



## AMERICAN ACADEMY *of* ACTUARIES

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The Honorable Nancy Pelosi  
Speaker, U.S. House of Representatives  
H-232 U.S. Capitol  
Washington, DC 20515

The Honorable Harry Reid  
Majority Leader, U.S. Senate  
522 Hart Senate Office Building  
Washington, DC 20510

The Honorable John Boehner  
Minority Leader, U.S. House of Representatives  
Longworth House Office Building, 1011  
Washington, DC 20515

The Honorable Mitch McConnell  
Minority Leader, U.S. Senate  
Russell Senate Office Building, SR-361A  
Washington, DC 20510

January 21, 2010

Dear Sirs and Madam:

As you prepare to reconcile the differences between H.R. 3962, “The Affordable Health Care for America Act,” and Senate bill H.R. 3950, “The Patient Protection and Affordable Care Act,” the American Academy of Actuaries’<sup>1</sup> Medical Professional Liability Subcommittee appreciates the opportunity to share its perspective on this legislative endeavor and its possible effects on medical professional liability insurance (referred to as “medical malpractice insurance” within H.R. 3962).

On behalf of the Academy’s Subcommittee, I respectfully request that you reconsider the inclusion of this provision of the House bill (Title II, Section 262) for a number of reasons enumerated in this letter, including the potential for it to have the opposite effect of its intent.

Last year, a member of the Academy testified before the House Judiciary Subcommittee on Courts and Competition Policy concerning H.R. 3596, “The Health Insurance Industry Antitrust Enforcement Act of 2009,” an earlier version of Section 262 of H.R. 3962. This letter reinforces the comments made in that testimony and specifically includes:

1. Background information on property/casualty insurance generally and medical professional liability coverage in particular;
2. Issues relating to data collection, aggregation, and analysis of medical professional liability data;
3. Select language from H.R. 3962 and its possible misinterpretation; and
4. Potential consequences of the proposed legislation.

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<sup>1</sup> The American Academy of Actuaries (“Academy”) is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

## **Background Information & Data Aggregation Issues**

In general, as a condition of being licensed, property/casualty insurance companies are required to designate an entity to which they will report data. Probably the most well-known of these entities is Insurance Services Office (ISO). ISO is approved by states to operate in this capacity and to analyze data and make results available to participants and others, subject to state regulations establishing rules as to what types of analyses are permitted.

These analyses of aggregated data serve several purposes; those purposes align with the original intent of the McCarran-Ferguson Act and assist state regulators charged with overseeing the pricing of insurance coverage and solvency of insurers. A few of these purposes are:

1. To provide credible data upon which to base loss estimates and premium rates.
2. To enhance competition by providing access to industry information to enable existing companies to offer products in new markets or for different types of exposure by reducing the uncertainty associated with determining loss estimates and premium rates.
3. To further support competition by providing data to newly-formed companies or self-insurers looking to begin covering medical professional liability exposure.
4. To guide companies, self-insurers, and regulators in reducing the likelihood of insolvencies, a long-term and recent concern. Through the review of industry data, companies, self-insurers, and regulators are better able to evaluate whether too little is being charged or not enough is being set aside in reserves for a given exposure situation.

These data aggregations serve the purposes outlined above, particularly for medical professional liability, which is a particularly statistically-challenging risk for companies and self-insurers.

For this coverage, any single company's own data, even for relatively large companies, is often not sufficiently credible to determine basic loss costs in multiple markets or to determine reasonable charges, for instance, on \$10 million or \$20 million limits of coverage.

Limitations relating to collecting and analyzing aggregated data are more problematic for medical professional liability than most other lines of insurance because, in comparison to other lines, medical professional liability is a low-frequency, high-severity, long-tailed coverage. ("Long-tailed" means that, on average, there is an extended period of time between the occurrence of an event, the report of a claim related to the event, and the ultimate resolution of the claim.) From a statistical standpoint, this makes the estimation of losses and premium rates more uncertain than for other lines of insurance, such as most types of health insurance. The low-frequency, high-severity, long-tailed nature of medical professional liability coverage contributes to the volatility in its coverage rates.

