Testimony of

Mr. Lawrence Smarr

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INTRODUCTION

Chairman Hatch, Chairman Gregg, members of the Judiciary and H.E.L.P. Committees, I am Lawrence E. Smarr, President of the Physician Insurers Association of America (PIAA). Thank you for allowing me the opportunity to appear before you today and speak about the impact of medical litigation on patient access to health care.

As we all know, professional liability insurance premiums for doctors and hospitals are rapidly rising in many states to levels where they cannot afford to pay them. These increased premiums are caused by the ever-increasing size of medical liability insurance payments and awards. The unavoidable consequence is that physicians are moving away from crisis states, reducing the scope of their practices, or leaving the practice of medicine altogether. Likewise, hospitals are being forced to close facilities and curtail high-risk services because they can no longer afford to insure them.

DOCTORS INSURING DOCTORS

The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists, and other health care providers. Collectively, our 43 domestic insurance company members insure over 300,000 doctors and 1,200 hospitals in the United States and our nine international members insure over 400,000 health care providers in other countries around the world. The PIAA member insurance companies can also be characterized as health care professionals caring for the professional liability risks of their colleagues - doctors insuring doctors, hospitals insuring hospitals. We believe that the physician owned/operated company members of the PIAA insure over 60% of America's doctors. Unlike the multi-line commercial carriers, medical liability insurance is all that the PIAA companies principally do, and they are here in the market to stay.

The PIAA was formed 26 years ago at a time when commercial insurance carriers were experiencing unanticipated losses and exited the market, leaving doctors, hospitals and other health care professionals no choice other than to form their own insurance companies. A quarter century has passed, and I am proud to say that the insurers who comprise the PIAA have become the driving force in the market, providing stability and availability for those they insure.

When the PIAA and many of its member companies were formed in the 1970's, we faced a professional liability market not unlike that which we are experiencing today. At that time, insurers, all of which were general commercial carriers, were experiencing rapidly increasing losses, which caused them to consider their continuance in the market. Many of the major carriers did indeed exit the market, leaving a void that was filled by state and county medical and hospital associations across the country forming their own carriers. Again we see the commercial

carriers, such as St. Paul, exiting the market. But, this time, the provider owned carriers are in place and are indeed providing access to insurance and stability to the market.

Unfortunately, the recent exodus from and transformation of the market is of such a magnitude that the carriers remaining do not have the underwriting capacity to take all comers. Facing ever-escalating losses of their own, many of the carriers remaining in the market are forced to tighten their underwriting standards and revise their business plans with regard to their nature and scope of operations. This includes the withdrawal from recently expanded markets, which adds to the access to insurance problem caused by carriers exiting altogether.

My goal here today is to discuss what the PIAA sees as the underlying causes of the current medical liability crisis. I want to stress that I believe that this situation should be characterized as a medical liability crisis, and not a medical liability insurance crisis. The PIAA companies covering the majority of the market are in sound financial condition. The crisis we face today is a crisis of affordability and availability of insurance for health care providers, and more importantly, the resulting growing crisis of access to the health care system for patients across the country.

INSURANCE INDUSTRY UNDERWRITING PERFORMANCE

Medical liability insurance is called a long-tail line of insurance. That is because it takes on average two years from the time a medical liability incident occurs until a resulting claim is reported to the insurer, and another two and one-half years until the average claim is closed. This provides great uncertainty in the rate making process, as insurers are forced to estimate the cost of claims which may ultimately be paid as much as 10 years after the insurance policy is issued. By comparison, claims in short-tail lines of insurance, such as auto insurance, are paid days or weeks after an incident.

Over the past three years medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. According to A.M. Best (Best), the leading insurance industry rating agency, the medical liability insurance industry incurred $1.53 in losses and expenses for every dollar of premium they collected in 2001. While data for 2002 will not be available until the middle of this year, Best has forecast that the industry will incur $1.41 in losses and expenses in 2002, and $1.34 in 2003. The impact of insurer rate increases accounts for the improvement in this statistic. However, Best also calculates that the industry can only incur $1.14 ½ in losses and expenses in order to operate on a break-even basis. This implies that future rate increases can be expected as the carriers move toward profitable operations.

