Medical Liability MONITOR
Publishing news about malpractice issues since 1975

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Rate Survey Issue

METHODOLOGY

Rate Report Presents State-by-State View of Changing Market

In this issue we bring you our 18th-annual rate survey. This survey provides a continuing overview of changing rates for physicians' liability insurance. It is a snapshot in time, reporting rates effective July 1, 2008.

It is a picture we paint state by state because where physicians practice largely determines the premiums they pay. This is because insurers base their rates on the aggregate claims experience in a particular geographic area.

Because state insurance departments may regulate rates, state tort reforms can affect the cost and patient compensation funds may influence the total premium, it is impossible to project a common national picture.

Each year we survey major writers of liability insurance for physicians. We ask for manual rates for specific mature claims-made specialties with limits of $1 million/$3 million, by far the most common limits. These are the rates reported unless otherwise noted.

We report on three specialties to reflect the wide range of rates charged: internal medicine, general surgery and obstetrics/gynecology.

With the exception of Medical Protective, all rates shown were volunteered by their respective companies. Medical Protective chose not to participate in the Rate Survey; the company's rates published herein were obtained through independent research and believed to be accurate.

>continued on page 2

Soft... with a Hard, Crunchy Center

RATE SURVEY SHOWS MORE DECLINES IN 2008, BUT MOSTLY DISCIPLINED PRICING (SO FAR)

by Chad C. Karls, FCAS, MAAA
Rate Survey Editor

The results of the 2008 MEDICAL LIABILITY MONITOR Annual Rate Survey should surprise no one who has followed the medical professional liability market lately; the downward trend of the past few years continues unabated.

The ongoing decline in reported rates may be predictable, but a closer look at how the 31 companies participating in the survey responded to some of the questions—or elected not to respond—provides a fascinating snapshot of where the market is today, as well as some tantalizing clues as to where the industry may be heading in the near future.

Interpreting attitudinal responses to a survey can be as much art as science. For example, an overwhelming majority of respondents said they would classify the current market as "soft," a word that can have several meanings, most of them quite nice, such as "pleasing to the senses" and "marked by gentleness, kindness or tenderness." But that is probably not what respondents meant. More likely they were reaching down to definition No. 20 from the *Merriam-Webster* on-line dictionary—"sluggish market conditions."

Nearly half of all respondents—45 percent—elected not to answer whether they were concerned about competitors' underwriting guidelines. At the same time, more than 35 percent said "yes" and less than 20 percent said "no." Extrapolating the ratio of "yes/no" responses to all respondents provides evidence that a solid majority—64 percent—believe the answer to be "yes"—and that a "yes" percentage as high as 80 is possible.

The responses to these two questions, taken together, suggest many respondents believe that a "soft" market is another way of saying an "irresponsible" market, at least when it comes to their competitors. Soft markets certainly can lead to irresponsible pricing on the part of some insurers, but we believe the results of the Rate Survey, in conjunction with our perception of the underlying loss cost environment, do not completely support that contention—at least not yet. On an overall basis, we believe companies are not irresponsibly priced but that rather most actions have been in step with the underlying cost dynamics—most notably the substantial improvement in claim frequency.

Many causes have been put forward to account for the reduction in the number of claims—from tort reform to the patient safety movement. We have our own ideas on this, which are discussed in more detail below, along with a cautionary note regarding prospective claim frequencies. For now, let's take a look at how filed rates appear to be behaving, based on the results of the 2008 Rate Survey.

UP AND DOWN—BUT MOSTLY DOWN

The total number of reported rate decreases in 2008 was 310, or 43 percent of the total number of reported rates. No change was reported for 362 (50 percent)

>continued on page 2

of all filed rates, and only 54 rates saw an increase—a scant 7 percent. The great majority of all increases (76 percent of them) was less than 10 percent.

Of the manual rate increases reported on the survey for this year, the magnitude of such increases ranged from less than 1 percent to nearly 40 percent. A breakdown of the rate increases into certain ranges is provided here:

- There were no reported increases exceeding 50 percent;
- Four reported increases between 25 and 49.9 percent;
- Nine reported increases between 10 and 24.9 percent;
- Forty-one reported increases between 0.1 and 9.9 percent

About half of all reported manual rates (362 of them) remained the same, slightly less than last year's 53 percent.

