Final Report of the Health Care Stabilization Fund Feasibility Board

December 2010

Health Care Stabilization Fund Feasibility Board

December 29, 2010

To: The Honorable Governor Jeremiah W. (Jay) Nixon
Terry Spieler, Secretary of the Senate
D. Adam Crumbliss, Chief Clerk of the House

From: Senator William H. (Bill) Stouffer

In accordance with 383.250 RSMo., I am pleased to submit the final report of the Health Care Stabilization Fund Feasibility Board (HCSFFB). The HCSFFB was created by statute to study the feasibility of establishing an excess medical malpractice insurer, or "stabilization fund," in Missouri. The board has determined that such a fund is not necessary and would not be useful at this time. Missouri's medical professional liability insurance market is robust and competitive. Medical practitioners can avail themselves of a wide variety of insurance products from traditional P&C insurers, mono-line assessable carriers, risk retention groups, and surplus lines carriers. Premiums have stabilized and even declined for most medical specialties, including the highest risk practices, and coverage is both readily available and affordable. Rather than disrupt the market with the establishment of a stabilization fund, the board recommends that steps be taken to enhance the existing market.

The board's final meeting was convened on December 17 of this year, at which time the report was adopted by a 5 to 1 vote. One member dissented from some of the conclusions presented in the report, and was permitted to attach an appendix to the report detailing various objections. However, on the central conclusion that an excess fund is not currently necessary, the board was unanimous.

I would like to conclude by extending my gratitude to the board members for performing a valuable service to the state of Missouri. Their hard work and dedication is reflected in the final product of the board. It has been my personal pleasure to work closely with these talented and committed professionals.

Sincerely,

Bill Stouffer

Senator William H. (Bill) Stouffer
Chairman, HCSFFB

Final Report of the Health Care Stabilization Fund Feasibility Board

Executive Summary

The Missouri Health Care Stabilization Fund Feasibility Board (hereinafter referred to as either "the HCSFFB" or "the Board") was created as part of the medical malpractice reform legislation enacted by the Missouri General Assembly in response to Missouri's 2003 medical malpractice insurance crisis. As a component of those legislative reforms, it was decided that a special panel should investigate whether the state would benefit from the type of excess insurance "stabilization fund" that has been in operation in the state of Kansas as well as a number of other states since the mid-1970s. Thus the Board was created within the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereinafter "DIFP") and assigned the task of investigating and deciding whether or not to recommend the creation of a similar fund in Missouri. The Board's legislative mandate ran to December 31, 2010.

It was appropriate that the General Assembly give the Board this task, since anecdotal reports from doctors in the Kansas City area of the state pointed to the Kansas Health Care Stabilization Fund (hereinafter, "the Kansas Fund") as one of the reasons medical malpractice premium rates were lower in Kansas than in Missouri. After researching the issue, the Board has concluded that the Kansas Fund *does indeed* seem to be working well for the market conditions that exist in the state of Kansas. Of the roughly one dozen stabilization funds in operation in the various states, the Kansas Fund is generally regarded as one of the more successful examples. The HCSFFB congratulates the Kansas Fund for their level of success.

However, in its research, the Board observed that the Missouri medical malpractice insurance market has evolved quite differently than the Kansas market since 1976, the year the Kansas Fund was created. Theoretically, while a stabilization fund can have a number of benefits if designed correctly, a stabilization fund is *not* the only tool states have used for addressing issues of "availability," "affordability" and "predictability" in the area of medical malpractice insurance, issues which are at the very core of the concerns of health care providers about the medical malpractice insurance market. Also, the Board has become aware that creation of a fund in Missouri *at this time* is not without a number of significant difficulties. Therefore, while the Board recognizes the strong initial appeal of this option, on balance, the Board has concluded that the benefits of such a fund are not so great under current conditions as to recommend this approach in Missouri at this time. Rather, the Board believes Missouri should concentrate on fine-tuning the various market reform mechanisms it is already pursuing, believing these are at least as likely to result in available, affordable and predictable insurance coverage for Missouri health care providers as would a start-up stabilization fund.

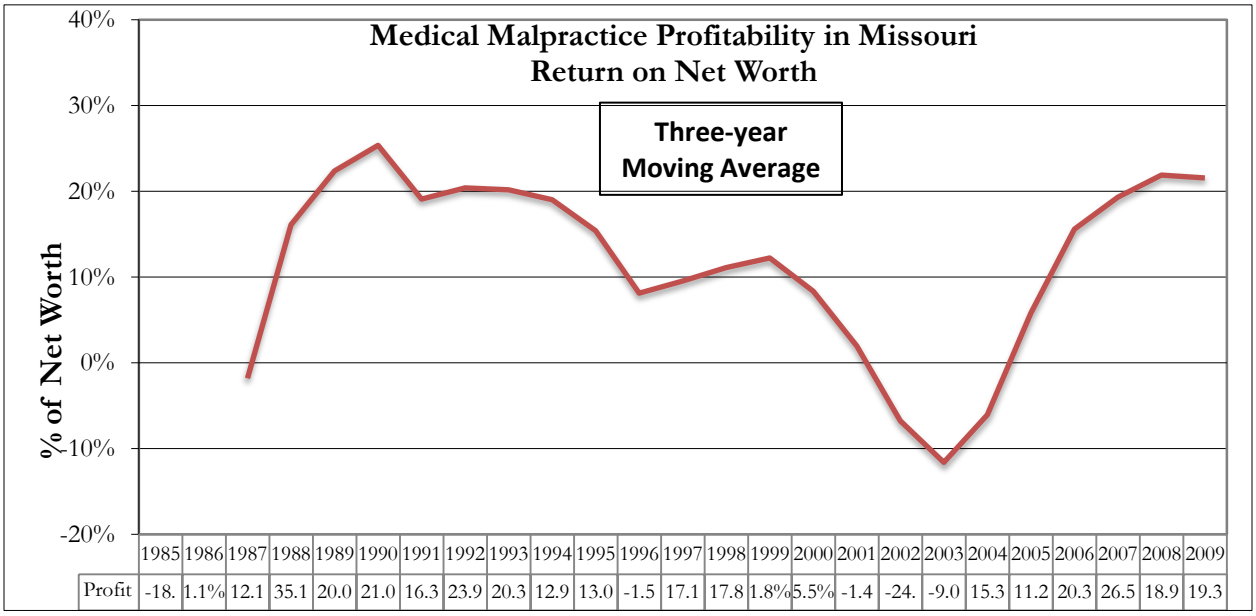
A Stabilization Fund Is Not Needed At This Time.

In 2003, Missouri's medical malpractice insurance industry was in the worst condition in its short history. Insurance companies that had recently entered the Missouri market and represented a large portion of the

business were either going insolvent or leaving the state. Major groups of providers, such as neurosurgeons and obstetricians, were finding it difficult to find or afford coverage. Many providers in Kansas City Missouri moved their operations across the state line to Kansas City, Kansas. The recently announced decision in the case of *Scott v. SSM Healthcare St. Louis* (App. E.D. 2002) 70 S.W.3d 560, threatened higher losses through multiple caps on non-economic damages. The Missouri medical malpractice insurance market was at its lowest level of profitability in history, paying out $1.20 dollars for claims and expenses for every $1.00 dollar of premium received.

In response to this situation, the Missouri General Assembly enacted a series of tort reforms in 2005 and a second series of insurance reforms in 2006. Among the latter was the formation of the HCSFFB to study the efficacy of creating a Kansas-style stabilization fund in Missouri. Such funds pay for losses in excess of a predetermined attachment point, basically covering the higher portions of high-dollar payouts. Some have argued that such funds can help to reduce overall premium rates by writing coverage on a not-for-profit basis, and also by reducing some administrative expenses such as those for commissions or advertising. In addition, particularly for those states that mandate participation by health care providers in such programs, rates may be lowered by spreading the risk over a much larger population than would be possible for a single private insurer. By insulating the private market from the impact of very high dollar claims, such funds can ameliorate the periods of rapid destabilization that have been a hallmark of medical malpractice insurance markets. As discussed in greater detail below, the HCSFFB examined the operation of such funds, focusing particularly upon the operation of the Kansas fund.

The stabilization fund issue has been studied by the HCSFFB since 2007, and by a Joint Legislative Committee before that in 2005. Much has changed in the Missouri medical malpractice marketplace since then. The market that was struggling in 2003 has rebounded, as the chart below indicates.



	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Profit	-18.	1.1%	12.1	35.1	20.0	21.0	16.3	23.9	20.3	12.9	13.0	-1.5	17.1	17.8	1.8%	5.5%	-1.4	-24.	-9.0	15.3	11.2	20.3	26.5	18.9	19.3

Source: Data from 1985 - National Association of Insurance Commissioners. **Profitability by Line by State.**

It is fair to say that the crisis of 2003 has passed. Medical malpractice operations in Missouri returned to profitability for six consecutive years, following depressed and even negative returns for the period of 1999-2003. Claims incurred plus loss adjustment and administrative costs amounted to 61.9 percent of earned premium in 2008. These costs had exceeded 100 percent of premium during seven of the eight years preceding 2004.

Profitability of the medical malpractice line may be assessed by adjusting Missouri underwriting results to account for expenses and revenues that are not state or line specific, such as investment returns, various unallocated costs, and federal taxes. The National Association of Insurance Commissioners (NAIC) reported that medical malpractice insurance in Missouri produced a net return of 43.5 percent of earned premium in 2007. Estimates produced by DIFP using the NAIC profitability formula indicate a profit on insurance transactions of 31.0 percent of earned premium in 2008. Adjusting this figure for federal taxes and total investment revenue, insurers earned a net return of 24.6 percent of total net worth.

