

STATEMENT OF JAY ANGOFF
before the
Human Rights and Wellness Subcommittee
of the
House Government Reform Committee
on
Medical Liability Insurance Costs

October 1, 2003

Mr. Chairman and members of the Committee, my name is Jay Angoff and I am a lawyer from Jefferson City, Missouri. I served as insurance commissioner of Missouri between 1993 and 1998, and I have also served as deputy insurance commissioner of New Jersey and director of the Private Health Insurance Group at the U.S. Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). I appreciate the opportunity to testify here today on the question whether patients are needlessly suffering because of the high cost of liability insurance.

One way, and perhaps the best way, to answer this question is to seek to quantify any changes in access to health care and to determine the causes of access problems in states in which such problems have been reported. This is what the GAO did in its August 2003 Report entitled Medical Malpractice: Implications of Rising Premiums on Access to Health Care ("GAO Access Report"). As you know, the GAO found only scattered access problems in the five states it analyzed with reported problems, and it found that such problems typically existed only in rural areas and that there were long-standing causes of these problems. GAO also emphasized that reports of access problems were often exaggerated. It summarized its findings as follows:

"GAO also determined that many of the reported provider actions were not substantiated or did not affect access to health care on a widespread basis. For example, although some physicians reported reducing certain services they consider to be high risk in terms of potential litigation, such as spinal surgeries and mammograms, GAO did not find access to these services widely affected, based on a review of Medicare data, and contacts with providers that have reportedly been affected."

The Executive Summary from the GAO Access Report is attached as Exhibit 1.

Another way to answer the question whether high malpractice premiums are a likely cause of access problems is to determine the percentage of doctors' incomes that is accounted for by malpractice premiums: the higher this percentage, the more likely it is that an increase in this percentage could result in a doctor restricting his practice in order to reduce his malpractice premium. The magazine Medical Economics publishes data relevant to this issue. For example, Medical Economics does an annual survey of doctors' incomes by specialty and by region, and has also done a recent survey of the average malpractice premium paid by specialty. In November 2002 Medical Economics found that the average doctor's net income--after malpractice premiums and other expenses--ranged from \$146,601 for family practitioners without obstetrics to \$362,208 for invasive cardiologists. See Exhibit 2. It also found that doctors' incomes were highest in the south, and lowest in the west: for example, the average gastroenterologist made \$354,680 in the south, but only \$251,252 in the west. See Exhibit 3. Medical Economics also found that malpractice premiums accounted for between 1.2% and 5.5% of a doctor's gross receipts, with cardiologists paying the lowest malpractice premiums as a percentage of their gross and ob-gyn's paying the highest. See Exhibit 4.

The Medical Economics surveys were conducted before the malpractice insurance increases of the last two years. As I will explain, these increases are likely to prove to be excessive, just as the malpractice insurance increases during the mid-1980's have proven to be excessive. Nevertheless, even assuming 100% increases in insurance premiums for all doctors since the Medical Economics surveys were conducted, and even assuming that no doctor's gross compensation increased, malpractice premiums today have reduced doctors' net incomes by only 1.2% (for cardiologists) to 5.5% (for ob-gyn's). Reductions

in compensation of these magnitudes--particularly when doctors' average net incomes range from \$147,000 to \$362,000--would not appear likely to have a material adverse impact on doctors or their patients.

Both the findings of the GAO and the level of malpractice premiums in relation to doctors' incomes indicate, therefore, that the level of malpractice premiums is not having an adverse effect on access to care. Nevertheless, there is no denying that malpractice insurance rates have increased sharply in the last two years, just as they did in the mid-1980's, and just as they did in the mid 1970's. To a certain extent, short periods of sharp increases in insurance rates are an inevitable result of the insurance cycle, as the GAO found in its June 2003 Report entitled Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates ("GAO Multiple Factors Report"). Nevertheless, Congress, state legislatures and state insurance commissioners can take certain actions to reduce these periodic sharp increases in rates and moderate the insurance cycle. They include the following:

1. Compress the rating categories, and more heavily weight experience within categories. Malpractice insurers typically charge the specialties paying the highest premiums--such as ob-gyn's--between 800% and 1300% of what they charge specialties paying the lowest premiums--such as psychiatrists and dermatologists. Conversely, malpractice insurers typically charge doctors with incidents no more than 200 to 300% of what they charge doctors with clean records. By reducing the differential in rates between categories and possibly combining certain categories, and by giving greater weight to experience within the categories, rates for doctors with clean records who are today paying the highest premiums--such as ob-gyn's--could be materially reduced.

2. Establish strict prior approval for both rate increases and rate decreases. In most states today malpractice insurers can implement rate changes--both increases and decreases--without first obtaining the approval of the state insurance department. Allowing insurers to unilaterally implement rate changes enables insurers to respond to competitive pressures, and made it easy for malpractice insurers to cut their prices during much of the 1990's when their investment income was high--which obviously benefited the doctors buying the insurance. On the other hand, the ability of insurers to increase their rates without first getting the insurance department's approval--particularly in

combination with the insurance industry's antitrust exemption--makes it easy for insurers to substantially raise their rates when their investment income is low, as is the case today. If conscientiously enforced by insurance commissioners, strict prior approval systems would moderate both price-cutting when investment income is high and price increases when investment income is low.