Almost 43 percent of all filed rates were lowered within this past year, a nearly 13 point increase in the percentage of decreasing rates from 2007, and a 40.4 point increase over the corresponding values from the 2003 Rate Survey when only 2.3 percent of rate changes were reductions.

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Specifically, for 2008 there were:

- One-hundred-and-fifty-one reported decreases between 0.1 and 9.9 percent;
- One-hundred-and-thirteen reported decreases between 10 and 19.9 percent;
- Thirty-eight reported decreases between 20 and 29.9 percent;
- Eight reported decreases of 30 percent or more;

Individual decreases ranged from the infinitesimal (.023 percent) to as high as 41 percent.

"Chart A" on page three shows the percentage of reported rate changes in the survey for every year from 2003. Note that last year there were no reported rate decreases in excess of 30 percent; this year there were eight. While perhaps not entirely actuarially sound, if one were to calculate an overall average rate change across the years by using the midpoint of the ranges (and endpoint for the two largest change categories) shown in the chart, an interesting and confirming trend emerges. After three years of significant rate increases, the most recent three years have shown a leveling and now a reduction in the overall average rate change (see Bar Graph No. 1 on page four).

An Increase in the Use of Schedule Credits Masks the Full Decline

Carriers not only reduced manual rates in 2008—they also increased their use of schedule credits as well. These adjustments lower the actual charged rates even further for individual doctors and groups. So a reported 10 percent reduction in manual rates could, in fact, be a 15 or 20 percent actual reduction when schedule credits are figured into the mix.

>*continued on page 3*

Survey Methodology Further Explained

>*continued from page 1*

The rates reported should not be interpreted as the actual premiums an individual physician pays for coverage. They do not reflect credits, debits, dividends or other factors that may reduce or increase premiums. Rates reported also do not include other underwriting factors that can increase premiums.

States without compensation funds, by far the largest group, are reported first. Patient compensation fund states are grouped at the end of the survey.

In patient compensation fund states, physicians pay surcharges ranging from a modest percentage to more than the base premium. Also, limits of coverage can differ in these states, which is noted.

When we contact survey participants, we ask them to provide data on all the states in which they actively market to physicians. We only report rates for companies that maintain filed and approved rates for each state in which they sell physicians malpractice insurance. We try to capture the leading, active writers in each state, but every writer may not be included.

In comparing this year's report with previous reports, it will be evident that the market is always changing. Many companies, formerly included, no longer sell physicians' malpractice insurance in certain states, do not currently entertain new business, have withdrawn from this line of insurance or no longer exist. The companies shown were available for business July 1, 2008.

We estimate that this survey represents companies that comprise 65 to 75 percent of the market, and as such, is the most comprehensive report on medical liability rates anywhere. The remainder of the market is made up of companies with very small market shares, risk purchasing groups, risk retention groups and excess and nonadmitted carriers.

The expanded rate report could not have been completed without the cooperation of the many people who work in the companies surveyed. Their cooperation is invaluable in providing this information to all who have an interest in this field.

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Call 312-944-7900 or email editor@mlmonitor.com for special bulk pricing. A complete set of all past rate surveys is also available.

CHART A

PERCENTAGE OF RATE CHANGES IN SURVEY BY RANGE

	YEAR OF SURVEY					
Range	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
>+100%	1.2	2.2%	0.0%	0.0%	0.6%	0.0%
+70.0 to +99%	1.1	4.1	0.6	0.0	0.6	0.0
+50.0 to +69.9%	3.7	3.7	0.7	0.0	0.4	0.0
+25.0 to +49.9%	26.8	14.8	6.5	2.3	0.5	0.6
+10.0 to +24.9%	31.4	34.9	28.5	5.6	5.9	1.2
+0.1 to +9.9%	13.1	22.5	29.3	22.6	8.2	5.6
0.0%	20.3	13.2	24.0	46.6	53.1	49.9
-9.9% to -0.1%	2.3	4.7	8.4	15.1	21.0	20.8
-19.9 to -10.0%	0.0	0.0	2.1	5.1	6.5	15.6
-29.9 to -20.0%	0.0	0.0	0.0	1.3	2.3	5.2
<-30.0	0.0	0.0	0.0	1.4	0.0	1.1

It is interesting to note that not one respondent to the survey indicated that the use of schedule credits for 2008 was being restricted, while nearly one-third issued new credits this year. Even more telling, 35 percent of respondents stated they do not adjust their manual rates to account for schedule credits (or at least the respondent was not aware of this adjustment), while another 10 percent discretely refused to answer the question. Nearly one-half of all respondents, then, could have decreased their collected rate levels by more than what the reported manual rate changes indicate.