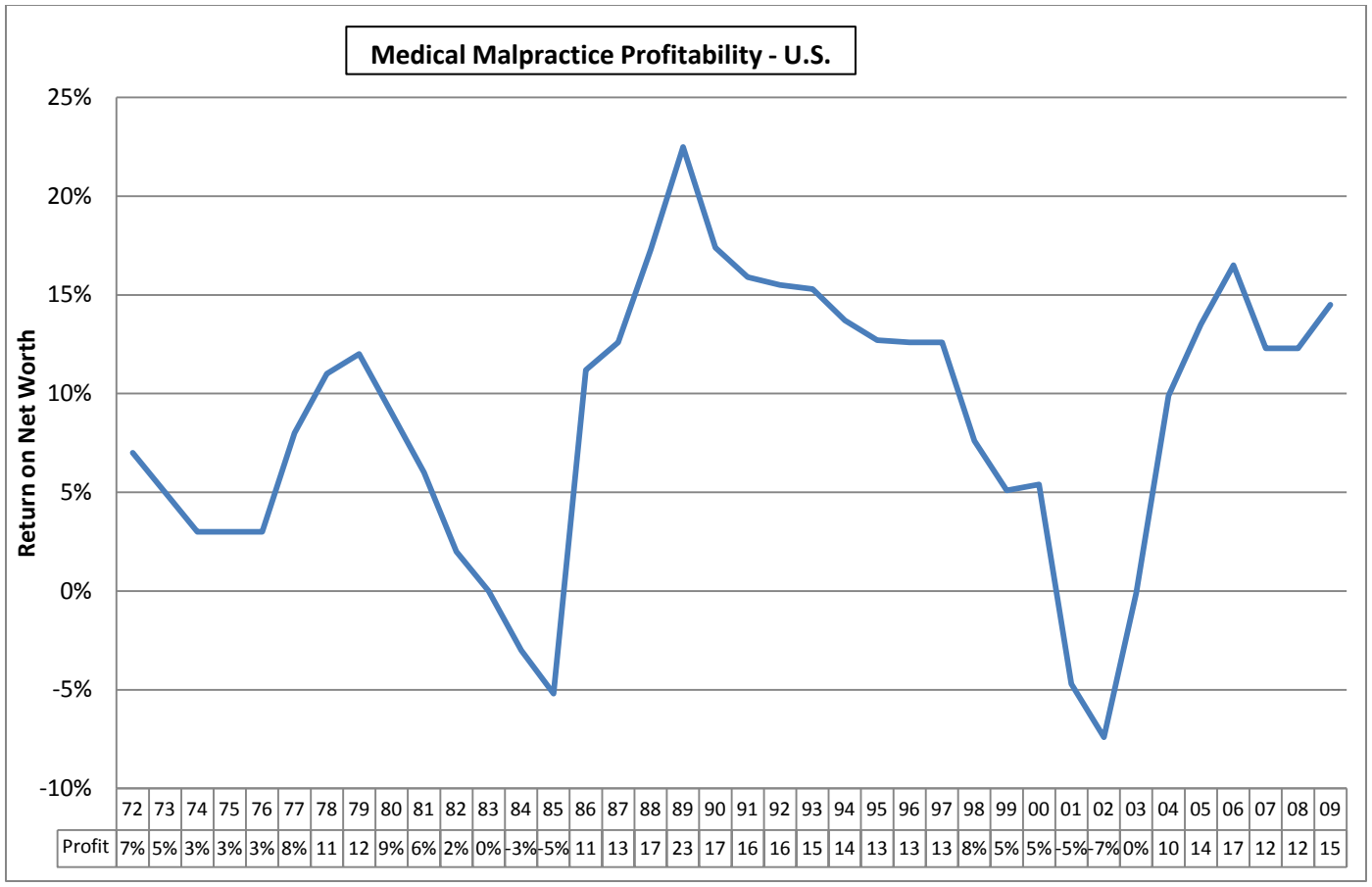
Incurred claims declined from $126.6 million in 2004 to $28.5 million in 2007, but increased slightly to $39.3 million in 2008. The loss ratio (claims incurred ÷ premiums earned) was 18.7 percent in 2008. Losses peaked in 2002, and have declined in every subsequent year through 2007 at an annual average rate of 31.6 percent,[1] but increased by over a third in 2008. In addition, defense and adjustment expenses related to settling claims, the largest expense component for medical malpractice insurance aside from claim payments, decreased between 2005 and 2007 from $81.2 million to $38.8 million, but increased slightly to $39.9 million in 2008.

For the licensed market,[2] claim payments decreased while incurred claim costs increased in 2008. Claim *payments* made in 2008, typically for claims opened in prior years, decreased by over a third to $52.8 million. Claim costs *incurred* in 2008, representing primarily insurers' expectations of future payouts on pending claims, increased 26.4 percent to $26.6 million. However, incurred losses remained well below losses paid in 2008. Earned premium declined by a more modest 3.5 percent. For physicians and surgeons, excluding other insured classes such as dentists, nurses, clinics and hospitals, paid claims declined from $53.9 million to $41.0 million in 2008, while incurred claims declined from $19.6 million to $14.1 million. Incurred claims in 2008 were only 11.4% of the period high of $122.9 million in 2002.

Some will legitimately argue that current conditions may not prevail forever and that a stabilization fund should be established in order to be ready to deal with the next crisis, whenever it occurs, and that such a fund will help stabilize the market. As the following charts suggest, the effect may be modest at best.

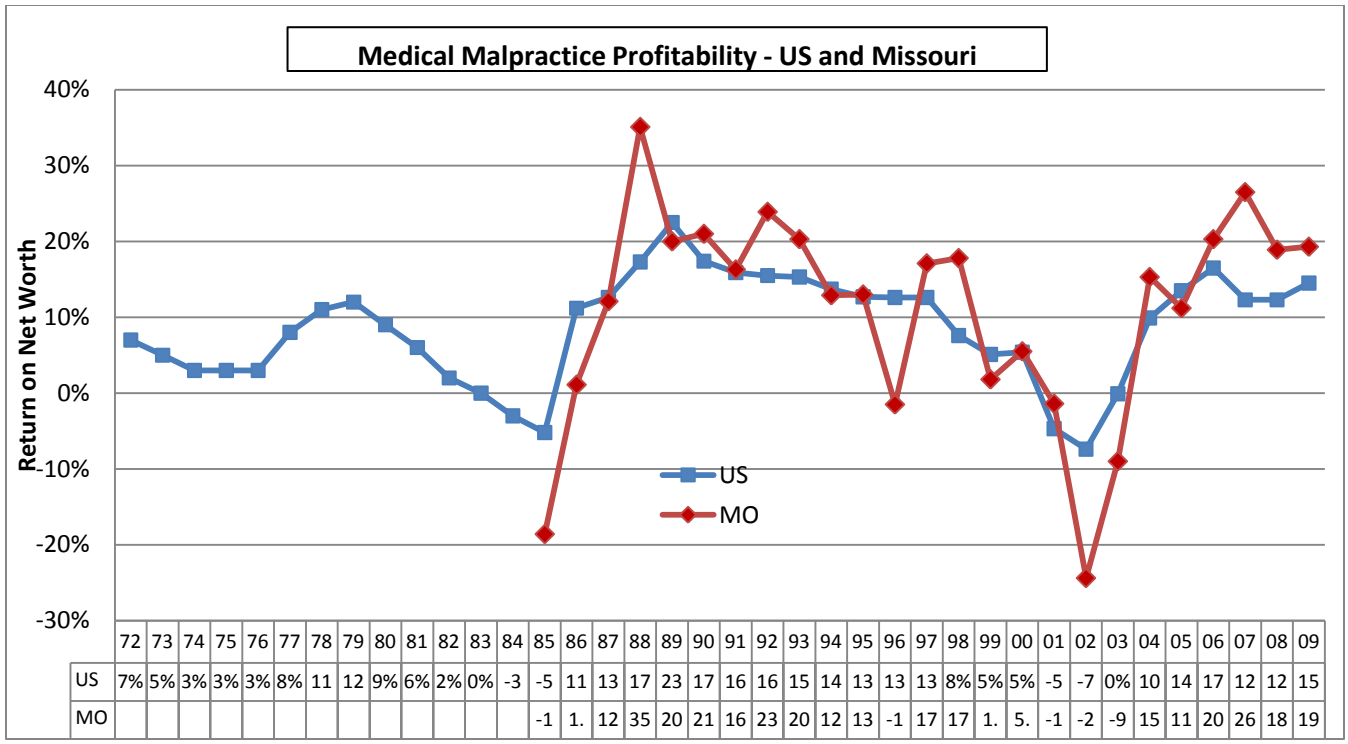
The U.S. medical malpractice market as a whole has gone through cycles since the mid-1970's, as the chart below indicates:

1 Calculated using the geometric mean, as appropriate for percentage changes over time.
2 That is, licensed insurers, excluding less-regulated surplus lines entities and risk retention groups.



Source: 1985-2008, National Association of Insurance Commissioners, **Profitability by Line by State:** Annual Reports. 2009: DIFP preliminary estimates. 1972-1984: AM Best, **Industry Aggregates and Averages.**