3. Require automatic hearings on any proposed rate increases of more than 15%. This is one of the many reforms included in California's Proposition 103, which was approved by the voters in 1988. It has had the practical effect of limiting proposed malpractice increases to less than 15%.

4. Repeal the antitrust exemption for the insurance industry. This is another of the reforms contained in California's Proposition 103. Insurers are exempt from the federal antitrust laws under the McCarran-Ferguson Act; in addition, most states both expressly exempt the business of insurance from their antitrust laws, and authorize conduct that would otherwise violate the antitrust laws in their insurance rating laws. Proposition 103 makes insurers subject to California's antitrust laws, as well as to its unfair business practices laws. While the effect of the antitrust exemption should not be overstated--it does not, for example, prevent insurers from cutting price when their investment income is high--it does permit insurers to raise their prices collectively when investment income is low. And Prop 103 does appear to have had the effect of reducing premiums: malpractice premiums tripled in California in the seven years before Prop 103 was enacted in November 1988, but thereafter they decreased, and even in 2000--12 years after the enactment of Prop 103--they were lower than they were in the year in which 103 was approved. See Exhibit 5.

5. Establish a state-authorized insurer to write medical malpractice insurance. Missouri established such an insurer for workers compensation insurance in 1994 with a \$5 million loan from the state, and that insurer has been a success: it paid back its loan ahead of schedule, and it is now a significant player in the Missouri workers compensation market. It initially was exempted from certain solvency requirements in order to facilitate its growth, which was controversial; it is no longer exempt from such requirements. Establishing a state-authorized medical malpractice insurer would also be controversial, and might also require certain start-up exemptions. But it potentially could be a major player in a state medical malpractice market, just as Missouri's workers comp insurer is in the Missouri workers comp market.

6. Establish standards that insurers must follow in estimating their "incurred losses." Perhaps the most fundamental reason for periodic sharp increases in insurance rates is that insurers base their rates not on the amounts they have actually paid out in the past but on the amounts they estimate they will pay out in the future, and insurers have virtually unlimited discretion in determining those estimates. Thus, the rates insurers are charging today are based not on what they are paying out today, but on what they estimate they will pay out in the future for claims covered by policies in effect today. We therefore will not know whether the rates insurers are charging today are excessive until

they pay all the claims covered by policies in effect today--and that will not happen for another 10 years.

On the other hand, we do know today that the rates malpractice insurers charged during the last insurance crisis were excessive, since according to data from Best's Aggregates and Averages, the amount they predicted they would pay out on claims-made policies in effect in 1986 and 1987 turned out to be 26.4% and 31.3% more than the amount they actually paid out on those policies; and the amount they predicted they would pay out on occurrence policies in effect in 1986 and 1987 turned out to be 32.2% and 37.8% more than the amount they actually paid out on those policies. Or as GAO put it, "insurer losses anticipated in the late 1980s did not materialize as projected, so insurers went into the 1990s with reserves and premium rates that proved to be higher than the actual losses they would experience." GAO Multiple Factors Report at 44. We can not know definitively today whether the rates malpractice insurers are charging today are excessive: as GAO put it, "it remains to be seen whether these increases will, as occurred in the 1980s, be found to have exceeded those necessary to pay for future claims losses, thus contributing to the beginning of the next insurance cycle." *Id.* at 45. Nevertheless, based on the precedent of the mid-1980's--as well as the dramatic difference between malpractice insurers' actual current payouts and their estimated future payouts--no one should be surprised if in 2012 or so the rates malpractice insurers are charging today are revealed to be materially excessive.

In short, incurred losses fluctuate substantially year-to-year because insurers have virtually unlimited discretion in establishing their incurred loss estimates. The substantial fluctuations in these estimates, combined with fluctuations in investment income and reinsurance rates, cause substantial fluctuations in insurance rates. If states enacted standards that insurers were required to follow in establishing their incurred loss estimates, these fluctuations could be reduced.

In conclusion, the GAO Multiple Factors Report found that "the medical malpractice insurance market appears to roughly follow the same cycles as the overall property-casualty insurance market, but the cycles tend to be more volatiles," GAO Multiple Factors Report at 33, and that "the year-to-year increase in premium rates can very substantially because of perceived future losses and a variety of other factors, including investment returns and reinsurance rates." *Id.* at 43. Those findings are supported by the evidence, as is the finding of the GAO Access Report that malpractice rates are not substantially affecting access to health care. I have tried in my testimony to set out an alternative method of measuring the likely affect of malpractice rate increases

on access to health care, and to set out ways to moderate the insurance cycle so that periodic sharp increases in medical malpractice insurance rates do not continue to occur in the future as they have in the past.

I appreciate the opportunity to testify here today and I would be happy to answer any questions the committee may have.