## **Language of the Bill**

H.R. 3962 includes exemptions, enumerated in paragraph 2, for limited use of historical loss data, performance of qualified actuarial services, and information-gathering and rate-setting. However, possible interpretations of the bill's language raise potential concerns.

In particular, it is possible that the language could limit or preclude the collection, aggregation, and analysis of data across companies. The bill does not specify what loss data may be collected. Additionally, it is unclear about what actuarial activities are allowable. Currently, such analyses are permitted in accordance with the provisions of the McCarran-Ferguson Act and with the oversight of state regulators. Results of these analyses can be provided to companies that participate in the data collection or, perhaps, to other entities that may be given the opportunity to purchase the information.

Additionally, the original text of H.R. 3962 would have explicitly permitted “information gathering and rate setting activities of a State insurance commission or other State regulatory entity with authority to set insurance rates.” The final version of H.R. 3962 omits this language. As stated above, if such limitations on data-gathering apply, it will result in a reduced level of reliability of determinations, with less data available to state regulators charged with evaluating rates.

### **Consequences of the Bill**

It is our understanding that one stated purpose of the proposed legislation is to reduce medical professional liability premiums. In our view, this bill will not accomplish that purpose. In fact, it is more likely to have the opposite effect, for reasons we now outline.

There are a number of possible consequences of not having credible information to assist in making loss cost determinations and new restrictions on who can make and how those determinations can be made. Insurers and self-insurers, in the interest of preserving their viability, would be more cautious, if not unwilling, to assume exposure given the risk of the coverage. These industry analyses facilitate having information available for new small companies, self-insurers, and large, established entities looking to cover this exposure in new states.

Thus, the end result of the enactment of H.R. 3962, relative to medical professional liability insurance, is likely to be reduced availability with fewer willing insurers, less vigorous competition among those that do write the coverage, and higher costs to the consumer. This outcome is particularly likely if the “information gathering and rate setting” language identified above is not restored to the final legislation.

Additionally, medical professional liability losses and rates have been flat or declining over the last two to three years without this proposed change. Attached is an exhibit containing a graph obtained from the *Medical Liability Monitor*, which summarizes the results of their annual survey looking at the last three years’ experience. The graph shows the percentage change in filed rates implemented by physician insurers and that, in the last three years, approximately 30% of the observations reflect rate reductions. These trends occurred following the implementation of, and debate about, tort reforms in many states as well as the growing impact of risk management and patient safety initiatives.

## Conclusion

In summary,

1. The broad intent of the bill is already being realized at the state level;
2. Clarification of other implications (e.g., on data collection and analysis) of the bill would help affected parties better understand the impact of the change;
3. Collection, aggregation, and analyses of data is an important element of the current environment; it supports better decisions, promotes competition, and aids in protecting solvency, particularly for new and/or smaller competitors;
4. Consumers benefit from a more competitive marketplace given the above;
5. Implementation of this proposal will not assure lower medical professional liability premiums; it may, in fact, increase them; and,
6. Medical professional liability rates have been declining without this change, coincidental with the timing of tort reforms and the growing impact of risk management and patient safety initiatives.