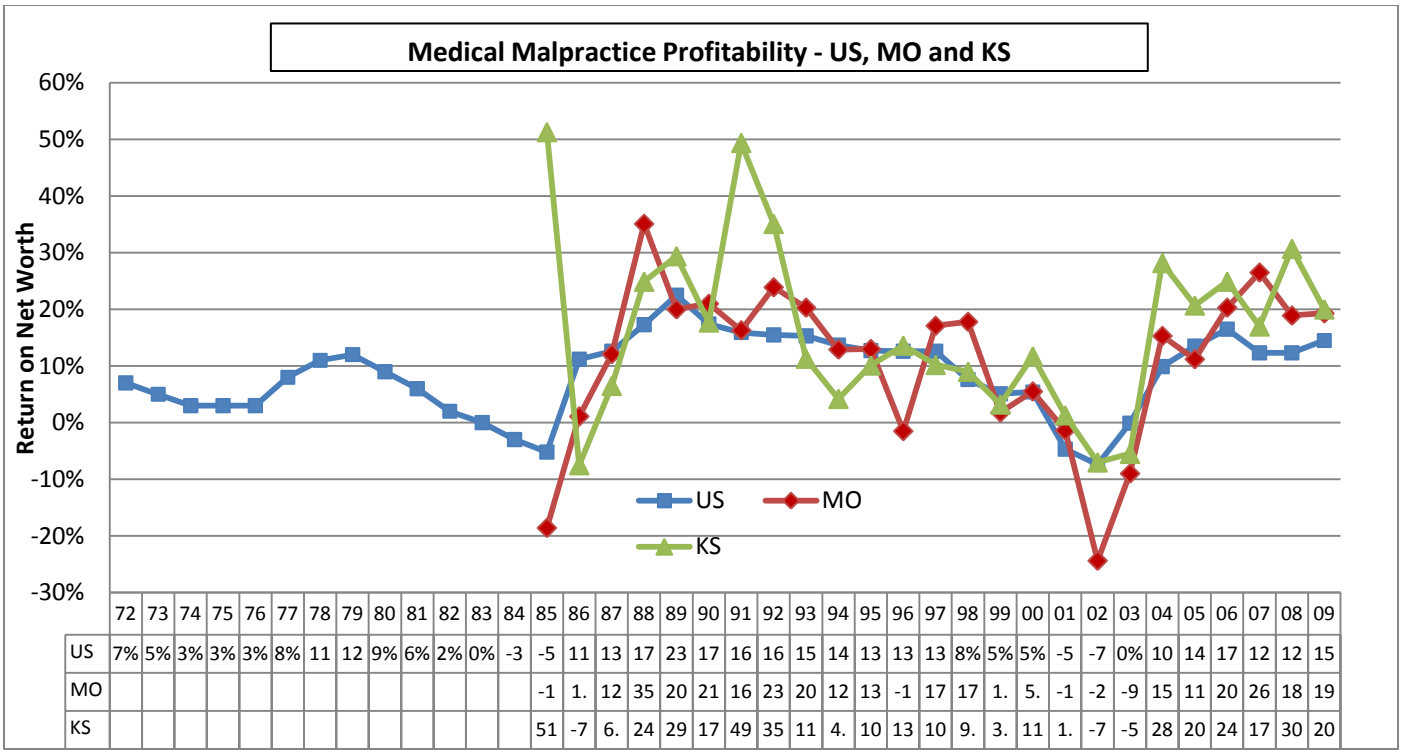
Detailed data on the various individual states only began to be collected in the mid-1980s. When you add Missouri's profitability information to the national data above, you get the following chart:



	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09
US	7%	5%	3%	3%	3%	8%	11	12	9%	6%	2%	0%	-3	-5	11	13	17	23	17	16	16	15	14	13	13	13	8%	5%	5%	-5	-7	0%	10	14	17	12	12	15
MO														-1	1.	12	35	20	21	16	23	20	12	13	-1	17	17	1.	5.	-1	-2	-9	15	11	20	26	18	19

Source: 1985-2008, National Association of Insurance Commissioners, **Profitability by Line by State:** Annual Reports. 2009: DIFP preliminary estimates. 1972-1984: AM Best, **Industry Aggregates and Averages.**

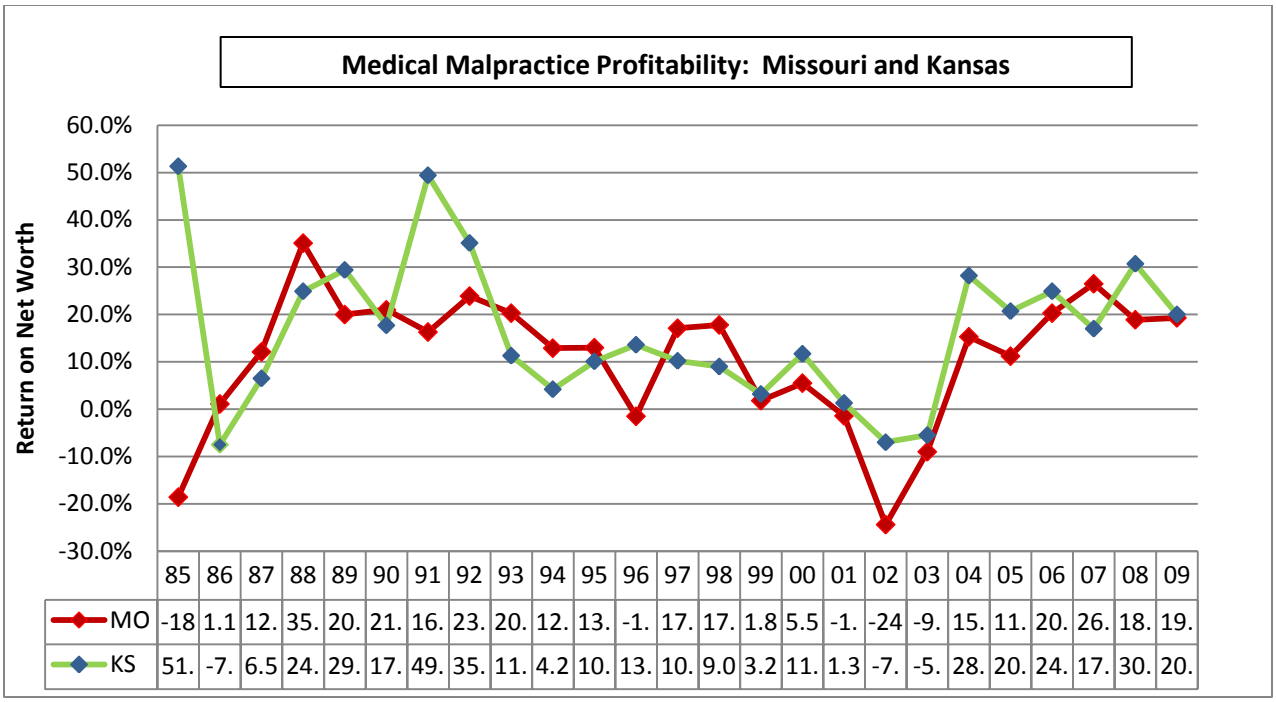
Adding in Kansas, we get:



	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09
US	7%	5%	3%	3%	3%	8%	11	12	9%	6%	2%	0%	-3	-5	11	13	17	23	17	16	16	15	14	13	13	13	8%	5%	5%	-5	-7	0%	10	14	17	12	12	15
MO														-1	1.	12	35	20	21	16	23	20	12	13	-1	17	17	1.	5.	-1	-2	-9	15	11	20	26	18	19
KS														51	-7	6.	24	29	17	49	35	11	4.	10	13	10	9.	3.	11	1.	-7	-5	28	20	24	17	30	20

Source: 1985-2008. National Association of Insurance Commissioners, **Profitability by Line by State:** Annual Reports. 2009: DIFP preliminary estimates. 1972-1984: AM Best, **Industry Aggregates and Averages.**

We can break out the Missouri and Kansas numbers and show them side-by-side:



	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09
MO	-18	1.1	12.	35.	20.	21.	16.	23.	20.	12.	13.	-1.	17.	17.	1.8	5.5	-1.	-24	-9.	15.	11.	20.	26.	18.	19.
KS	51.	-7.	6.5	24.	29.	17.	49.	35.	11.	4.2	10.	13.	10.	9.0	3.2	11.	1.3	-7.	-5.	28.	20.	24.	17.	30.	20.

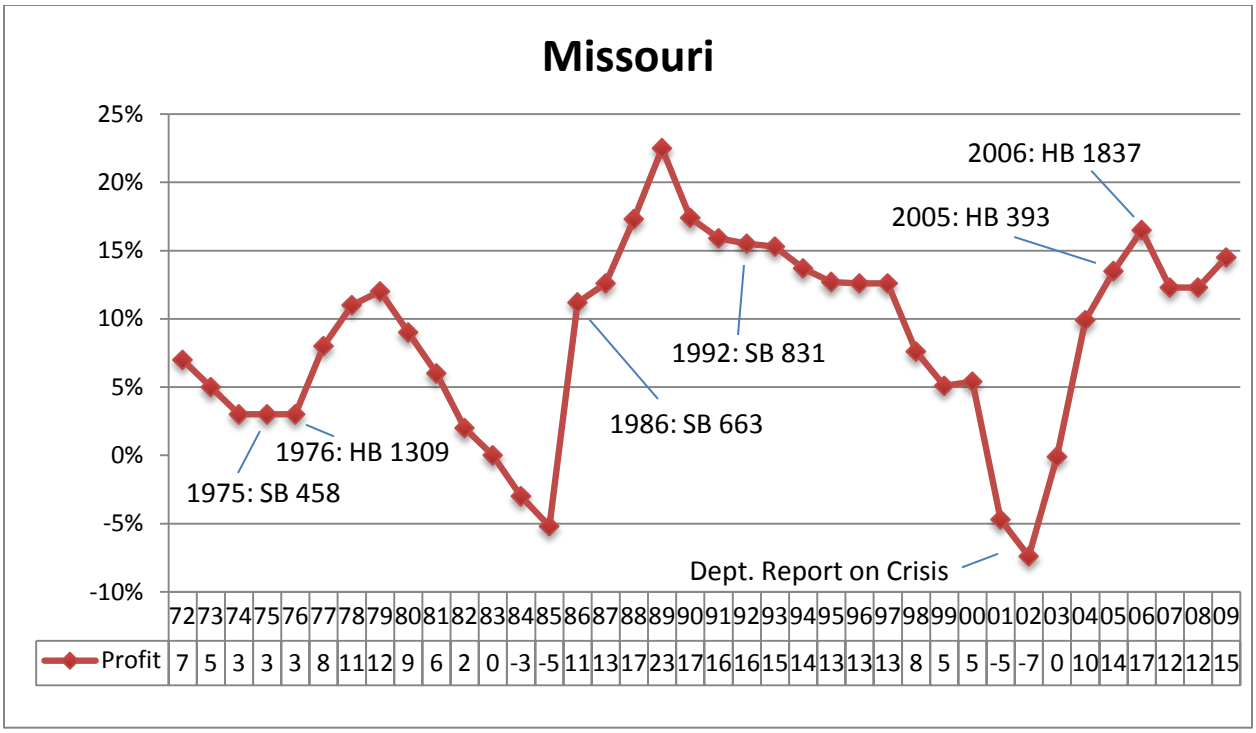
Source: 1985-2008, National Association of Insurance Commissioner, **Profitability by Line by State:** Annual Reports. 2009: DIFP preliminary estimates.

