FRONT LINE

MEDICAL MALPRACTICE INSURANCE NEWS

We've been telling you the medical malpractice insurance hard market is over but now we're wondering if the cycle has turned soft too soon! According to experts at AM Best, Towers Perrin, Prime Advisors, and others, it may have.

Medical Malpractice Insurance A Retrospective Perspective

By Rick Mortimer

According to AM Best, on the average, med-mal underwriters can expect to breakeven at a 119% combined ratio of incurred losses and operating expenses to premium and investment income. In early spring 2005 Best predicted that the 2004 industry wide combined ratio would settle at approximately 133%, down from the 136.9% suffered in 2003. Instead, 2004 unexpectedly came in at 112.35%. During the first quarter of 2005, the macro view of the med-mal market indicated that the combined ratio for 2005 would hover around a burdensome 130% and return to profitability in 2006. Things would have to turn awfully sour in just a few short months for underwriters not to at least breakeven in 2005. There is little reason why they shouldn't see some black ink over the next two or three years generated by the material increases in rates they imposed during the past several years. But, logic, combined with a good dose of business judgment, dictates that med-mal underwriters cannot afford to relax their underwriting standards or engage in price cutting until their combined ratios drop significantly below their breakeven point.

But, competition for market share has a way of clouding the judgment of otherwise prudent underwriters. They have watched the pool of med-mal premiums increase dramatically during the five year period 2000 through 2004. In 2000, med-mal underwriters booked $6.3 billion in direct premiums with an adjusted loss ratio (ALR - does not include operating expenses) of 82.7%. By the end of 2004 the pool of direct written premium totaled $11.4 billion and the ALR declined to 63.8%. The allure of a growing pool of potentially profitable premium income is too much for some to resist.

The improvement in the total numbers is, however, misleading. To appreciate what has really happened in the market place, we need to compare the list of competing carriers in 2000 with those in 2004. Let's start by looking at the combined market share of the top 20 writers ranked by direct premiums. During 2000, the top 20 collectively captured 68.6% of the market with a 79% ALR.

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ADVICE

It is always a silly thing to give advice, but to give good advice is fatal.

~ Oscar Wilde

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In 2004, the top 20 garnered a 68.8% share and incurred a 68.2% ALR.

Now let's look at how the market was shared between commercial carriers and the doctor owned and/or managed companies. In 2000, 13 commercial carriers held 42.1% of the market with a less than stellar ALR of 86.2%. The remaining seven provider operated carriers only captured 26% but they enjoyed a 67% ALR. In 2004 nine commercial carriers held 33% and enjoyed an ALR of 59.6% while the 11 provider operated companies share increased to 35.7% although their ALR deteriorated by slightly over five points to 72.2%. Again, numbers only tell part of the story.

Keep in mind that for all practical purposes, the malpractice crisis of 1975-'76 was triggered because commercial carriers had either abandoned or priced themselves out of the market. The following table illustrates how the list of commercial players in the top 20 in 2000 and their respective market share changed between 2000 and 2004.

RETROSPECTIVE — PERSPECTIVE

	2000 Results				2004 Results			
Carrier	Rank	Share	$000 DWP	ALR	Rank	Share	$000 DWP	ALR
St. Paul	1	9.1	575,184	132%	Out of Top 20			
GE Capital/MedPro	3	5.1	320,977	51%	3	7.1	801,788	60.2%
CNA	5	3.7	232,050	57%	6	4.0	459,160	86.9%
Zurich/Farmers	6	3.6	230,061	145%	16	1.8	206,418	136.6%
PHICO	10	2.9	182,476	20%	Out of Top 20			
Medical Assur.[1]	11	2.7	168,266	32%	See footnote			
AIG/Nat. Union	13	2.5	156,569	70%	1			
SCPIE[2]	14	2.4	154,021	46%	Out of Top 20			
Professionals Grp[1]	15	2.2	136,731	98%	See footnote			
Allianz	17	2.1	131,442	49%	19	1.4	155,747	38.4%
HUM Group[3]	18	2.1	131,030	106%	See footnote			
AP Capital	19	1.9	122,265	66%	17	1.7	195,043	62.2%
FPIC Ins. Group	20	1.8	112,872	74%	12	2.5	286,871	45.4
Total		**42.1**	**2,653,944**	**86%[4]**		**18.5**	**2,105,027**	**70.1%[4]**

[1] Medical Assurance and Professionals Group merged to form ProAssurance ranked #4 in 2004.

[2] SCPIE is a publicly traded company, although its roots are provider owned and operated.