The physician owned/operated carriers that I represent insure a substantial portion of the market (over 60%). Each year, an independent actuarial firm (Tillinghast Towers-Perrin) provides the PIAA with a detailed analysis of annual statement data filed by our members with the National Association of Insurance Commissioners (NAIC). This analysis is very revealing with regard to the individual components of insurers financial performance.

Exhibit 1 below details the operating experience of 32 physician owned/operated insurance companies included in the analysis. A widely relied upon insurance performance parameter is the

combined ratio, which is computed by dividing the losses and expenses incurred by insurers by the premiums they earn to offset these costs. For these companies, this statistic has been deteriorating (getting larger) since 1997, with major increases being experienced in 2000 and 2001.

EXHIBIT 1

For calendar year 2001, the combined ratio (including dividends paid) was 141, meaning that total losses and dividends paid were 41% more than the premiums collected. Even when considering investment income, net income for the year was a negative ten percent. This follows a meager 4 percent net income in 2000. This average experience is indicative of the problems being experienced by insurers in general, and demonstrates the carriers' needs to raise rates to counter increasing losses. All of the basic components of the combined ratio calculation (loss and loss adjustment expense, underwriting expense) have risen as a percentage of premium for all years shown. The only declining component has been dividends paid to policyholders.

To compare this group of PIAA companies with the industry, Exhibit 2 is taken from the 2002 edition of Best's Aggregates and Averages. This shows that medical malpractice is the least profitable property and casualty line of insurance in 2001, following reinsurance, which has been greatly impacted by the World Trade Center losses. The adjusted combined ratio for the entire industry is 153, as compared to 141 for the PIAA carriers represented on Exhibit 1.

EXHIBIT 2

THE ROLE OF INVESTMENT INCOME

Investment income plays a major role for medical liability insurers. Because medical liability insurance is a "long tail" line of insurance, insurers are able to invest the premiums they collect for substantial periods of time, and use the resulting investment income to offset premium needs. As can be seen on Exhibit 3, investment income has represented a substantial percentage of premium, and has played a major role in determining insurer financial performance. However, investment income as a percentage of premium has been declining in recent years primarily due to historic lows in market interest rates.

EXHIBIT 3

Contrary to the unfounded allegations of those who oppose effective tort reforms, medical liability insurers are primarily invested in high grade bonds and have not lost large amounts in the stock market. As can be seen in Exhibit 4, the carriers in the PIAA survey have been approximately 80% invested in bonds over the past seven years.

EXHIBIT 4

As shown on Exhibit 5, stocks have averaged only about 11% of cash and invested assets, thus precluding major losses due to swings in the stock market. Unlike stocks, high grade bonds are carried at amortized value on insurer's financial statements, with changes in market value having no effect on asset valuation unless the underlying securities must be sold.

EXHIBIT 5

The experience of the PIAA carriers is confirmed on an industry-wide basis through data obtained from the NAIC by Brown Brothers Harriman, a leading investment and asset management firm. Brown Brothers reports that "Over the last five years, the amount medical malpractice companies has invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%." As Exhibit 6 shows, medical liability insurers invested significantly less in equities than did all property casualty insurers.

EXHIBIT 6

Source: Brown Brothers Harriman & Co., Insurance Industry Asset Allocation Study using NAIC data

Brown Brothers states that the equity investments of medical liability companies "...had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

The Brown Brothers report further states:

Since medical malpractice companies did not have an unusual amount invested in equities and what they did was invested in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.

While insurer interest income has declined due to falling market interest rates, when interest rates decline, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown in Exhibit 7 below. Thus, the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

EXHIBIT 7

Source: A.M. Best Aggregates & Averages, 1997 through 2002 Editions,
(Predominantly Medical Malpractice Insurers).

