

Guy Carpenter Views

Reprinted from www.guycarp.com

March 2003

Developments in the Medical Professional Liability Insurance Markets



Years of underwriting losses combined with skyrocketing jury awards have created a new paradigm of claims severity for insurers and reinsurers in the medical professional liability marketplace.

The medical professional liability market is facing challenging times. Insurers and reinsurers in this segment have suffered years of underwriting losses, caused by intense competition and underpricing of business to gain market share. In addition, medical malpractice jury awards have increased to record levels, causing a new paradigm of claims severity.

Industry losses were less problematic during the bull market, when they were offset by investment income. Now, however, claims costs and related expenses have skyrocketed, while investment gains have all but disappeared. Many insurers have responded by either leaving the market or imposing strict underwriting conditions under which they will consider writing this business.

Guy Carpenter Views speaks with Steve Underdal, Managing Director and Guy Carpenter's Medical Professional Liability Practice Leader, about developments currently affecting this market and the changes he expects to see in the future.

In Part One of this interview, Steve describes the types of coverage provided by medical professional liability policies and offers an overview of events contributing to current market conditions. He continues in Part Two with a discussion of current changes in the price and availability of this product, what reinsurers are doing to reduce their exposure, and the impact of new and proposed legislation. Then, in Part Three, Steve shares his views on how he expects the medical professional liability market to evolve going forward.

■ Part One

Description of Primary Insurance Product

Guy Carpenter Views: Can you briefly describe the coverages provided under medical professional liability policies? How is coverage structured? What limits are typically offered? Are the costs of

defense typically included?

Steve Underdal: Medical professional liability (MPL) insurance covers doctors, healthcare facilities, and other professionals in the medical field from liabilities arising from alleged errors or omissions in the rendering of professional services.

Two distinct forms of MPL insurance coverage are available: "claims made" and "occurrence."

The vast majority of MPL insurance policies are claims made, which means that the medical incident or claim must be reported to the insurance company during the time that the policy is in force. Once the policy has been terminated, coverage no longer exists (unless "tail," or extended reporting period, coverage has been purchased).

Claims-made policies allow the insurer to more accurately predict the cost of pending claims and to price the product, because the exact inventory of claims is known at the end of a report year. With the occurrence policy form, in contrast, the number of ultimate reported claims might not be known for decades after the policy's issuance date.

The occurrence form covers medical events that happen during the policy period regardless of when the ultimate claim is made. This type of coverage is the broadest protection available, but it is the exception today because of the difficulty it creates for insurers in projecting their long-term claims costs.

The coverage and policy limits purchased are driven by the needs of the medical professional. For example:

- Under physicians and surgeons policies, most insureds purchase primary policy limits of \$1 million per claim/\$3 million in the annual aggregate. The coverage trigger is usually claims made, with defense costs covered in addition to policy limits.
- As respects allied healthcare professionals (e.g., nurses, dentists, chiropractors), insureds commonly purchase \$1 million/\$3 million primary limits, with defense costs covered in addition to policy limits. Because this coverage has not been as volatile as other MPL classes, a number of insurers continue to issue coverage on an occurrence policy form.
- For hospital professional liability business, it is important to note that most MPL lawsuits name the hospital as a "deep pocket" defendant. Consequently, hospitals require higher policy limits than do individual medical practitioners and typically purchase primary coverage of \$1 million/\$3 million (usually with a deductible, but first-dollar coverage is still in vogue in rural areas), combined with excess umbrella limits of \$5 million or \$10 million. Defense costs are generally covered in addition

to policy limits within the primary layer, and can be either inside or outside the liability limits in the excess layer.

Large hospital systems typically have risk management attorneys on staff and intricate loss control procedures in place. Thus, they generally elect to retain a sizeable amount of risk via a captive insurance company, self-insured retention (SIR), or large deductible.

Some of the larger hospital systems purchase excess-layer policy limits of several hundred million dollars from commercial insurers and reinsurers. Most high-layer excess policies include defense costs within policy limits.

Reinsurance Product Description

GCV: What is covered under MPL reinsurance treaties? How have these treaties traditionally been purchased and structured (e.g., in terms of exclusions, policy limits, retentions, triggers)?