On a purely visual level, the charts appear to indicate that, at least as to the stabilization of the market as a whole, neither the Missouri regulatory model nor the Kansas model have yet to show they can tame market forces very well. Luckily, for both states, their markets are on an upswing.

A conclusion to be drawn from this information is that the Kansas market is not significantly more stable than the Missouri market, and, regardless of the potential merits of a stabilization fund, the creation of such a fund now, during a strong Missouri market, seems contraindicated.

Rely on a Regulated Private Market.

The directive for the HCSFFB to investigate the utility of establishing a stabilization fund in Missouri came as part of a package of reforms enacted in Missouri in 2005 and 2006. Each serious downturn in the Missouri medical malpractice market in the past has led to legislative reforms. See the chart below for the key measures taken in Missouri:



Source: 1985-2008. National Association of Insurance Commissioners. **Profitability by Line by State.** Annual Reports. 2009: DIFP preliminary estimates.

1975 SB 458: Authorized the creation of Chapter 383 assessable mutual insurers in Missouri as a way to provide malpractice coverage where it was otherwise unavailable. The law allows three licensed professionals to form the entity for a $100 fee. Should premiums fail to cover losses, member professionals are to be assessed the difference.

1976 HB 1309: A Joint Underwriting Association (or "JUA") was authorized whenever a Missouri Director of Insurance determines coverage is not reasonably available. Premiums are to be actuarially sound, but deficits can be spread out on a pro rata basis to the individual insurance companies that make up the Missouri Property and Casualty market. Entrance standards for health care providers obtaining coverage through the JUA include a surcharge equal to 100% of premium.

1986 SB 663: A major tort reform effort: Established a $350,000 cap on non-economic damages; provided rules on punitive damages; required itemized jury awards, structured settlements, and certificates of merit to proceed with a suit. Made modifications to the doctrine of joint & several liability; stated that the Board of Healing Arts was to receive reports from DIFP on medical malpractice claims; required physicians in certain locations to maintain $500,000 of coverage.

1992 SB 831: An omnibus insurance act, which included upgrades to oversight of the 383s. The upgrades where an attempt to apply the key regulatory provisions used by the state's regulators to oversee other insurance entities to the 383 companies as well.

2005 HB 393: Tort Reform: Reversed the *Scott* decision, thereby providing a single $350,000 cap on non-economic damages, regardless of the number of defendants. Future medical payments are to be based on a schedule. Cases are to be dismissed where there is no medical affidavit. Public physicians are largely free of liability. Benevolent gestures are inadmissible in court. Peer Review Committees were established. Venue provisions to limit venue changes under circumstances where new parties are added after the commencement of a suit were specified. Damages for certain decedents with dependents were set. A statute of limitations of 18 years plus 2 years for minors with claims was established. The changes became effective on August 28, 2005.

2006 HB 1837: Allowed Limited Liability Companies, etc., to join 383s. 383 companies were required to specify their assessments procedure in case there are insufficient funds to cover liabilities. 383s are made subject to certain notification, rating and reporting requirements. DIFP is to develop risk reporting categories to help in developing base rates and schedule rates. DIFP is to publish "market" rates. Reasonable rates are to be based on Missouri experience, where possible. Restrictions on rate increases, refusals to renew or outright withdrawals by carriers from the state require prior notification. Finally, the HCSFFB was created to study stabilization funds, with a sunset date of December 31, 2010.

These various legislative changes reflect the fact that the medical malpractice insurance market has historically been a relatively volatile one, financially speaking. While the graphs above indicate instability in "profitability," a similar instability exists regarding the availability and affordability of coverage, at least for certain high-risk specialties. In the most recent crisis of 2003, neurosurgeons, obstetricians and nursing homes were among the specialties having difficulty finding available and affordable coverage.

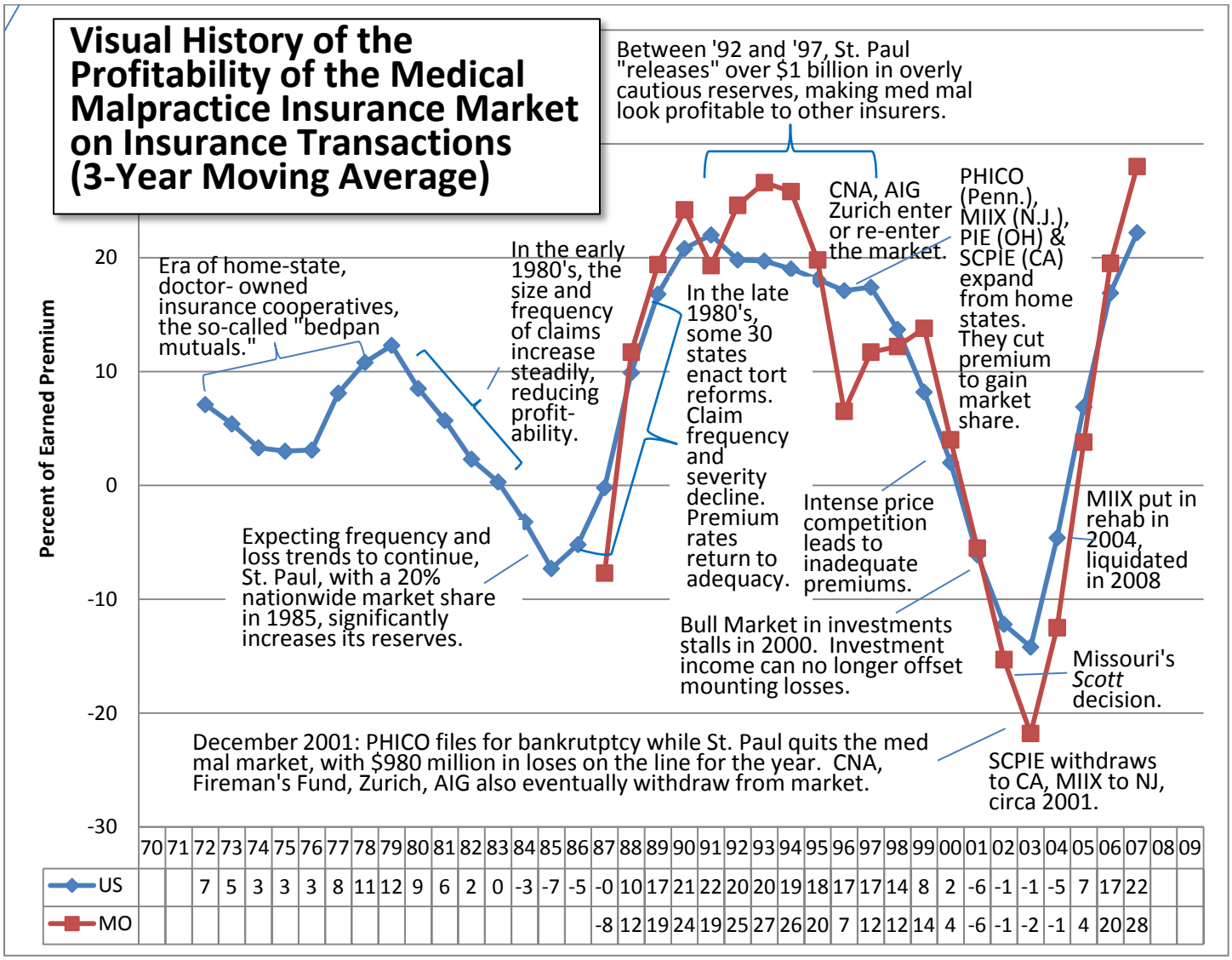
This instability, be it in Missouri, Kansas or nationally, can be traced to the nature of this particular line of insurance:

1. Medical malpractice is a "long-tail" line of coverage, meaning claims do not achieve final resolution until many years after the initial claim is made. Such a time lag makes it more difficult for actuaries to calculate accurate premium rates.
2. While an "important" line of coverage from the standpoint of the public's wellbeing, the number of insureds is relatively small, again making prediction of future losses harder. Missouri has millions of insured automobiles but fewer than 20,000 insured physicians and surgeons. In addition, there is no central clearinghouse for the kind of data analysis one would need to estimate accurate rates.
3. Constricting the available data for ratemaking even further, the healthcare providers are subdivided into specialties. While done in the interest of rating "fairness" (some specialties perform more high-risk procedures than others), the high degree of segmentation further limits the pool of information from which to make accurate rates.
4. Losses are driven by claim frequency and claim severity, but these can change over time due to a host of factors, such as the public's attitude to the medical profession, to individual providers, to expectations regarding outcomes to procedures, mass tort situations, changes (or

lack thereof) in safety procedures, medical innovations that may not produce optimal results, and often, the sheer grief of survivors of malpractice who feel "someone" ought to pay for what happened to them or their loved one.

5. Outside of the medical profession itself, the legal profession, court decisions, legislative changes, decisions by multi-state insurers to enter or withdraw from a state, and the decisions of the reinsurance market to deploy capital to reinsure the primary carriers all play a part in the market's instability.

To take but one example from the list above, below is a timeline of some of the "external" factors that have led to the various crisis situations felt across the nation at various times.



Source: Rachael Zimmerman and Christopher Oster. "Assigning Responsibility: Insurers' Missteps Helped Provoke Malpractice 'Crisis'," *The Wall Street Journal*, June 24, 2002.

As the timeline indicates, medical malpractice markets have been subjected to different types of pressures at different times, such as increases in claim frequency and severity, as well as periods of intense price competition. Each state suffering a crisis has responded in its own unique way. In the case of Missouri and Kansas, the initial responses to the first crisis in 1976 still resonate today. The Kansas approach was a centralized one focused on creating the Kansas Fund as a way to attract and retain primary insurers by helping them avoid larger losses. In Missouri, the approach was to allow the health care providers who felt abandoned by their insurers to band together to insure each other through Chapter 383 assessable mutual insurance companies. (The federal government allows something similar with Risk Retention Groups, or RRGs).