[3] HUM and MLMIC numbers are now combined by AM BEST in 2004

[4] Weighted Average

And, here's how the provider operated carriers positions changed.

	2000				2004			
Carrier	**Rank**	**Share**	**$000 DWP**	**ALR**	**Rank**	**Share**	**$000 DWP**	**ALR**
MLMIC	2	7.9	499,719	52%	2	8.0	909,052	118.7%
Health Care Ind.	4	3.9	243,144	96%	8	3.3	371,280	44.0%
Norcal	7	3.4	212,374	55%	10	2.6	294,482	46.5%
MIIX	8	3.3	209,750	112%		Out of	Top 20	
Doctors Co.	9	3.3	204,966	52%	5	4.4	494,674	42.3%
ISMIE	12	2.1	163,848	69%	7	3.8	426,235	64.7%
Physicians Rec.	16	2.1	133,995	39%	11	2.5	287,978	77.4%
Total		**32.9**	**1,865,915**	**68%**		**24.6**	**2,883,701**	**74.0%**

The following carriers filled the voids left in the top 20 rankings in 2004.

Carrier	Rank	Share	$000 DWP	ALR	Type
American Intl. (AIG)	1	8.1	916,126	59.6%	Commercial
ProAssurance	4	4.9	557,144	25.5%	Commercial
Mag Mutual	9	4.1	353,744	56.3%	Provider
ProMutual Group	13	2.5	282,764	54.6%	Provider
State Volunteer	14	2.1	244,764	53.1%	Provider
MCIG RRG	15	2.0	244,379	89.9%	Provider
Markel/Evanston	18	1.6	184,744	42.3%	Commercial
MedMutual	20	1.4	155,195	93.1%	Provider
Total		**25.7**	**2,922,443**	**54.7%***	

* Weighted Average

Significantly, the five provider operated carriers captured 11.1% of the market and incurred a 65.9% ALR compared to 14.6% garnered by the three commercial carriers with a 46.2% ALR.

Only one conclusion can be drawn with any certainty from the foregoing tables. Competition for market share is chaotic. Despite significant rate increases over the past four years, the ALRs of most of the carriers that have stayed in the market, with a few exceptions, have not moved significantly into the black. Overall, only those who are either new to the market or have climbed into the top 20 appear to be making a profit.

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Although the market does not appear to be collectively dominated by either the commercial or provider operated carriers ranked in the top 20, (see top 25 markets below) it is interesting to note that a significant number of slots left open by the departing carriers have been filled by provider operated carriers although the commercial carriers have captured more premium. The emerging story is that provider operated carriers are currently confronted by the same issues faced by commercial carriers before the '75-'76 malpractice crisis. When doctors overcame the lack of availability and affordability of malpractice coverage by forming their own companies, they literally started out with a clean slate. They started out with fresh capital unburdened by incurred but not reported claims. They took the occurrence monkey off their carriers' backs by agreeing to accept claims-made policies. And, those in states that enacted tort reform legislation benefited from the caps placed on liability for pain and suffering and attorneys' fees as well as the improvement in cash flow realized through the use of structured settlements.

The financial benefits afforded by claims-made policies has diminished with the passing of time. As claims made policies reach premium maturity, they become more occurrence like. Typically, the maturing process takes place over three to five annual renewal cycles or immediately upon a carrier's agreement to provide a new applicant with coverage for prior acts. The character of the claims made policy becomes even more occurrence like when non-renewing policyholders purchase extended reporting coverage. The point is, those provider operated companies that have been in business for an extended period of time are confronted with the same difficulty in accurately estimating their liability for incurred but not reported claims as "occurrence" carriers were in '75-'76. The question is, are the carriers' reserves for losses inadequate and as a consequence, policyholder's surplus overstated?

Conspicuously, no one seems to be focusing on whether provider owned companies have the financial surplus needed to support their existing policyholder base and related increasing written premium income along with their accumulating liabilities for incurred claims. Historically, the most commonly employed bench mark for determining the adequacy of a carrier's surplus is its ratio of net written premiums to policyholder surplus. There has been a long standing disagreement among industry experts as to what is an "acceptable" ratio. The arguments range between ratios of 1:1 to 3:1 with some industry observers asserting 5:1 is adequate. State regulators, who have the last say, typically set the ratio at 1:1. According to National Underwriter Insurance Data Services, in 2003 the ratio of med-mal carriers rated A- or better by AM Best ranged between .45 and 1.25; those below A- ranged between .53 and 1.45.