SU: Primary medical professional liability reinsurance coverage is usually structured on an excess of loss basis. During the soft market cycle, some reinsurers were willing to entertain primary business on a quota share basis. With some MPL insurance companies experiencing financial leverage problems today, insurers are also considering surplus relief quota share reinsurance coverage to provide the additional capacity to take advantage of primary rate increases or new business opportunities.

Reinsurance coverage for high-layer excess hospital professional liability business is usually covered on a pro-rata basis. Most reinsurers require such coverage on high excess layers in order to benefit fully from the tremendous increases in premiums per exposure, as well as in recognition of the inherent difficulty in developing an appropriate excess reinsurance rate for "excess on excess" business.

GCV: Are reinsurers in this market generally willing to follow the fortunes of their clients, or have they imposed certain limits on the coverage that they offer?

SU: Following-form reinsurance coverage, even for underlying occurrence MPL business, was commonplace during the protracted soft market.

During the last two reinsurance renewal cycles, however, we have witnessed the following reinsurance coverage restrictions:

- Reinsurer loss ratio caps on ultimate liability, or limited reinstatements of the reinsurance limit. These provisions are prevalent on business emanating from claims severity "hot spot"

jurisdictions,
or for "imbalanced" excess layers.

- Exclusions. Reinsurers have insisted on some, or all, of these exclusions:
 - Terrorism;
 - Bioterrorism;
 - Cyberterrorism;
 - Toxic mold.

As an aside, the Terrorism Risk Insurance act of 2002 specifically exempts MPL coverages from its scope. The terrorism exclusions outlined above, however, would still be applicable to ancillary general liability coverages written in conjunction with a hospital professional liability policy.

- Policy form coverage restrictions, such as an express reinsurance warranty that all subject business must be insured on a claims-made basis.
- Reinsurance sublimits of liability for perceived volatile classes, such as managed care or nursing homes. We have also witnessed the inclusion of reinsurance sublimits for commercial auto liability coverage written in conjunction with a hospital professional liability umbrella policy in response to a recent industry claim that settled for more than \$50 million.

GCV: What types of entities generally purchase this class of reinsurance coverage (e.g., hospitals, physician and surgeon groups, nursing homes, captives)?

SU: Guy Carpenter's MPL client base is diverse, ranging from large commercial insurance companies to captive insurers of physician groups or hospitals. Our firm currently provides reinsurance services to 5 of the 10 largest MPL insurance companies.

The traditional MPL insurance market comprises approximately \$7 billion of industry premiums. Our clients within this segment include stock insurance companies as well as provider-owned insurers (e.g., the Physicians Insurers Association of America (PIAA) group of companies, sometimes referred to as the "bedpan mutuals," or the Hospital Insurance Forum group of companies). The market share of the provider-owned insurers has grown dramatically in recent years.

Alternative market MPL insurance products, which have historically enjoyed a robust presence, have grown significantly during hard market cycles to where they now comprise almost \$6 billion in industry premiums. This is an area of expansion for Guy Carpenter's Healthcare Practice, and we have initiated a number of alternative market mechanisms to address the availability and affordability problems of the MPL market. Working closely with Marsh HealthSpectrum, our client base includes the following alternative market entities:

- Risk retention groups;

- Captive insurance companies;
- Trusts;
- Residual market mechanisms, such as joint underwriting associations or other state-administered plans;
- Patients' compensation funds.

Impact of the Move to Managed Care

GCV: How has the move to managed care affected your clients' exposures?

SU: The perceived rationing of medical services under managed care plans has shifted the focus of medical malpractice from committed medical errors to omitted medical procedures. Since capitation arrangements were first introduced, many lawsuits have developed in which patients allege that the necessary care was not provided.

Primary care physicians in most managed care plans serve as "gatekeepers" to specialists in an effort to control healthcare costs. Limiting access to specialists has arguably lowered the quality of healthcare and has caused managed care organizations and physicians to become attractive targets for trial lawyers attempting to capitalize on the social backlash against managed care.