In 2002, at the lowest point in Missouri's most recent medical malpractice market cycle, Chapter 383 assessable mutuals accounted for only about 15% of the total licensed medical malpractice market, whereas today, they write over 50% of the market. Historically, they have not been without their problems, as several went out of business in the 80s and 90s, but as time has passed, they seem to be maturing into the dominant players in this evolving segment of the Missouri insurance market. Since both Kansas and Missouri seem to have experienced the same general market cycles over the years, it is not clear one state's system is inherently better than the other's. Missouri has simply opted for a more "competition-oriented" approach to the matter, in large part by encouraging the state's medical professionals to form their own insurance companies via Chapter 383 to compete with the multi-state carriers.

Build on Missouri's Past Market Reforms

The objective, then, should not be whether we adopt some other state's approach to the problem, but rather, making our own "Missouri" approach function in a way that achieves the three goals of available, affordable and predictable coverage. The Board believes that the state's competition-oriented approach, although healthy today, would likely be enhanced through: 1) more transparent data collection and publication; 2) more traditional insurance market rate oversight by DIFP concerning excessive, inadequate and unfairly discriminatory rates; and, 3) more rigorous treatment of 383 company assessment rules and insolvency situations.

In addition, the Board believes that policymakers should be made aware of certain limitations that exist in the state's current medical malpractice market "safety net," which is the Missouri Medical Malpractice Joint Underwriting Association, more commonly referred to as "the JUA." Should a future medical malpractice crisis develop despite an enhanced competitive environment, the limitations required by the JUA's enabling legislation could hamper its ability to respond to that crisis.

More Transparent Data Collection and Publication

The three goals of available, affordable and predictable coverage would be served by reducing the size of the peaks and valleys of the market and get the profitability of the medical malpractice line of insurance on a firm footing. If this could be accomplished, predictability would improve, and affordability and availability would stabilize because insurers would have a better actuarial picture of what to expect in terms of future losses.

One way to help accomplish this is with more comprehensive statewide data to help identify trends and allow for the development of more actuarially sound premium rates. Language in House Bill 1837, passed during the 2006 legislative session, attempted to empower DIFP to collect and analyze such data and then distribute it to both the insurance industry to assist them in developing accurate premium rates and also to the public at large, but DIFP's three initial attempts to promulgate regulations on the matter proved problematic. Partly it was a matter of clearly specifying the data elements to be collected and partly is was a matter of clarifying that *all* individual and company-specific data would be maintained by DIFP under the strictest confidentiality standards, and be made public only after being aggregated with other information from numerous sources. As part of its work with the HCSFFB on its industry-wide data call, DIFP gained firsthand experience in how to conduct such data collection and is now in a much better position of explaining what is necessary. The Board was frequently frustrated by the current system's inability to provide certain basic information, and believes that credible data is vital to monitoring and maintaining the health of the state's medical malpractice insurance environment. To the degree that more detailed statutory data collection and protection requirements – based on the Board's own recent data call experience –are needed for DIFP to implement a functioning system, the Board encourages the General Assembly to enact such additional statutory requirements.

More Traditional Rate Oversight

In addition to providing insurance companies with the data needed to develop appropriate premium rates, the General Assembly should consider giving DIFP the same authority to regulate any excessive, inadequate or unfairly discriminatory rates as it already possesses for other lines of property and casualty insurance. As it stands now, the premium rates for medical malpractice insurance are, for all practical purposes, unregulated in the state of Missouri. Adequate regulation of insurance rates is important because, without such regulation, insurers are in a better position to decide to deliberately *undercharge* for coverage in order to attract business, increasing the premium dollars available for lucrative investments elsewhere (a practice sometimes referred to as "cash-flow underwriting"). This is precisely what happened in Missouri during the profitability crash between 1999 and 2003. Currently, Section 383.206, RSMo requires that the Director of DIFP produce "competent and compelling evidence" that the "base" rates are not correct. The "compelling evidence" standard is unique to this particular statute (the usual standard in administrative law is "competent and substantial evidence") and is likely to be nearly impossible to meet because: 1) insurance rate making is a matter of the expert judgment of actuaries; and, 2) medical malpractice ratemaking contains so much subjective variation from the base rates that reviewing base rates, in isolation, is for all practical purposes irrelevant. One solution would be to make the same general rate standards applicable to all other lines of property and casualty insurance applicable to medical malpractice insurance as well, while also allowing the unique features of medical malpractice ratemaking. This would allow DIFP to, for example, challenge the type of inadequate premium rates that contributed to the most recent downturn of the insurance cycle in the late 1990s and the early 2000s.

Treatment of 383 Company Assessments and Insolvencies

The other broad area for improvement to Missouri's various market reforms is in the oversight of the 383 companies. During the course of its investigation, the HCSFFB was advised of a number of ways in which Missouri's statutes regulate Chapter 383 companies significantly differently than they do Missouri's traditional insurers. Given the vital role 383s now play in the Missouri market, the Board

believes it would be remiss if it did not note these disparities (and their possible ramifications), and urge the General Assembly to consider reasonable alternatives.

1. **Special Assessments:** Currently, Section 383.016, RSMo is very flexible regarding the types of assessment methodologies Chapter 383 mutuals may employ to supplement the premiums that fund their operations, including using assessments to restore them to financial solvency. Arguably the current law allows 383 medical malpractice associations to become insolvent and then assess only the *current* policyholders to provide the funds to pay claims. If a 383 begins to have financial problems, those policyholders with sufficient foresight might cancel or nonrenew their policies and thereby escape responsibility for paying assessments for claims, leaving fewer and fewer policyholders to be assessed, thereby increasing the likelihood that claims will go unpaid. In addition, insurance insolvencies are often caused by carriers having charged too little premium on policies issued in previous years; in such cases it is arguably inequitable to require the more recent policyholders to pay for shortfalls caused by failing to charge adequate premiums to past policyholders. Granted, there has apparently been no need for special assessments by medical malpractice 383s since they were first authorized in 1975, but because, under Section 375.773, RSMo, Chapter 383 companies are *not* covered by the Missouri Property and Casualty Guaranty Association, assessments on past and current members may be necessary in order to pay the claims of a financially distressed 383. Therefore, the General Assembly should consider an alternative to the current assessment provisions, one which clarifies that assessments apply to both current and former members and which specifies how these assessments will be applied, in a manner deemed acceptable to the Director of DIFP as being equitable.

2. **Insolvency Procedures:** Current law allows a 383 with less than zero surplus to forestall regulatory action for three years while the 383 company merely files a plan to cure the situation. Financial problems at insurance companies tend not to get better without regulatory intervention; indeed, they tend to get worse. (Of the two hundred plus insolvencies in Missouri since regulation began in the 1869, only a handful have been successfully rehabilitated.) The current law on 383 companies permits them to continue to collect premium and reimburse management for three years before the department is allowed to take any action. Such a delay is a prescription for the 383 becoming so insolvent that claims will not be paid. To address this problem, the Director of DIFP ought to have the same broad flexibility he has in other insolvency situations, which, depending on the severity of the insolvency, may run the gamut from mere administrative supervision, to rehabilitation to outright liquidation proceedings. Having been informed that 383s can operate for extended periods at zero surplus, the Board feels it would be imprudent if it did not take note of this fact and suggest that the General Assembly replace the current provisions with provisions that mirror how other regulated insurers are treated in this regard.

3. **Auditing Requirements**: Currently, 383 companies are subject to less stringent auditing requirements than are traditional medical malpractice insurers. To bring oversight of the 383

carriers into conformity with the remainder of the industry, their financial statement should be subject to an independent annual audit, in parity with other regulated insurers in Missouri.

The MMM JUA (our Market-of-Last-Resort)

During the worst of the last crisis in 2003, the Director of Insurance activated the Missouri Medical Malpractice Joint Underwriting Association for the first time under Section 383.155, RSMo. The MMM JUA functions as a market-of-last-resort for health care providers who cannot find coverage elsewhere. To date, it has mainly insured nursing homes. As a final comment on its fact-finding efforts, the Board takes note of the fact that there is debate among some in the medical malpractice community over whether various provisions of the JUA's enabling legislation are appropriate, given the JUA's mission and current market circumstances.

Appendix: Additional Analysis of the Medical Malpractice Market in Missouri
Data

The DIFP initiated a data call at the behest of the Board to obtain information about the medical malpractice market for the period 1997 to 2008. The period was selected to provide a broad overview of market dynamics through the peaks and troughs of the last market cycle. Unfortunately, much of the data that were submitted to the DIFP proved unsuitable to support detailed analysis, due to the following problems.

1. A Lack of Standardization: Unlike many other Property & Casualty lines of business, few medical malpractice carriers report data to a rating organization, nor is there any other industry standard with respect to data categories or formats. As a result, the DIFP was unable to develop a data call to which all carriers could provide consistent responses which allowed a detailed analysis. Many requested data elements and codes could not be provided.

2. The "Retrospective" Nature of the Data Call: The data call was "retrospective" in that it asked carriers to report on events from the past using reporting parameters that had not previously been required in Missouri (or any other state, for that matter). Some of the data requested were not readily accessible for many carriers in either electronic or paper formats.

3. Currently Inactive Medical Malpractice Insurers: A few major carriers have withdrawn from the market or have become insolvent. It was not possible to obtain data from these entities. Hence, the data had large gaps.

For these reasons, the data are incomplete across time and inconsistent across carriers. Many carriers were unable to produce counts of covered physicians (those insured under a group policy, for example), identify the geographic location of physicians, provide comparable risk categories, or provide other data elements essential for the type of thorough analysis sought by the Board.

The tables and graphs below were produced using the most credible data, and at least afford a summary of the medical malpractice market. However, in interpreting these exhibits, readers should bear in mind the caveats with respect to the overall credibility of the data. These tables are supplemented with medical malpractice claims data that have been collected by the DIFP for nearly 30 years. Both sets of data produce broadly consistent results.

However, even with these significant limitations, DIFP was able to glean some useful information on market trends from a subset of the data that was reported as a result of the Board's data call.