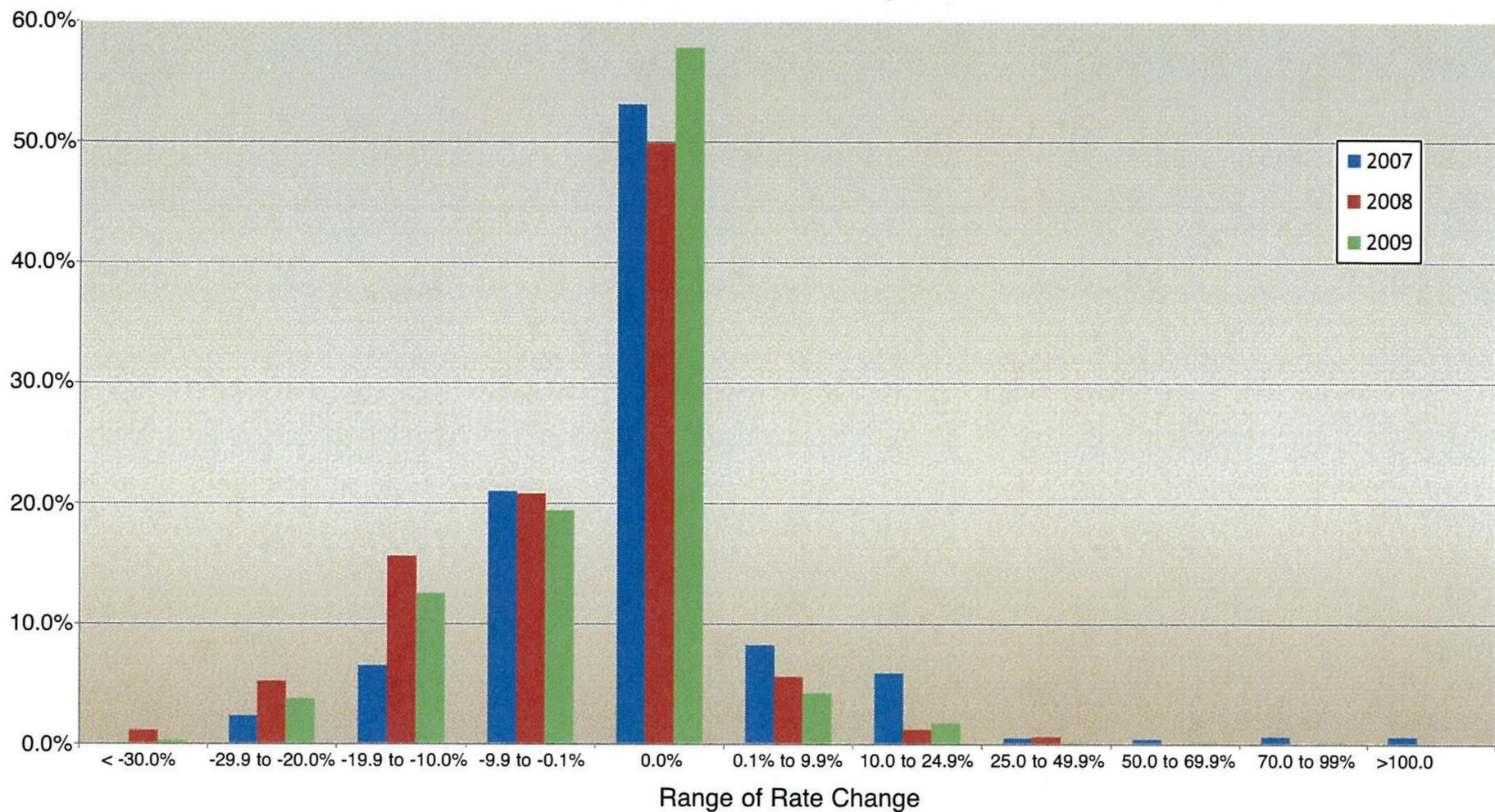
We hope that you will find these comments helpful. The Subcommittee would be pleased to assist in the reconciliation process in any way that we can. If you have any questions, please feel free to contact Lauren Pachman, the Academy's casualty policy analyst, at [pachman@actuary.org](mailto:pachman@actuary.org). Again, thank you for this opportunity to comment on the proposed legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Bingham". The signature is fluid and cursive, with a long horizontal stroke at the end.

Kevin Bingham, ACAS, MAAA  
Chair, Medical Professional Liability Subcommittee  
American Academy of Actuaries

Distribution of Rate Changes in MLM Survey by Range  
Survey Years 2007 through 2009



## METHODOLOGY

In this issue of the MEDICAL LIABILITY MONITOR, we bring you our 19th 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, 2009.

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 has historically opted not to participate in the Rate Survey; the company's rates published herein were obtained through independent research and believed to be accurate.

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, 2009.

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 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.