Of note, the federal Employee Retirement Income Security Act, known as ERISA, generally has restricted lawsuits against managed care organizations to instances of denial of covered benefits, as opposed to medical malpractice claims. In recent years, courts have weakened this defense and have allowed cases to proceed where decisions by managed care organizations allegedly caused harm to patients.

GCV: Has the move to managed care affected the types of coverages offered by MPL insurers?

SU: During its infancy, managed care was an unknown exposure with no credible industry data. During the recent soft market cycle, MPL insurers commonly added managed care liability coverages for little or no premium, resulting in huge industry losses.

Today, most MPL insurers shy away from offering managed care coverage because of its claims volatility, leaving it to the few insurers willing to offer this business on a stand-alone basis.

Managed care industry loss data is beginning to attain credibility. One favorable claims trend we have noted is the improvement in loss experience for denial-of-benefit claims, which has resulted from managed care organizations' implementation of formal utilization review procedures and mandatory

rights of appeals for such claims. The trial lawyers, however, have recently brought suits seeking billions of dollars in damages against the larger managed care organizations via class actions initiated on behalf of providers and subscribers. In view of the size and scope of potential damages, the resolution of these cases will determine the fate of the managed care liability insurance industry.

The Evolution of Current Market Conditions

GCV: What are some of the factors that have contributed to the current crisis in the availability and affordability of MPL insurance?

SU: During the 1990s, the MPL insurance market was in the middle of a soft underwriting cycle. Price competition was intense, and primary rates were inadequate. To gain market share, many companies began to turn to geographic and product expansion. For example, certain physician companies decided they could write coverage for hospitals, and several carriers that were successful in one state decided that they could write business in other states or regions. For some of these companies, the outcome was disastrous.

At the same time, a handful of the PIAA insurers became publicly traded companies, which changed their mission from being stable providers of medical malpractice coverage to being for-profit companies bent on meeting or beating street earnings expectations, which is difficult to accomplish in a soft market.

As the 1990s ended and we entered a new millennium, a confluence of factors began to occur that ultimately led to the hard MPL market that we are experiencing today:

- Increased claims severity. The average medical malpractice jury award has risen to almost \$3,500,000, with several well-publicized verdicts exceeding \$100 million. This phenomenon has created a "lottery mentality" in the eyes of the trial bar and disaffected patients.
- Unprofitable primary and reinsurance results. The MPL insurance industry's combined ratio soared to 143 percent during 2001, with most carriers contributing to this sea of red ink.
- Deficient industry loss reserves. A.M. Best Company believes the MPL industry is currently under-reserved to the tune of several billion dollars.
- Declining investment yields caused by low interest rates and the free fall of the equity market.
- Increased reinsurance costs.
- The market's slow reaction to years of intense price competition and lax underwriting standards. A number of insurers were reluctant to take the corrective rate and reserve actions that were necessary, thereby exacerbating the depth of the soft market.

In 2001, MPL premiums increased by double-digit percentages, forcing many healthcare providers to cut back even further on high-risk locales, procedures, and specialties. The American Medical Association reported that 12 states are in the middle of an MPL crisis, and medical professionals in 30 other states report having problems finding available and affordable coverage. Pricing and availability trends continued to escalate during 2002.

■ Part Two

Claim Frequency and Severity

GCV: Have the frequency and severity of MPL insurance claims changed much over the past few years? What are the major reasons behind such changes?

SU: Although claim frequency has remained fairly steady for the past several years, the tremendous and unexpected increase in claim severity is the most troubling issue currently facing the medical professional liability insurance marketplace.

A number of factors have contributed to this increase, including greater public attention to patient safety, increased publicity about hospital and doctor errors, desensitization to huge jury awards, and public backlash against the managed care industry.

Changes in Pricing, Availability, and Coverage Terms

GCV: In your opinion, what is causing MPL premiums to spiral? Do the various stakeholders agree about the reasons behind these price hikes?

SU: Increased industry claims costs for both indemnity and defense are the major drivers of the rise in premiums. However, the principal constituencies strongly disagree about what is causing prices to escalate.

The insurance industry places the blame on the increasing size of jury awards and ultimate settlements.

