- In this 2007 report, I said "an important question that remains unanswered is, have the reserves been made excessively strong in recent years, as typically happens at the end of the reserve build-up cycle, and will we see a decline in reserves in the near future?" I took a look at MLMIC's annual reports in the last few days and note that since I raised the issue of possible excessive reserving in 2007, the company has released over three-quarter of a billion dollars of loss and LAE reserves, a whopping $788 million to be precise. So it appears that we were correct that reserves were hyped up in 2007.
- Paid losses ("severity trend") seems to be growing in NY at a rate less than medical inflation, but data are scanty on this. We do know that in recent years loss costs have not matched inflation so real costs are dropping for insurers. I understand that Mr. Serio will release the PRI data on this , which should help us understand these figures more clearly.
- Frequency is down in NY and around the nation. I also said at the time, "To analyze overall trends in frequency, severity and pure premiums properly, we must have data from all carriers showing paid losses by quarter, number of doctors insured by quarter and number of paid claims by quarter." We still do not have these critically important data.

OTHER POINTS

- Observations about MMIP:
    1. As of year-end 2010 MMIP insured 254 physicians as well as 184 others, including dentists and nurses. The physicians' insured by the pool represented only five-tenths of one percent of the 47,981 practicing physicians in the State per the NY Academy of Medicine. This means private market insurance for physicians is available and affordable. There are also 3,602 excess layer insureds, mostly there due to MLMIC's decision to stop writing excess policies.
    2. The "problem" with the deficit is wildly overstated. The $1½ to $2 billion deficit of 2007 has collapsed to under $1/2 billion today. And even that is high since, like the Guarantee Fund, the expected payouts in the near term, not the expected payout in the infinite term, should be on the books of the carriers. Also, who knows if the reserves for MMIP are anywhere near accurate, since they are in a black box the public cannot see and analyze. If MLMIC set the reserves in MMIC the way they set them in their own books, how can we know just how inflated these reserves might be?
    3. MMIP issues no annual statement; there is almost a complete lack of data on the Pool.

- Some comparisons to the rest of the country:
    - New York has higher med mal costs than most states. For example, the per occupied bed hospital med mal loss cost was estimated by Zurich North America Insurance at $4,522 per bed in New York, less than Florida and Pennsylvania, about the same as DC, Illinois, and New Mexico but more than most other states. 50% of the cost difference is because NYS has the third highest number of physicians per 100,000 in population, at 392 per 100,000. The USA figure is 267. Thus, NY has 1½ doctors for every doctor in the nation. Doctors are attracted to states with teaching hospitals, which also causes cost increases because of their use of cutting-edge technology. There is no sign that the slightly higher MM costs in NYS chases off many, if any, doctors. Further, NY has a 30% higher inpatient day hospital utilization rate than the national average and 25% more outpatient visits. NY also has higher income, higher medical care costs and higher Medicare costs than the nation. Some studies, such as the US Agency for Healthcare Review, indicate that hospitals in NY are less safe than national safety figures. Another cause of apparent higher cost is reserves in NY are inflated compared to the nation. 2008 data from A. M. Best shows that the Incurred Losses in NY are $200 million higher than paid losses because of reserve increases, while in the rest of the nation, incurred losses are $1.1 billion less than paid losses due to releases of excess reserves from the earlier hard market. Florida, for example, has paid losses in 2008 of $361 million but incurred losses of only $171 million, almost $200 million less. Some states

have negative incurred losses due to massive reserve releases, including Idaho, Louisiana, Mississippi, Washington and West Virginia. These data and other research on 2008 data raise serious questions about whether reserves are still significantly excessive in NY compared to reserves in the rest of the country but more data, data that is unavailable to the public, is required so that needed research can be done to determine if that is as true today as it was when we thought the reserves were overstated in 2007.
    - Careful analysis of the underlying causes of higher med mal premiums in NY would be a fruitful area of research for this committee.

Take a look at the third slide --DATA NEEDS. NYS suffers from an extreme lack of data on medical malpractice.

The lack of important data on MM in NYS is extremely troubling. Where are the independent analyses of reserves? Where are the severity and frequency trend data and independent reviews of the trends? Where are any of the facts and analysis of the MMIP? Where are the closed claims studies? Where are the studies of claims geared to improve patient safety? The lack of transparency in this line of insurance in this state is a serious problem and surely results in less patient safety.

Here are just a few of the key missing data needs as shown on the slide:

- Frequency and severity trends for the whole industry and for each company, going back for at least six years.
- Reserves (including IBNR) of all med mal insurers in NYS need careful study since, as at least as of 2008, they were remarkably high and likely excessive. Public policy recommendations have been made and sometimes adopted on these outlandishly inaccurate reserves and careful analysis of reserves is critically required. Are reserves manipulated to support rate increases or to hide large profits or, worse, to push for legislation? The study should include a review of Statutory Page 14s and full Schedule Ps, which must be made available from all insurers, including from MMIP (which, astonishingly, files no Annual Statement).
- Analysis of the real financial status of MMIP, with full disclosure of the statistics. An Annual Statement should be required, going back to 2005.
- A full closed claims study for each company should be undertaken for at least a ten-year period to determine: (1) the major causes of NY MM claims, (2) the trends in such causal factors which underlie the trends in loss costs, (3) ways to help physicians practice safer medicine (see Texas http://www.tmlt.org/newscenter/closedclaimstudies.html and http://www.facs.org/fellows_info/bulletin/2007/griffen0107.pdf for examples of such research) Other important uses of closed claims data can be incorporated in the design of the data collection effort.

- Rate comparisons between areas in NYS and areas with similar demographics in contiguous states.
- On line interactive rate comparisons should be developed to help physicians find the best deal for them. (This research might also be used to help other shoppers (e.g., auto insurance applicants) gain more transparency.
- All recent rate filings (e.g., from 2005) should be made available for study, analysis and critiquing by doctor groups and other interested parties.