Summary

In the early 2000s, the medical malpractice market experienced a sharp contraction fueled by rising claim costs and declining investment income. Several large insurers abruptly withdrew from the market or became insolvent. For example, between 1998 and 2005, 12 large companies terminated their Missouri

malpractice business. At their peak, these companies collectively wrote $48.3 million annually, and had captured about one third of the licensed market. By 2005, their premium volume had shrunk to $2.1 million annually, or 1.1% of the market. Over the same period, total annual premiums for malpractice coverage increased from $81.8 million to $190.0 million annuallly. Missouri physicians scrambled to find affordable coverage in the midst of diminished market capacity, rapidly rising premiums, and tighter underwriting standards.

Medical Malpractice Insurance-Missouri Licensed Market			
Year	**Total Premium Written**	**Premium Written, 12 Large Companies**	**Market Share, 12 Cos**
1998	$81,825,564	$22,958,301	28.1%
1999	$94,908,930	$27,592,436	29.1%
2000	$92,838,702	$24,984,489	26.9%
2001	$109,081,420	$33,101,436	30.3%
2002	$171,916,338	$48,342,111	28.1%
2003	$186,479,369	$11,982,921	6.4%
2004	$205,581,129	$7,138,440	3.5%
2005	$190,032,878	$2,115,673	1.1%

Source: Insurers Annual Financial Statements

As presented in the body of the report, the Missouri's experience largely mirrored that of other states. The evidence indicates that, like most other lines of P&C insurance, the medical malpractice market is prone to a cyclical pattern of contraction and expansion. Some scholars have suggested that insurance cycles are driven by the competitive dynamics of insurers, who aggressively price product during soft markets to expand market share. As rates drop due to competitive pressures, insurers begin to experience cash flow problems, and their focus shifts to underwriting. Rates increase and underwriting standards are tightened. Other scholars have suggested that insurance cycles are the product of other economic cycles related to interest rates or other rates of return. While the cause of insurance cycles is subject to some debate, the existence of such cycles is not.

Indeed, the markets in virtually every state that experienced dislocations began to rapidly recover after 2003, as clearly indicated by the profitability figures presented in the body of the report. The following tables provide other indicators of market performance, affordability and availability over the same time-frame.

Average Premiums

The tables below present the annual average cost of coverage for various medical specialties for two common policy limits. Both high-risk medical specialties, such as neurology, and low-risk specialties, such as family practice, are presented. The cost of coverage trends are comparable for all specialties: rates increases rapidly from 2000 to 2003-2004, and then stabilized and slightly decreased thereafter. For example, the cost of a year of coverage for an OB/GYN was $26,938 in 1997. Costs peaked at $57,838 in 2003, but declined to $53,078 in 2008. Neurosurgeons paid an annual average of over $89,000 in 2003, but only $61,000 in 2008.

Claims Made Policies, Individual Limits		
Surgery - Ob/GYN (ISO Code 80153)		
	Policy Limit	
	500,000	**1 Million**
1997	$26,839	$26,938
1998	$26,530	$27,842
1999	$34,021	$29,265
2000	$35,172	$32,261
2001	$48,839	$32,494
2002	$33,713	$48,477
2003	$52,218	$57,838
2004	$55,372	$51,503
2005	$34,963	$33,384
2006	$30,959	$53,069
2007	$33,298	$50,345
2008	$25,146	$53,078

Neurology - Surgery (ISO Code 80152)		
	Policy Limit	
	500,000	1 Million
1997	$26,417	$36,945
1998	$17,611	$34,351
1999	$32,183	$44,068
2000	$49,103	$42,571
2001	*	$54,280
2002	$48,045	$68,584
2003	*	$89,228
2004	*	$58,643
2005	*	$66,221
2006	*	$37,291
2007	*	$49,685
2008	*	$61,237

***Missing due to lack of credible data.**

Emergency Medicine - No Major Surgery (ISO Code 80102)		
	Policy Limit	
	500,000	1 Million
1997	$10,291	$10,556
1998	$10,552	$8,320
1999	$10,552	$14,446
2000	$10,552	$13,887
2001	$11,336	$26,912
2002	$18,985	$14,778
2003	$16,176	$25,224
2004	$23,262	$27,817
2005	$17,644	$31,099
2006	$18,881	$28,066
2007	*	$24,538
2008	$25,968	$22,601

*Missing due to lack of credible data.

Internal Medicine, No surgery (ISO Code 80257)		
	Policy Limit	
	500,000	1 Million
1997	$3,635	$3,915
1998	$3,819	$4,102
1999	$4,143	$4,834
2000	$4,946	$6,067
2001	$6,300	$6,877
2002	$7,705	$8,677
2003	$11,754	$11,150
2004	$10,655	$11,776
2005	$12,526	$11,374
2006	$12,557	$10,974
2007	$12,642	$11,212
2008	$11,201	$10,805

Pediatrics, no surgery (ISO Code 80267)		
	Policy Limit	
	500,000	1 Million
1997	$3,383	$4,531
1998	$4,887	$3,296
1999	$4,710	$4,497
2000	$5,303	$5,805
2001	$6,845	$6,728
2002	$8,400	$8,027
2003	$10,087	$12,944
2004	$13,693	$14,859
2005	$18,333	$15,048
2006	$9,148	$17,330
2007	$6,528	$12,279
2008	$6,062	$10,574

Family Practice (ISO Code 80420)		
	Policy Limit	
	500,000	1 Million
1997	$3,993	$4,259
1998	$4,033	$4,644
1999	$4,406	$5,204
2000	$4,933	$6,226
2001	$6,285	$7,171
2002	$7,003	$9,347
2003	$9,248	$11,909
2004	$11,255	$13,574
2005	$12,297	$14,142
2006	$10,975	$14,232
2007	$12,566	$12,378
2008	$11,818	$11,156

General Surgeon (ISO Code 80143)		
	Policy Limit	
	500,000	1 Million
1997	$18,035	$15,429
1998	$18,251	$16,377
1999	$19,812	$19,201
2000	$20,797	$21,164
2001	$28,132	$29,682
2002	$36,383	$38,953
2003	$42,084	$46,943
2004	$30,652	$42,153
2005	$42,905	$34,749
2006	$19,132	$31,110
2007	$16,316	$36,423
2008	$25,173	$35,203

Urology - Surgeon (ISO Code 80145)		
	Policy Limit	
	500,000	1 Million
1997	$9,261	$9,629
1998	$9,859	$10,611
1999	$9,922	$11,993
2000	$9,066	$11,343
2001	$11,344	$14,496
2002	$13,075	$17,940
2003	$14,413	$22,666
2004	$21,967	$33,080
2005	$21,988	$34,025
2006	$26,115	$35,387
2007	$28,640	$30,366
2008	$27,740	$24,574

Loss Frequency for Individually-Insured Physicians & Surgeons

Loss frequency represents the percent of physicians for whom there were claims closed during a given year. For the following tables, *only physicians and surgeons with individual coverage were included,* since many insurers were unable to provide physician counts for practitioners insured under group policies and since only the physician and surgeon populations were large enough to provide statistically credible results. The percentages were adjusted to hold factors such as the mix of professions and policy characteristics constant. Thus, the frequencies represent the "true" underlying temporal market trend rather than such factors as a changes in the mix of medical practitioners to higher or lower risk professions, or changes in coverage.

Loss frequencies also tended to exhibit cyclical characteristics. In 1997, 0.9 percent of physicians had a claim closed with payment in 1997. By 2002, this figure more than doubled to 2.0 percent, but declined rapidly in subsequent years. Loss frequency rose substantially again in 2007-2008. However, based on extensive analysis of claims data, it appears that the increased number of claims closed during this latter period is attributable to the implementation of tort reform in August of 2005. Immediately prior to the effective date of the tort reform legislation, Missouri insurers reported historically unprecedented numbers of newly filed claims. Thus, loss frequency exceeded 2 percent in 2007. **However, this figure is anomalous, and does not appear to represent a reversal of the trend.** This interpretation is supported by the fact that loss frequency declined to 1.3 percent in 2008.

Loss Frequency Claims Made Individual Coverage, All Claims-made years Adjusted by ISO Risk Class and Claims-made Year		
Year Closed	**All Closed Claims**	**Paid Claims**
1997	3.3%	0.9%
1998	5.1%	1.4%
1999	4.8%	1.4%
2000	5.8%	1.2%
2001	6.5%	1.5%
2002	6.3%	2.0%
2003	4.8%	1.2%
2004	6.1%	1.1%
2005	5.8%	1.0%
2006	7.2%	1.3%
2007	7.2%	2.1%
2008	6.7%	1.3%

Loss Severity and Adjustment Expenses for Individually-Insured Physicians & Surgeons

Loss severities, or the average indemnity per paid claim, tend to be much more volatile over time than other market indicators. In part, this is attributable to the relatively low volume of insureds compared to other lines of insurance. The statistical "law of large numbers" dictates that a large number of insureds produces actual losses close to predicted values. A low volume of insureds makes losses much more subject to random fluctuation or external factors. Nevertheless, loss severity has also declined in the last two data years.