THE INSURANCE CYCLE

Opponents of effective tort reform claim that insurance premiums in constant dollars increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the industry's investment performance. The researchers at Brown Brothers also tested this theory, and found no correlation between changes in generally accepted economic parameters (Gross Domestic Product (GDP) and 5-year treasury bond rates) with direct medical liability premiums written. In fact, Brown Brothers conducted 64 different regression analyses between the economy, investment yield, and premiums, and found no meaningful relationship. The report produced by Brown Brothers states:

Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.

INSURER SOLVENCY

A key measure of financial health is the ratio of insurance loss and loss adjustment expense (amounts spent to handle claims) reserve to surplus. This ratio has deteriorated (risen) for the PIAA carriers since 1999 to a point where it is approximately two times the level of surplus, as shown on Exhibit 8 below.

EXHIBIT 8

The relationship between reserves (amounts set aside to pay claims) and surplus is important, as it is a measure of the insurer's ability to contribute additional amounts to pay claims in the event that original estimates prove to be deficient. At the current approximately two-to-one ratio, these carriers in aggregate are still in sound financial shape. However, any further deterioration in surplus due to underwriting losses will cause a deterioration in this important benchmark ratio indicating an impairment in financial condition. Under current market conditions, characterized by increasing losses and declining investment interest income, the only way to increase surplus is through rate increases.

Net premiums written as compared to surplus is another key ratio considered by regulators and insurance rating agencies, such as A.M. Best. This statistic for the companies in the PIAA survey has also been deteriorating (rising) since 1999, showing a 50% increase in the two years ending in 2001. The premium-to-surplus ratio is a measure of the insurer's ability to write new business. In general, a ratio of one-to-one is considered to be the threshold beyond which an insurer has over-extended its capital available to support its underwritings.

As can be seen on Exhibit 9, this statistic has also deteriorated, and the carriers in aggregate are approaching one-to-one. As the carriers individually approach this benchmark, they will begin to decline new risks, causing further availability problems for insureds. Rate increases the carriers are taking also have an impact on this important ratio as well as new business written.

EXHIBIT 9

THE CAUSE OF THE CRISIS

The effects described in the previous pages were caused by the convergence of six driving factors making for the perfect storm, as follows:

? Dramatic long term paid claim severity rise
? Paid claim frequency returning and holding at high levels
? Declining market interest rates
? Exhausted reserve redundancies
? Rates becoming too low
? Greater proportion of large losses

The primary driver of the deterioration in the medical liability insurance industry performance has been paid claim severity, or the average cost of a paid claim.

EXHIBIT 10

Exhibit 10 shows the average dollar amount paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9% during this period, as compared to 2.6% for the Consumer Price Index (CPIu). The data for Exhibit 10, as well as that for slides which follow, comes from the PIAA Data Sharing Project. This is a medical cause-of-loss database, which was created in 1985 for the purpose of identifying common trends among malpractice claims. PIAA member companies use the database for risk management and patient safety purposes. To date, over 180,000 claims and suits have been reported to the database.

Allocated loss adjustment expenses (ALAE) for claims reported to the Data Sharing Project have also risen at alarming rates. ALAE are the amounts insurers pay to handle individual claims, and represent payments principally to defense attorneys, and to a lesser extent, expert witnesses. Average amounts paid for three categories of claims are shown below. As can be seen, the average amount spent for all claims in 2001 has risen to just under $30,000.

EXHIBIT 11

One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. Exhibit 12 shows the distribution of claims closed

in 2001 as reported to the PIAA Data Sharing Project. Sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.7% were won by the doctor at trial. Only 33.2% of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80% of the time. This data clearly shows that those attorneys trying these cases are woefully deficient in recognizing meritorious actions to be pursued to conclusion.

Analyses performed by the PIAA have shown that of all premium and investment income available to pay claims, only 50% ever gets into the hands of truly injured patients, with the remainder being principally paid to attorneys, both plaintiff and defense. Something is truly wrong with any system that consumes 50% of its resources to deliver the remainder to a small segment of those seeking remuneration.

EXHIBIT 12

A review of the average claim payment values for the latest year reported to the PIAA Data Sharing Project (2001) is revealing. As shown on Exhibit 13, the mean settlement amount on behalf of an individual defendant was just over $299,000. Most medical malpractice cases have multiple defendants, and thus, these values are below those, which may be reported on a per case basis. The mean verdict amount last year was almost $497,000 per defendant.