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MEDICAL MA
Top Writers, U

Ranked by 2004 direct premi

RANK	GROUP
1.	Amer Intl Group Inc
2.	MLMIC Group
3.	GE Global Ins Group/MedPro
4.	ProAssurance Group
5.	The Doctors Co/PULIC
6.	CNA Ins Cos/Columbia Casu
7.	ISMIE Mutual Group
8.	Health Care Indemnity Inc
9.	Mag Mutual Group
10.	Norcal Group
11.	Physicians' Reciprocal Insurer
12.	FPIC Ins Group Inc
13.	ProMutual Group
14.	State Volunteer Mutual Ins C
15.	MCIC VT Inc Risk Retention
16.	Zurich Finl Svcs NA Group
17.	APCapital Group
18.	Markel Corp Group/Evanston
19.	Allianz of America Inc
20.	Medical Mutual Group (MD)
21.	Mutual Ins Co of AZ
22.	Fairfax Financial (USA) Group
23.	SCPIE Cos
24.	Midwest Medical Ins Co
25.	Medical Mutual Group (NC)
	Top 25 P/C Writers
	Total U.S. P/C Industry

Source: A.M. Best Co. Best Review 08-05

04

ALPRACTICE
United States

iums written. ($ Thousands)

	DIRECT PREMIUMS WRITTEN	ADJUSTED LOSS RATIOS
	$916,126	59.6
	909,052	118.7
o	801,799	60.2
	557,144	25.5
	494,674	42.3
ualty	459,660	86.9
	426,235	64.7
	371,280	44.0
	353,744	56.3
	294,482	46.5
rs	287,978	77.4
	286,871	45.4
	282,364	54.6
o	241,379	53.1
Group	228,347	89.9
	206,418	136.6
	195,043	62.2
n	184,744	42.3
	155,741	38.4
	155,195	93.1
	152,759	65.6
p/TIG	142,554	70.6
	133,886	60.2
	117,368	64.9
	116,172	47.3
	$8,471,019	**65.9**
	$11,366,007	**63.8**

Unlike their commercial competitors, the options available to provider owned carriers to raise additional capital are limited. Instead of selling stock, their special capital needs can generally only be satisfied by "borrowing". Subject to regulatory approval, the mutual and reciprocal insurers can issue subordinated Surplus Notes. For balance sheet purposes, they are treated as capital rather than debt. Virtually all of the mutual and reciprocal companies organized during the '75-'76 crisis were capitalized with Surplus Notes.

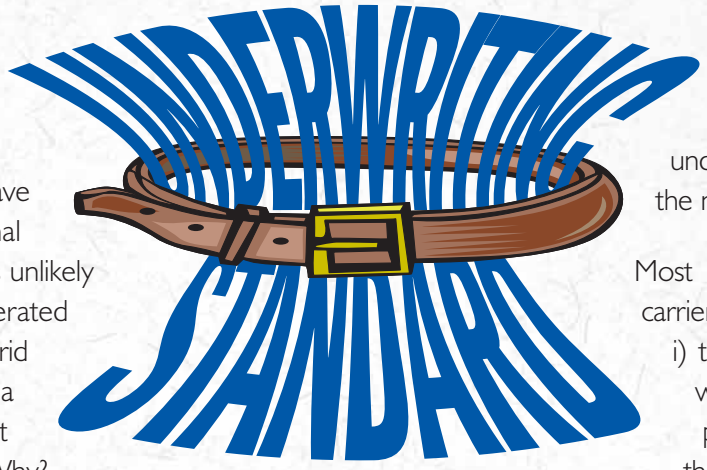
The organizers were able to convince their policyholders to purchase the Notes by promising to use operating profits to repay the loans. With profits obliterated by a river of red ink, and the availability of a wide selection of well financed companies, the issuance of Surplus Notes is not a viable alternative. If those carriers with stressed surplus ratios want to maintain their existing policyholders and continue to raise rates, they will have to resort to other means to increase their surplus.

Typically, carriers rely upon investment income to offset underwriting losses and increase their surplus. If loss ratios cannot be reduced below the breakeven mark, interest rates remain below 5%, and the stock market remains relatively stagnate, it is highly unlikely that carriers will be able to generate enough income from investments to offset underwriting losses much less grow their surplus. The pressure on those carriers with combined ratios above 114% to improve underwriting results will be intensified over the next one to three years.

> *"There are two general ways underwriters can improve their results; raise rates and tighten underwriting standards."*

There are two general ways underwriters can improve their results; raise rates and tighten underwriting standards. The preferred strategy is to combine the two. However, the ability to raise rates is tempered by competition. Profitable policyholders lost to competitors further aggravates the problem. Therefore, the most viable alternative is to tighten underwriting standards, decline new

submissions, and non-renew those who don't meet the standards.