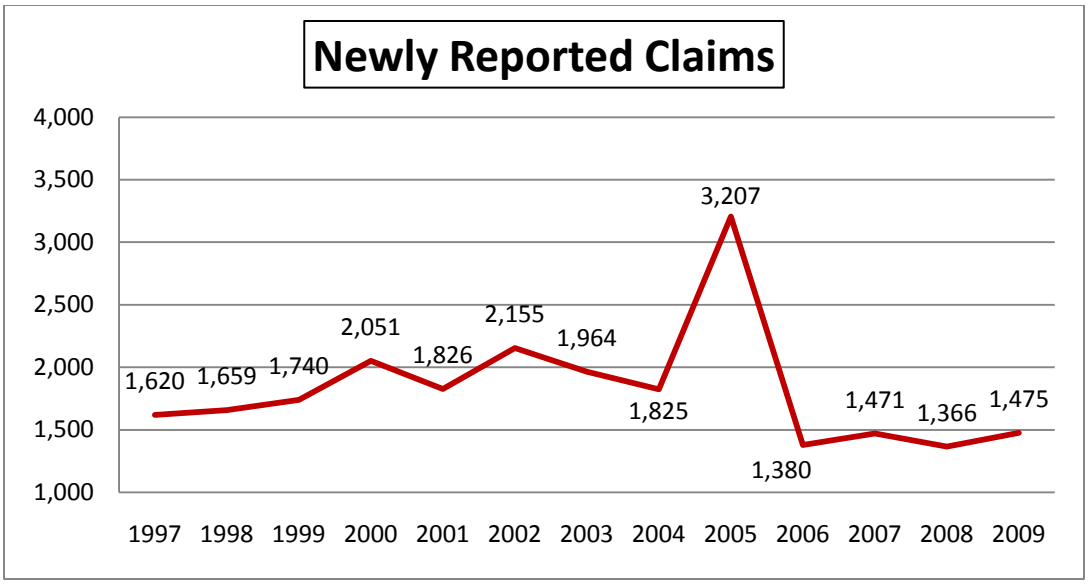
Loss Severity and Adjustment Expenses		
Year Closed	**Loss Severity**	**Severity + LAE***
1997	$182,877	$206,486
1998	$135,265	$151,044
1999	$221,784	$247,324
2000	$248,008	$288,976
2001	$198,936	$247,504
2002	$214,994	$268,029
2003	$201,771	$255,384
2004	$264,698	$338,997
2005	$253,724	$330,096
2006	$314,441	$375,217
2007	$263,733	$297,147
2008	$172,983	$248,522

*LAE means the insure'rs loss adjustment expense in administering a claim.

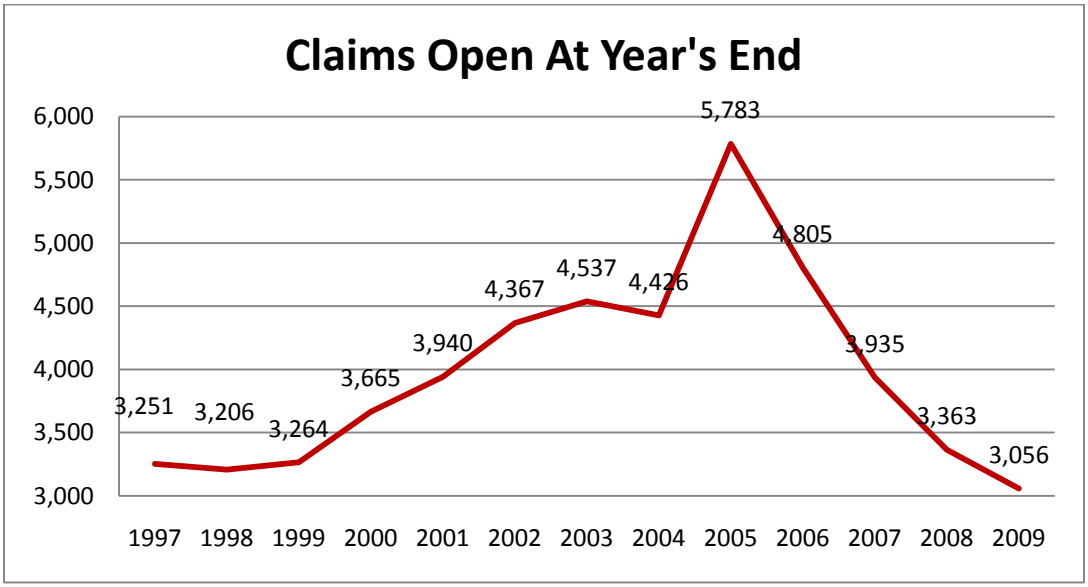
DIFP Claims Data for Individually-Insured Physicians & Surgeons

The DIFP has collected medical malpractice claims data for nearly thirty years. These data also indicate trends similar to those indicated by the HCSFFB data call's premium and exposure information. Claims for physicians and surgeons have declined substantially in recent years. Subsequent to the anomalous 2006 and 2007 period, the number of claims closed, the number of newly-reported claims, and the number of claims outstanding at year's end have all declined substantially.

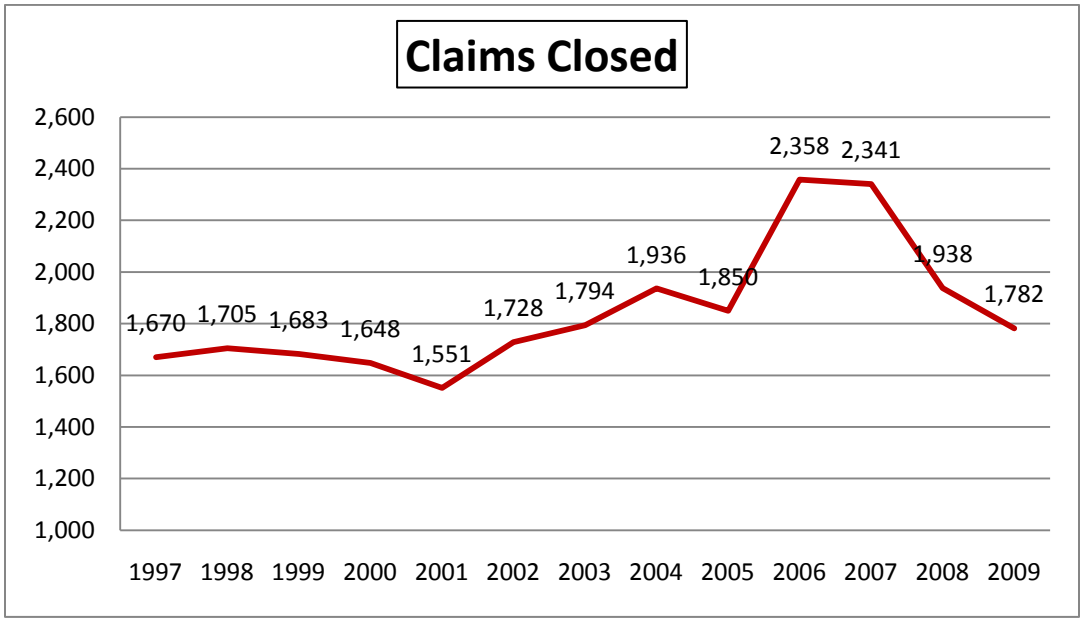
Newly-reported claims drive costs in subsequent years as these claims are adjudicated and closed. In 2007, the number of newly reported claims declined to 1,366, the lowest level since 1997. This figure increased somewhat to 1,475 in 2009, a figure still relatively low by historical standards.

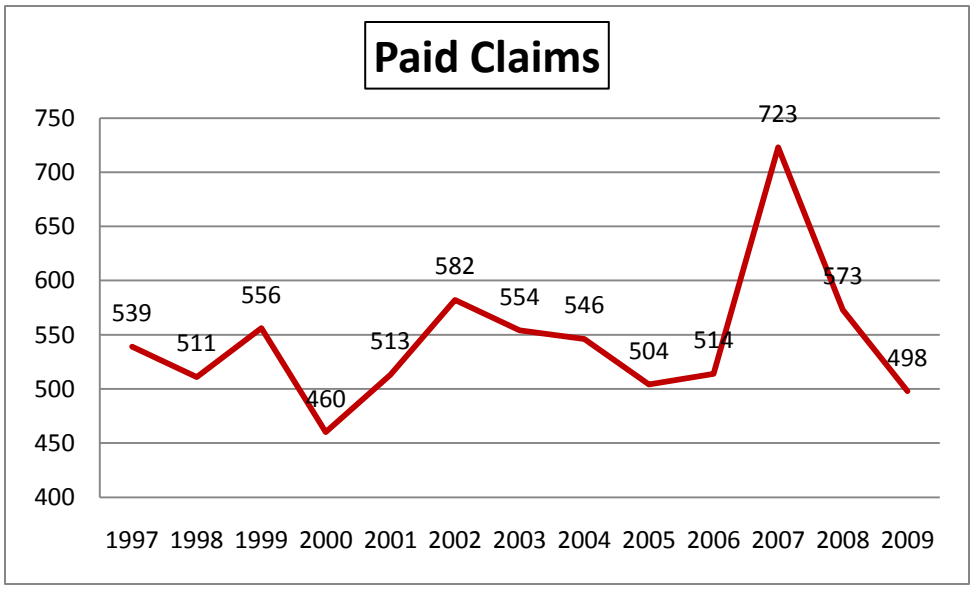


Similarly, the number of claims open at the end of the year declined to 3,056 in 2009, the lowest level over the entire time studied.



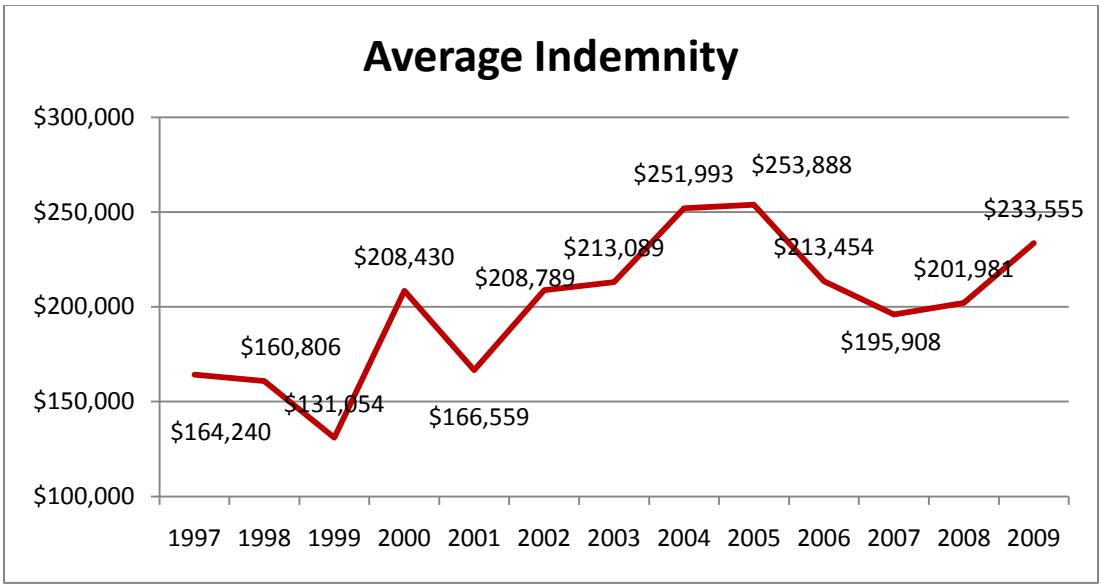
The number of claims closed and claims paid also seem to indicate a downward trend.