EXHIBIT 13

Exhibit 14 shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching $100,000.

EXHIBIT 14

Exhibit 15 shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments.

EXHIBIT 15

This is especially true for payments at or exceeding $1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2001 (Exhibit 16). This percentage has doubled in the past four years, and clearly demonstrates why insurers are facing dramatic increases in the amounts they have to pay for reinsurance. While medical liability

insurers are reinsured by many of the same companies having high losses from the World Trade Center disaster, their medical liability experience was rapidly deteriorating prior to September 11, 2001.

EXHIBIT 16

In addition to rising claim severity, like all other investors, medical liability insurers have faced declining market interest rates. Eighty percent of PIAA insurers' investments are placed in high-grade bonds. Exhibit 17 shows the long-term decline in high-grade bond earnings. As can be seen, this is not a recent phenomenon, but a long term trend.

Critics of the medical liability insurance industry say that insurers' reliance on investment income to offset premiums has caused turmoil in the marketplace, implying that the use of investment income is a bad thing. Nothing could be further from the truth. If insurers did not ever use investment income to offset premium needs, then rates would always be 30 - 40% higher than otherwise necessary. The role market interest rates play in determining pricing in medical liability insurance (and other lines as well) is a fact of life which we cannot control.

EXHIBIT 17

THE ANSWER

Medical liability insurers and their insureds have faced dramatic long-term rises in paid claim severity, which is now at historically high levels. Paid claim frequency (the number of paid claims) is currently remaining relative constant, but has risen significantly in some states. While interest rates will certainly rise and fall in future years, nothing has been done over the past three decades to stem the ever-rising values of medical malpractice claim payments or reduce the number of meritless claims clogging up our legal system at great expense - except in those few states that have effective tort reforms. In many states not having tort reforms, costs have truly become excessive, and insurers are forced to set rates at levels beyond the abilities of doctors and hospitals to pay. States having tort reforms, such as California, provide a compelling example that demonstrates how such reforms can lower medical liability costs and still provide adequate indemnification for patients harmed as a result of the delivery of health care.

The following reforms are those which the PIAA advocates be adopted at the federal level, which we also feel should be the standard for any state reforms enacted. They are based on the reforms found in the Medical Injury Compensation Reform Act (MICRA) which became effective in

California in 1976 and which have been successful in compensating California patients and ensuring access to the health care system since their enactment.

EXHIBIT 18

The keystone of the MICRA reforms is the $250,000 cap on non-economic damages (pain and suffering) on a per-incident basis. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care, etc. In addition, injured patients can get as much as one-quarter million dollars for pain and suffering. Advising juries of economic damages that have already been paid by other sources serves to reduce double payment for damages. An important component of MICRA is a reasonable limitation on plaintiff attorney contingency fees, which can be 40% or more of the total amount of the award. Under MICRA, a trial lawyer must be satisfied with only a $220,000 contingency fee for a $1 million award.

A Gallup poll published on February 5, 2003 by the National Journal indicates that 57% of adult Americans feel there are too many lawsuits against doctors, and 74% feel that we are facing a major crisis regarding medical liability in health care today. Seventy-two percent of respondents favored a limit on the amount that patients can be awarded for their emotional pain and suffering. Only the trial lawyers and their front groups disagree, seeing their potential for remuneration being reduced. Especially displeasing to them is MICRA's contingency fee limitation, which puts more money in the hands of the injured patient (at no cost reduction to the insurer).

The U.S. House of Representatives adopted legislation containing tort reforms similar to MICRA, including a $250,000 cap on non-economic damages, for the seventh time in September of last year. HR 4600, known as the HEALTH Act, was introduced and adopted on a bi-partisan basis. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 4600, and reported to Congress that if the reforms were enacted, "...premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The CBO found that HR 4600 reforms would result in savings of $14.1 billion to the federal government through Medicare and other health care programs for the period 2004 - 2012. An additional $7 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not consider the effects that federal tort reform would have on reducing the incidence of defensive medicine, but did acknowledge that savings were likely to result.