Alternatively, trial lawyers and plaintiffs believe that insurers are raising rates to make up for underpricing their coverage during the competitive market of the 1990s, and that they are using the September 11 industry losses as political and economic justification for doing so.

GCV: What measures do observers feel would be necessary to keep MPL premiums affordable?

SU: Substantive tort reform has proven to be an effective means of keeping premiums in check.

Non-economic damages strike at the heart of this issue. Although no one argues that an injured party should be able to recover money for economic damages, such as medical care and loss of income, many observers believe that limits should be placed on subjective awards for noneconomic damages, such as pain and suffering. Critics argue that juries have abused their discretion with the recent trend toward large and random awards for noneconomic damages.

GCV: How have primary writers and reinsurers been protecting themselves in this challenging environment? Are they withdrawing capacity? Inserting exclusions? Reducing limits?

SU: Since many underwriters have diminished capacity to assume MPL risks, they are being far more cautious about the risks that they do elect to write.

Both primary writers and reinsurers are now closely examining the geographical areas in which they write MPL business and are withdrawing capacity from states that are considered "plaintiff friendly." They are also less willing to assume business from healthcare industry segments considered to be high risk.

Coverage terms are changing as well, with insurers and reinsurers attempting to minimize their exposure by raising attachment points and lowering the limits being offered on a single policy. In addition, underwriters may impose some or all of these stipulations:

- No multiyear policies or rate guarantees.
- Limitations on "prior acts" coverage.
- Restrictions on aggregate policy limits.
- Attachment on an each-and-every-claim basis above underlying self insured retentions (SIRs), to prevent the chance of "drop down" in the event of erosion of underlying aggregate limits of the SIR.
- Mandated minimum insured retentions in difficult jurisdictions.
- Limited duration and increased price for extended reporting period or "tail" coverage.

GCV: Which states are currently considered trouble spots in this market? How are providers and insurers dealing with availability problems in those states?

SU: The American Medical Association has recently declared the MPL market to be in a "crisis" stage in

18 states: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. These jurisdictions have a high incidence of medical malpractice claims, and juries in these states are considered to be more likely than in other states to award large damages to the plaintiff.

Healthcare providers in these claims-severity "hot spots" are having a difficult time finding adequate and affordable MPL insurance. Some of these organizations are responding to this capacity shortfall by assuming more risk—via SIRs, large deductibles, or captives—while others are turning to state-assigned risk pools or even going bare.

GCV: What about certain specialty areas? Are they having problems finding coverage?

SU: MPL insurers and reinsurers have come to view certain medical specialties—such as emergency medicine, internal medicine, obstetrics/gynecology, and neurosurgery—as high risk because of their potential for costly litigation in the event of allegations of medical negligence. Most writers of MPL insurance and reinsurance coverage are selectively underwriting and allocating limited capacity to these troubled specialties, and the coverage that is available has become much more expensive.

GCV: Did the events of September 11 have much of an effect on capacity in this line?

SU: The impact of September 11 on the MPL insurance sector was less direct than on other business classes. Still, writers of this coverage feel the effect because capital has been reallocated to lines of business having the greatest returns on equity, and the MPL insurance segment has been a "loss leader" in recent years.

Several insurers, however, are optimistic about the longer-term viability of the MPL marketplace and have entered this class to capitalize on the current availability and affordability crisis. Guy Carpenter is at the forefront in providing reinsurance capacity for several of the new MPL players.

GCV: What has been the impact on the market of the recent withdrawal of St. Paul from the MPL arena? Can you discuss some of the other factors affecting MPL coverage availability in the current marketplace?

SU: The withdrawal of St. Paul from the MPL market late in 2001 shocked the industry, and has created a market vacuum of more than \$500 million in written premiums. From a policy count perspective, St. Paul's market exit has left the following number of insureds in search of replacement coverage:

- Physicians—42,000.

- Hospitals—750.
- Healthcare facilities—5,800.
- Nurses and allied healthcare professionals—72,000.

The MPL marketplace has suffered even greater dislocation as a result of insurance carrier rating downgrades and financial impairments. Frontier, Legion, MIIX, PHICO, and Reciprocal of America are all examples of insurers that have exited the market due to financial impairment.