Average Indemnity for Individually-Insured Physicians & Surgeons

As discussed earlier, average indemnity amounts are subject to large random fluctuations over time, so that it is more difficult to identify longer-term trends. However, even these amounts declined in 2006 and 2007. While they increased in subsequent years, they are still below the period high observed in 2005.



Objections to Portions of the Report

By Representative Schaaf

The preceding report summarizes much of the material the Healthcare Stabilization Fund Feasibility Board studied during its existence. But the report goes beyond that, and includes recommendations on issues the board did not study. I object to the inclusion of such recommendations, and offer these explanations for my objections:

The Board is issuing its report pursuant to the following statute:

383.515. 1. There is hereby created within the department of insurance the "Health Care Stabilization Fund Feasibility Board". The primary duty of the board is to determine whether a health care stabilization fund should be established in Missouri to provide excess medical malpractice insurance coverage for health care providers. As part of its duties, the board shall develop a comprehensive study detailing whether a health care stabilization fund is feasible within Missouri, or specified geographic regions thereof, or whether a health care stabilization fund would be feasible for specific medical specialties. The board shall analyze medical malpractice insurance data collected by the department of insurance under sections 383.105 to 383.106 and any other data the board deems necessary to its mission. In addition to analyzing data collected from the Missouri medical malpractice insurance market, the board may study the experience of other states that have established health care stabilization funds or patient compensation funds. If a health care stabilization fund is determined to be feasible within Missouri, the report shall also recommend to the general assembly how the fund should be structured, designed, and funded. The report may contain any other recommendations relevant to the establishment of a health care stabilization fund, including but not limited to, specific recommendations for any statutory or regulatory changes necessary for the establishment of a health care stabilization fund.

The statute authorizes the board to report on issues relevant to the creation of a Health Care Stabilization Fund. Other recommendations are not authorized by the statute. The words "The report may contain any other recommendations relevant to the establishment of a health care stabilization fund…" give permission for other recommendations, but only to those relevant. The sentence continues with the abbreviated laundry list "including but not limited to, specific recommendations for any statutory or regulatory changes *necessary for the establishment of a*

health care stabilization fund." It is clear that the words, "for the establishment of a health care stabilization fund", which were stated twice, were intended to prevent the Board from doing precisely what it has done, to include other recommendations in the report. Having now done so, others who want the legislature to act upon the recommendations (for their own political reasons), will argue that they have more weight, because they came from the Board, when the truth is that the Board did not study the issues in depth nor even discuss the potential effects such recommended actions would have on the medical liability insurance market.

Regarding the true weight of these recommendations, one must note that at our final session, held by teleconference on December 17, 2010, this report was adopted by a vote of only five Board members. By statute, there are ten members of the Board; thus the report was not adopted by a majority of the Board, only a majority of those present on the call. I voted no, and four other members were absent. I appreciate that the Board did allow me to append these objections to the report.

On page 11 of the report, under the paragraph "Build on Missouri's Past Market Reforms", is the sentence "The board believes that the state's competition-oriented approach, though healthy today, would likely be enhanced through: 1) more transparent data collection and publication; 2) more traditional insurance market rate oversight by DIFP concerning excessive, inadequate and unfairly discriminatory rates; and, 3) more rigorous treatment of 383 company assessment rules and insolvency situations." The Board studied item 1 extensively, but it did not thoroughly study items 2 and 3, nor the effects such items would have on the market.

I object to the statement that the Board believes items 2 and 3 above would enhance the state's competition-oriented approach. To the contrary, these items could destroy the healthy competition that now exists. On page 12 of the report, under the paragraph "More Traditional Rate Oversight", the report states "…the General Assembly should consider giving DIFP the same authority to regulate any excessive, inadequate or unfairly discriminatory rates as it already possesses for other lines of property and casualty insurance." The entire paragraph, drafted by the DIFP, goes on to argue that the DIFP should be given more power to regulate premium rates, and it would not be surprising if legislation were to appear giving DIFP that authority during the coming legislative session.

While it would have nothing to do whatsoever with the creation of a health care stabilization fund, legislation giving DIFP the authority to regulate (and in effect set) rates could have a chilling effect on competition in the market. Companies shy away from states that have more

regulation, and sometimes leave states that increase the burden of regulation. Also, increasing regulation makes company startup less attractive to entrepreneurs. Competition was the factor that caused premiums to decline following the crisis of 2000 to 2003. If DIFP had been given increased authority to regulate rates at that time, the increase in competition might not have materialized, and the crisis might have been prolonged.

I further object to the recommendations on pages 12 and 13 in the section "Treatment of 383 Company Assessments and Insolvencies". The Board simply did not study in any significant depth the issues of Special Assessments, Insolvency Procedures and Auditing Requirements of 383 companies. None of the people who testified before our committee asked for these new laws; they are all being suggested by the DIFP, and all would increase the power of the DIFP. On page 11 of the report is this sentence: "Historically, they [383's] have not been without their problems, as several went out of business in the 80's and 90's, but as time has passed, they seem to be maturing into the dominant player in this evolving segment of the Missouri insurance market." The sentence is misleading, and implies that 383's failed, leaving doctors in the lurch. To the contrary, the 383's that "went out of business in the 80's and 90's" converted to stock companies that became the dominant market players leading up to the crisis of 2000-2003. It was only when physician groups formed new competing companies under the Chapter 383 laws that competition was increased, and premiums were brought down for doctors. Tinkering with the 383 laws to make it harder for companies to operate as they do now will make it less likely that 383's will be able to form and provide the competition that will be needed when the next premium crisis occurs.

The statement that the General Assembly should consider changes to the current assessment provisions is particularly worrisome and wrong-headed. As a physician, I would not buy an insurance policy that permanently places me at financial risk, even after I retire. I would buy a policy from a stock company instead, even if it cost more. A requirement that 383 companies assess former members in times of financial difficulty will destroy the marketability of 383 companies. Physicians like me will simply not purchase such policies. Further, once such a requirement is passed and about to take effect, current policyholders will cancel their policies and purchase stock company policies, creating a catastrophe for 383's identical to the one the requirement was intended to avoid.

The idea that a 383 company would need to assess former members is order to remain solvent is based not on any historical facts, but only upon a stated theoretical fear. To the department's knowledge, no 383 company has ever assessed its members. Yet many non-383 companies have

gone bankrupt, leaving individual doctors to defend themselves, even with the inadequate help offered by the Guaranty Association law. 383's have not been the problem—they have been the solution—destroying their marketability will only hurt physicians. It will, however, help the for-profit stock companies with whom the physician-owned 383 companies compete.

The insolvency procedures for 383 companies have been critical to their success. After the Tort Reform law of 2005, some if not all the 383 companies were technically insolvent as defined by a sub-zero shareholder surplus. The insolvency procedures worked well, and allowed the companies to overcome the insult of multiple lawsuits filed the day before the new tort law went into effect. That insult caused the companies to appear insolvent on paper, yet a high percentage of the lawsuits, filed without usual preparation, were dismissed. The recommendation in the report that 383 companies lose this important feature is based only upon a theoretical fear of something that has never occurred in the thirty-five years since Chapter 383 was passed—and it ignores the current example that the feature works well. If legislation passes to take away the current insolvency procedure for 383 companies, it will dampen the ability of physicians to raise sufficient capital to form 383 companies, and it will make it harder for 383's to survive their first year or two, or an event such as the tort law of 2005.

383 companies are owned by the physicians they insure, and while few physicians attend the annual shareholders' meetings, some do, and all could. These physician owners have the ability to know about, and effect the operations of, their own companies. In some ways, 383 companies are to the doctors they insure as is The Missouri Consolidated Health Care Plan (MCHCP) to the State of Missouri and the state workers MCHCP insures. MCHCP has no reserves, and relies completely upon the State to fund it in times of high claims. 383 companies do have reserves, but are allowed to rely on themselves (their doctor owners) for needed funds in times of high claims. The General Assembly has shown no fear of allowing MCHCP to operate without reserves, and it should not deny willing doctors the ability to self-insure under the current 383 laws (which place them in much less danger than MCHCP does the state by going completely bare).

The auditing requirements of 383 companies were never discussed by the Board, and the inclusion of the suggestion that they be changed comes as a surprise. Since no 383 has ever gone bankrupt nor even assessed its members, no problem with auditing has been shown. The report suggests that oversight of 383's should be brought into "conformity with the remainder of the industry". The examination by DIFP of each 383 company every 3 years has worked well, and in addition, yearly audits are done by the auditors retained by each company under strict rules.

Again, increasing regulations for no demonstrated reason only works to inhibit new 383 companies from forming. The costs of yearly examination would be substantial, and would increase the premium costs doctors must pay for their insurance. Such an increase is not warranted without a demonstrated cause. The stock companies with which 383 companies compete would, however, benefit competitively from new requirements on 383's.

In summary, I object to the inclusion of recommendations that new regulations be placed upon the medical malpractice insurance industry and upon 383's in particular. Such recommendations were not authorized by the statute that created the Health Care Stabilization Fund Feasibility Board, and the Board did not adequately study and discuss the effect such recommendations would have on the market. The Board should not be making these recommendations. A majority of the full board did not vote on them. Their inclusion in the report will likely be wrongly and unfairly used during legislative debate as evidence that the Board did fully study these issues, when in fact it did not. Some market players may unfairly use the recommendations to better their market positions, e.g., stock companies to argue that 383 companies need more regulation. Newly proposed laws on 383's may be encouraging for any 383 looking to convert to a stock company, leaving its old competitors to deal with the new regulatory environment. In short, there may be hidden politics behind these recommendations, which go far beyond the scope of consideration for a Health Care Stabilization Fund. I strongly object.

Rob Schaaf, M.D., State Representative, District 28