THE LOWEST AND THE HIGHEST ALL SEE DOUBLE-DIGIT RATE DECLINES

As in 2007, the upper Midwest—Minnesota, Wisconsin and South Dakota—enjoyed the lowest rates. Even this already low-rate group reported sizable rate declines. Midwest Medical Insurance Company dropped their rates by 13 percent in South Dakota and nearly 15 percent in Wisconsin. It kept its rates unchanged for Minnesota, a strategy also employed by PIC Wisconsin in all three of these states.

Florida kept its near monopoly on the highest reported rates, but competition for the top rates came from individual, plaintiff-friendly counties in Michigan, Illinois and New York.

Among this group, only Physicians Reciprocal Insurers kept their OB/Gyn rates unchanged—and only in Nassau and Suffolk Counties, New York. For all others, reported rate reductions ranged from approximately 1 percent to 22 percent in all specialties surveyed, with an average reported rate reduction of 12.5 percent for the Florida counties (Miami, Dade and Broward), and an average reported rate reduction of 12 percent overall, when the Michigan (Wayne County) and Illinois (Cook, Madison and St. Claire counties) rate reductions are factored in.

2008 UNDERWRITING ENVIRONMENT: SOFT, NOT IRRESPONSIBLE

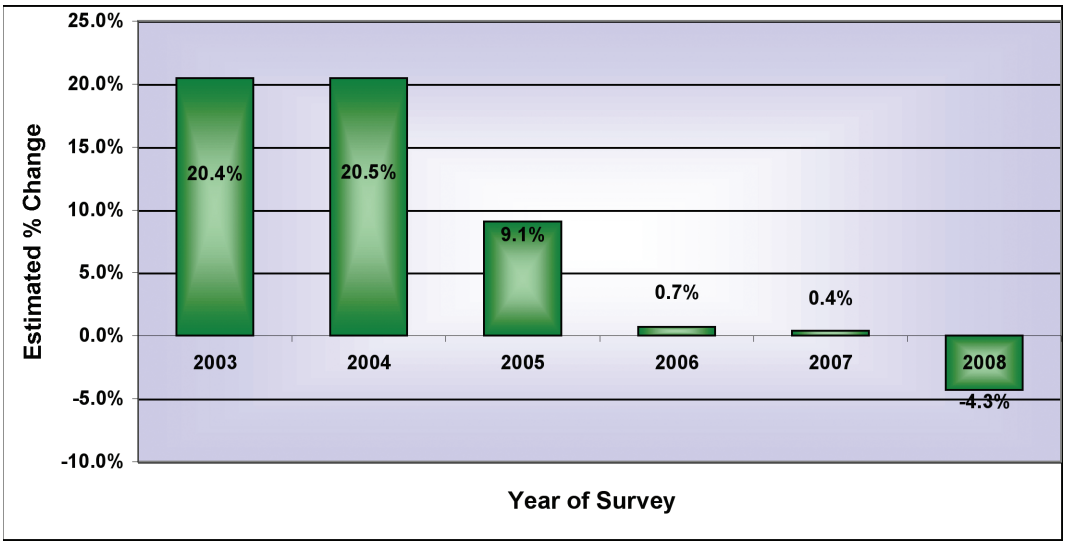
So rates are definitely going down, and if rate reductions are one's definition of a "soft" market, then this market is definitely soft. Certainly most underwriters can (and oftentimes do) relay examples of seemingly irresponsible behavior from one of their competitors on a particular account. While we believe these situations do occur, we don't believe that those examples fairly represent the overall market. It is understandable that the aggressive and perhaps even seemingly irresponsible actions of a competitor are more likely to be remembered and thus make for a more colorful and interesting discussion with colleagues than the more common and uneventful successful renewals. Thus, while it is tempting to extrapolate these more colorful renewals to the entire market, as we noted earlier, we do not believe the softening market, defined as lower rates, have, as yet, inspired widespread irresponsible levels of pricing in the market. The primary reasons for this view—that is, the items that make up the hard, crunchy center—are as follows:

• **Rates increased dramatically in the years prior to 2006.** In 2004 10 percent of all reported rate increases were in the range of 50 percent to more than 100 percent. During this most recent crisis, rates increased dramatically as demonstrated by any metric one were to use. Therefore, a leveling off and then reduction of rates needs to be considered in the context of the point from which they have leveled off and are beginning to fall. It only takes but a short conversation with any healthcare provider to be reminded of this perspective.

• Marked improvement in reported claim frequencies. Many people have noted the decrease in claim frequencies that began occurring a few years ago. While the timing and magnitude of the reductions varied by region and, perhaps, by reason, having observed this phenomenon across many data sets and discussed it with many industry experts, it has become an established fact. What's not been established is "why?"

BAR GRAPH NO. 1

OVERALL AVERAGE RATE CHANGE BY YEAR



POSSIBLE REASONS FOR FEWER CLAIMS

There has been much debate in the medical professional liability community about possible reasons for the reduction in claims frequency. Hard evidence supporting one factor or another as the sole cause is scant and unconvincing. We believe four of the most often cited reasons are working together to fuel the drop-off in claims.

1. Fewer medical provider mistakes and better risk management due to the patient safety movement. For a number of years, there has been a steadily growing movement in the healthcare delivery community to minimize harmful mistakes and reduce the number of patient deaths as well as injuries due to infection and other preventable causes.

A number of events and institutions have helped to spur this movement along recently, including the Institute for Healthcare Improvement's 100,000 (and now 5,000,000) Lives Campaign, the continued expansion of the Leapfrog Group's initiatives and participating hospitals (now more than 1,300) as well as Congress' passage of the Patient Safety and Quality Improvement Act of 2005. Additionally, Medicare has also placed additional pressure in this direction by changing its reimbursement structure so that it will no longer pay for "never events"; these changes to the old diagnosis-related group (DRG) system are the most significant since 1983. The increased focus on hospital-acquired infections and wrong-side surgeries, among other mistakes, has put the responsibility for payment on the healthcare provider. With the biggest healthcare payer leading the way, healthcare providers have even greater motivation to minimize mistakes and private payors now have precedent to implement similar structures that reward quality.

To the extent the reduction in claim frequency is a result of these efforts, everyone wins. Given the size and complexity of the nation's healthcare delivery system, it does not seem likely though that these initiatives can be the sole reason for the somewhat abrupt drop in claim frequencies seen in the market.

2. Tort reform. Many believe that tort reform is one of the main drivers for the reduced frequencies; in certain states that have enacted significant reforms, the data would seem to support this contention. Tort reform legislation varies widely from state to state, making it unlikely that this item is the sole reason for the reduced claim frequency on a national scale.

Companies doing business in jurisdictions with recently enacted tort reforms are faced with another issue to manage—namely trying to quantify the impact of the new legislation as well as assessing the prospects of the reform's long term survival in light of future (and in some cases current) judicial challenges that will surely be forthcoming from the plaintiff's bar.

According to the American Tort Reform Association (ATRA), 23 states have in place some time of limitation on the amount of noneconomic damages that can be awarded. Over time a number of states have had its cap on noneconomic damages found unconstitutional. Illinois, which had its 1995 $500,000 cap on all civil actions ruled unconstitutional in 1997, tried again in 2005 with a $500,000 cap per physician and $1 million cap per hospital on medical liability cases only. In December of last year, a Cook County Circuit Court Judge ruled the cap violates the separation of powers between the Legislature and the Judiciary. The case will now go to the Illinois Supreme Court, which has previously twice struck down caps as being unconstitutional.

Texas tort reform advocates bypassed the courts in 2003, taking their case to the voters, who approved a state constitutional amendment that allows state legislators to impose a cap on noneconomic medical liability damages. The state's legislature followed through with a $250,000 cap per physician, and Texas has since joined California as a poster child for tort reform proponents. Advocates note that there's been a sizable drop in medical professional liability rates since the cap was imposed and that medical license applications in Texas have soared since the cap on noneconomic damages has been put in place.