A relatively large number of the remaining MPL players now accept business only from their state of domicile, have implemented restrictive underwriting procedures, and suffer from a lack of premium volume capacity to assume new business opportunities. All told, we estimate that as much as \$2 billion in written premiums, which equals almost one-third of the traditional market premiums, are potentially in need of a new home.

GCV: Where is new capacity coming from? Is Bermuda playing a role?

SU: The MPL insurance "crisis" has attracted new capacity attempting to capitalize on the hard market conditions. Both domestic and Bermuda insurers are entertaining MPL business. As I mentioned earlier, Guy Carpenter is playing a leading role in developing reinsurance capacity for these new players.

The Regulatory Environment

GCV: Many market participants and observers believe that tort reform at the federal level is the only way to control excessive litigation and to limit escalating liability premiums. Can you discuss the ways in which the current administration is seeking to address problems regarding the cost and availability of MPL insurance and the severity of lawsuits?

SU: The U.S. House of Representatives has passed nationwide tort reform via H.R.4600, a bipartisan bill championed by the Bush administration as a way to address insurance availability and affordability problems. The purpose of the bill is reduce MPL insurance costs by limiting the noneconomic damages that injured patients could win from healthcare providers, while still allowing uncapped reimbursement of actual financial losses. Specifically, H.R. 4600 would:

- Limit noneconomic damages, such as pain and suffering, to \$250,000.
- Place a cap on punitive damages of up to two time economic damages, or \$250,000, whichever is greater.
- Implement a "fair share" rule that allocates damage awards equitably and in proportion to a party's degree of fault.

- Allow medical providers to pay judgments in periodic installments rather than in one lump sum.
- Limit to three years, or to one year after the claimant discovers the injury, the time period within which a healthcare liability action must be filed.
- Require juries to be informed if a plaintiff has other potential sources of reimbursement for an injury.

Critics of H.R. 4600 have insisted that the bill limits medical malpractice damages to \$250,000 and thus deprives plaintiffs of fair compensation in the event of gross medical negligence. These opponents fail to mention, however, that the cap applies only to noneconomic damages, such as pain and suffering, while economic damages, such as the loss of present and future earnings, continue to be uncapped. In coming months, this bill will be the focus of Senate hearings.

■ Part Three

January 2003 Renewals

GCV: What changes did you see at January 2003 renewals in terms of pricing, limits, and coverage terms?

SU: Although the January 1, 2003 renewal process was more orderly than the previous cycle, reinsurers are still pushing the envelope on pricing and general terms and conditions. The market is very disciplined, with reinsurers being reluctant to quote against established leads. Reinsurers also have very stringent ROE requirements that must be met on each reinsurance layer.

Most reinsurers sought and attained double-digit rate increases at January 1, 2003, on top of the double-digit strengthening that they achieved in 2002. They were willing to accept lower effective rate increases, however, where companies agreed to raise primary rates and to increase limits factors to favorable levels or where business emanated from locations with substantive tort reform.

Our general market observations regarding January 1, 2003 renewals are that:

- Primary rate adequacy and claims severity potential are the chief concerns of reinsurance underwriters.
- Reinsurers ignore investment income in their pricing models for this long-tail line of business, which is a wholesale change from the soft market practice of discounting reinsurance pricing for investment returns.
- As a precondition of support, reinsurers often mandate primary rate increases and may require

triple or quadruple increases in minimum premiums for each \$1 million band of offered policy limits on high excess layers.

- Reinsurers have tightened terms and conditions significantly by:
 - Eliminating or reducing profit sharing.
 - Reducing ceding commissions.
 - Including loss ratio caps or limiting reinstatements of the reinsurance limit.
 - Increasing margins.
 - Requiring pre-approval of certain risks, such as hospitals that exceed a certain bed size or healthcare providers located in a tough claims jurisdiction, or physicians engaged in volatile specialties.
 - Requiring sublimits of liability, or excluding coverage, for nursing home, managed care, or occurrence business, all of which have been unprofitable in the past.
 - Limiting reinsurance capacity for MPL startup operations, primary layer pro-rata business, or insurers operating in one of the claims severity "hot spot" jurisdictions.