EXHIBIT 19

The US Department of Health and Human Services published a report on July 24, 2002, which evaluated the effects of tort reforms in those states that have enacted them. As stated in Exhibit 20, HHS found that practitioners in states with effective caps on non-economic damages were

currently experiencing premium increases in the 12 - 15% range, as compared to average 44% increases in other states.
EXHIBIT 20

Annual data published by the National Association of Insurance Commissioners (NAIC) also documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As shown in Exhibit 21, total medical liability premiums reported to the NAIC since 1976 have grown in California by 167%, while premiums for the rest of the nation have grown by 505%. These savings can only be attributed to MICRA.

EXHIBIT 21

These savings are clearly demonstrated in the rates charged to California doctors as shown in Exhibit 22. Successful experience in California and other states makes it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care.

EXHIBIT 22

PROP 103 HAD NO EFFECT ON CALIFORNIA MEDICAL LIABILITY PREMIUMS

In an effort to derail desperately needed tort reforms as described above, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects of MICRA as shown on Exhibit 21 are due to Proposition 103, a ballot initiative passed in 1988 aimed primarily at controlling auto insurance costs. The ballot initiative passed by a 51% majority vote, with voters in only 7 of California's 58 counties approving the measure. The major changes made by Prop 103 include:

? Making the insurance commissioner of California an elected, rather than appointed, official;
? Giving the insurance commissioner authority to approve rate changes before they can take

effect;
? Requiring insurers to reduce rates by 20 percent for two years from their levels on November 8, 1987;
? Requiring auto insurance companies to offer a 20 percent "good driver discount."
? Requiring auto insurance rates to be determined primarily by four factors;
? Allowing for payment of "intervenor fees" to outside groups that intervene in hearings conducted by the Department of Insurance .

Medical liability insurers were not the intended target of Prop 103, but were covered by the resulting regulations. However, Prop 103 did not have any substantive effect on medical liability insurance rates. Prop 103 did have the effect of freezing most insurance rates in California until as late as 1994. This all came at a time when medical liability insurers across the nation were seeing their rates level off or even decline. One major California medical liability insurer, the NORCAL Mutual Insurance Company, actually had two rate decrease filings (-2%, -12%) which had been made with the department of insurance in 1990 and 1991 held up until the conclusion of legal challenges and exemption issues were resolved. NORCAL reached a consent agreement with the California Department of Insurance in November of 1991, at which time its rate decreases were granted. NORCAL was specifically permitted to declare a one-time 20% return of premium for policyholders insured between November 8, 1988 and November 8, 1989 as a dividend and was not required to reduce its rates as a result of Prop 103. As NORCAL had already paid dividends exceeding 20% during the period in question, no monies were returned to policyholders as a result of Prop 103. The experience of other California physician owned companies was similar to that of NORCAL. Even if California medical liability insurers had been required to reduce rates by 20%, this in no way could explain the wide gap in experience shown on Exhibit 21.

CONCLUSION

Increasing medical malpractice claim costs, on the rise for over three decades, have finally reached the level where the rates that insurers must charge can no longer be afforded by doctors and hospitals. These same doctors and hospitals cannot simply raise their fees, which are limited by government or managed care companies. Many doctors will face little choice other than to move to less litigious states or leave the practice of medicine altogether.

Legislators are now challenged with finding a solution to the medical liability insurance affordability and availability dilemma - a problem long in coming that has truly reached the crisis stage. The increased costs being experienced by insurers (largely owned/operated by health care providers) are real and documented. It is time for Congress to put an end to the wastefulness and inequities of our tort legal system, where only 50% of the monies available to pay claims are paid to indemnify the only 30% of claims filed with merit and the expenses of the remainder. The system works fine for the legal profession, which is why trial lawyers and others fight so hard to maintain the status quo.

The PIAA strongly urges members of the Senate to pass effective federal health care liability reform, thereby stopping the exodus of health care professionals and institutions which can no

longer afford to fund an inequitable and inefficient tort system which benefits neither injured plaintiffs or the health care community.