But the referendum-driven constitutional amendment tactic is no guarantee that the cap will remain in force nor as effective. For one thing, the amendment only gives the legislature the right to impose a cap—it does not specify the

amount. Today the cap is $250,000, but at any time lawmakers could increase it to a level that would render it moot.

3. Plaintiffs' bar has become more selective. Just as the cost to defend a medical professional liability claim has been increasing significantly in recent years, it follows that the cost of preparing a case for trial from the plaintiff's side has also increased dramatically. These increasing costs to prepare a case, coupled with the additional caps on damages cited above, have placed additional economic pressure on the plaintiff's bar when deciding whether or not to pursue a particular claim. The end result is that it seems likely the plaintiff's bar may be taking fewer marginal cases than in the past, thus contributing to the reduction in claims frequency.

One potential side effect of this item is that if, in fact, the plaintiff's bar is being more selective in the type of cases it brings, there may be a greater tendency for these claims to be ultimately resolved in favor of the plaintiff, for perhaps a greater amount. The evidence to date on the validity of this side effect is mixed.

4. Medical professional liability crisis was successfully characterized in the media (and in the jury box) as an "access-to-care" issue. When the medical professional liability rates were climbing higher and higher in the early years of this century, the healthcare delivery community responded with public relations campaigns that framed the issue as an "access-to-care" crisis. If medical malpractice rates continued to climb as high and as fast as they had been, they argued, medical practitioners would not be able to afford to stay in business and the public will suffer from a sharp reduction in the availability of quality healthcare. Statistics indicating physicians were leaving states with high insurance costs buttressed their arguments. The national and local media paid attention and it was not uncommon for medical liability stories to be presented on television and in the print media, ultimately raising the general public's awareness of the issue. It's possible that this increased awareness among the public of the potential ramifications from runaway medical liability costs made its way into the jury box, influencing verdicts and ultimately settlements.

A soft market—yes. But so far, not a widespread undisciplined one. Whether that continues or not will depend, for the most part, on how the industry handles the increasing competitive pressures as well as wherever claim cost trends take us in the future.

Outcomes for the Year Ahead

Recent events on Wall Street and in Washington should provide a stark reminder to everyone that the future is unpredictable and many unintended consequences can come from the decisions people and firms make in difficult market conditions. Thus, while we believe there are mitigating circumstances to the rate pressures facing companies in this softening environment, vigilance is needed to ensure that the reductions in rates do not ultimately translate to reductions in surplus. So, while the future may, in fact, be unpredictable in some ways, we nonetheless offer up the following thoughts as the market heads into 2009:

- There will be continued pressure on rates throughout the next twelve months as the most recent several years of earnings in the market will act to buoy the confidence of the market participants and lend more momentum to competition from new entrants.
- There will be a deterioration of the financial results across the board compared with the more recent years. Profits will be down, but when one considers that 2007 was the industry's best year ever, a reduction in earnings does not imply that the market will experience losses in the near term.
- The most serious destabilizing pressures will be felt by the newer startup companies, particularly those that began operations during the last two or three years. These niche companies may become targets for mergers and acquisitions by the larger, more traditional providers as the revenue forecasts made at the time of their inception prove to be optimistic with the rate pressures.
- So far, insurers have largely retained underwriting discipline in an increasingly competitive market. Further erosion could undermine that.
- One determining factor will be the outcome of current and forthcoming tort reform challenges across the country. If history is any guide, we can expect the tort reform pendulum to be swinging back towards the anti-tort-reform side of the debate.
- There appear to be some indications that the industry's claim frequency may have bottomed out a year ago with the early indications for the current year showing some slippage in this important metric. While the data is still immature and developing, it may be that the ultimate claim frequency in the current year will be higher than the previous year or two. That is not to say that the current claim frequency will revert back to the values experienced in the early part of this decade, though it certainly deserves the industry's attention.

A "soft" market—yes. But so far, not a widespread undisciplined one. Whether that continues or not will depend, for the most part, on how the industry handles the increasing competitive pressures as well as wherever claim cost trends take us in the future.

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