GCV: Do you expect reinsurers to exclude coverage for terrorism exposures?

SU: Medical professional liability business is specifically excluded from the scope of the Terrorism Risk Insurance Act of 2002 (TRIA). General liability coverages for hospitals have seen exclusions of terrorism, or specific sublimits of liability.

Guy Carpenter's Role

GCV: What competitive advantages do Guy Carpenter brokers offer their MPL clients in this market?

SU: Guy Carpenter's highly experienced medical professional liability broking team provides the intellectual capital needed to help our clients better respond to their insureds' needs, while managing their own evolving exposures.

Knowledge of each state's legal and regulatory climate is absolutely essential. Our strong local presence is augmented in numerous ways by the unparalleled resources of the global Marsh/Guy Carpenter HealthSpectrum organization. Working as a team with other offices, we ensure that we are able to provide all of the technical expertise that our clients may need.

For example, our actuarial and modeling group, InStrat, is comprised of a number of MPL experts who can assist us in helping our clients analyze and quantify their spectrum of risks, develop risk curves by geographic regions, and assess the impact of their risk management decisions. InStrat's experts also have the tools to illustrate the reinsurance programs that will optimize operating capital.

The Future

GCV: What are some of the current and emerging issues that are likely to affect the MPL market going forward?

SU: Several issues are on the horizon that will affect the MPL environment in the years to come:

- The Health Insurance Portability and Accountability Act (HIPAA). This federal law establishes rights and liabilities concerning patient privacy issues and the release of medical data.
- The Patients' Bill of Rights. The U.S. Senate and House have passed different versions of this proposed legislation, with conferees and the White House yet to agree on the particulars of a final bill. The statute is designed to improve access to healthcare for those participating in managed care organizations, as well as establish remedies and damages for violations of the law.
- Tort reform. The U.S. House of Representatives as well as several states have enacted tort reform legislation. Whether the U.S. Senate will act on federal tort reform with an election year looming, or whether state courts will hold the specific reforms constitutional, remains an open question.
- Evolving exposures from managed care.

GCV: Are you optimistic about the future of the MPL reinsurance market? What developments do you expect to see over the next few years? How is Guy Carpenter preparing for the future?

SU: A number of positive signs leave us fairly bullish about the future prospects of the MPL marketplace. Both primary and reinsurance rates are on the rise, and companies have strict underwriting guidelines in place and are practicing policy limits management. There has also been a pullback in product and geographic expansion, while substantive tort reform is on the rise. Several negative market influences also exist:

- The new MPL players are well capitalized and have aggressive growth plans.
- The plaintiffs' bar is well funded, with pockets lined from tobacco litigation and excellent political connections.
- Claims severity is unchecked in jurisdictions that lack tort reform or have runaway jury verdicts.

In the near future, we think the MPL market will be rather disjointed. We expect to see some pricing moderation in geographic areas that have instituted tort reforms and have no significant problems with claims severity.

In jurisdictions currently identified as being in a state of "crisis," we expect market hardening to continue. Until and unless steps are taken to improve the regulatory and legal environment in these locations, market softening is not likely to occur in the near term.

Working closely with Marsh and InStrat, our goal is to be on the cutting edge of products, services, and coverages needed to address the ever-changing requirements of the medical professional liability marketplace.

Guy Carpenter & Company, Inc. ("Guy Carpenter") provides this publication for general informational purposes only. The data contained herein is based on sources Guy Carpenter believes to be reliable, as of a specified date, but Guy Carpenter in no way guarantees its accuracy. Guy Carpenter makes no representations or warranties, express or implied, concerning the statements made herein or the financial condition or solvency of reinsurers. Past performance does not guarantee future outcome, and readers are cautioned against placing undue reliance upon any forward-looking statements. Guy Carpenter does not undertake any obligation to publicly update or revise the material herein, regardless of new data, future events or otherwise.

This document is not an offer to sell, or a solicitation of an offer to buy any financial instrument or reinsurance program. This report, its data and the methodology utilized are proprietary to Guy Carpenter. The dissemination, reproduction or use of this report without Guy Carpenter's express written permission is prohibited.