Commercial carriers seldom have a problem dumping marginal risks. On the other hand, it is unlikely that the provider operated companies will be able to get rid of their marginal insured's on a wholesale basis without changing their value system. Why? Because they are loyal to the medical societies that initially sponsored their organization and base their underwriting standards on society membership. This approach makes it extremely difficult to hold down prices for the majority of good risks because their premiums are loaded to subsidize the 5% to 10% of practitioners that generate over 75% of the claims. Too many provider operated underwriters have learned the hard way that they can't clean house without upsetting their local medical societies and/or state association sponsors.

"Because the market appears to be softening, buyers need to be extraordinarily careful in selecting their carrier."

It can be reasonably argued that the provider operated carriers insure more preferred risks than the commercial carriers. The argument is logical because commercial underwriters tend to complement, not compete with the provider operated carriers. They are willing to entertain hospitals, nursing homes, emergency room physicians and high risk specialties that provider operated carriers typically shun. Obviously these higher risk classes command commensurately higher premiums to balance the risk of losing money with the profit potential.

Because the market appears to be softening, buyers need to be extraordinarily careful in selecting their carrier. If the past is any predictor of the future, compare the ALRs of the present top 20 carriers with those of past years. St. Paul, Farmers, PHICO, MIIX, PIE Mutual, Frontier, Reliance and others have abandoned over a billion dollars of med-mal premiums and tens of thousands of policyholders in the past four years. If your choice of carriers has a history of underwriting losses, it's more than an even bet that they will either tighten their underwriting significantly or leave the market altogether.

Most of the risks of the departing carriers fell into one of two categories; i) those preferred physicians, who were largely absorbed by provider operated carriers, or ii) those who had to look to excess and surplus lines carriers such as GenStar, PULIC, Columbia Casualty, Lloyds of London, and others including Admiral and Evanston that have a reputation of always being willing to take up the slack in a stressed market.

A frequently asked question is, can the provider operated carriers offer their not for profit, provider owned and/or managed philosophy to the higher risk classes and still hold down prices for the preferred risks? Following are two examples of carriers who have found a way.

Prosurance, the 2004 fourth ranked med-mal carrier has joined the fray by offering their own excess and special risk product through Red Mountain. Fifth ranked Doctors Company (TDC) owns Professional Underwriters Liability Insurance Company (PULIC), a high risk, national physicians and surgeons market that accepts risks that don't qualify for TDC. Red Mountain and PULIC are able to offer higher priced coverages for special risks free from medical society pressure and regulatory rate and policy form controls.

But even PULIC and Red Mountain can't and won't write all risks today. They are largely constrained by their reinsurance carriers who tell them that emergency rooms, bariatrics, abortion clinics, telemedicine and large national risks are unacceptable.

To the point, should provider operated carriers try to become all things to all comers, they risk following in the footsteps of commercial carriers like St. Paul, MMI, PHICO, Reliance, and Farmers. After many years of trying, all failed in their attempt to become national leading markets for the tougher risks. But it can't be said that provider operated carriers are without failure. PIE Mutual, MIIX, among others, missed their 25th anniversary. And, in the world of insurance making the 25 year mark is akin to getting your training wheels off. In contrast, Medical Protective has a

100+ year continuous history of providing med-mal insurance. And they are still going strong with Berkshire Hathaway now at the helm.

My point, the commercial for profit market will always play a meaningful role in the market place. The role played by the provider operated carriers depends upon which fork in the competitive road they decide to take. Will they stay the course set 30 years ago and not deviate from their mission to help local doctors satisfy their insurance needs? Or, will they leave their comfort zones to chart a new course? Will they expand their facilities beyond their traditional geographic boundaries and offer their underwriting facilities to special risks such as bariatric surgeons, telemedicine risk, nursing homes, and others?

Their decisions will be influenced by the amount of surplus capital they have. If their premium to surplus ratio is marginal, they will fair better by sticking to their knitting. On the other hand, if they have an abundance of surplus, the direction they take will depend upon how they believe the excess can be utilized most effectively. Expansion outside their geographical region and exploration of special risks may or may not be the provider operated carrier's best choice.

By taking a conservative approach, provider operated carriers should collectively be able to capture and retain 80% plus of all physician and surgeon insured's by keeping rates at the lowest prudent levels. If they broaden their underwriting standards to allow a more diversified array of disciplines, they risk contaminating their existing pool of policyholders. The insidious costs associated with expansion can drive otherwise adequate rates up for all policyholders.

What history has taught us is that expansion into unfamiliar territory can lead to adverse consequences. Preferred and even standard risks will leave if they believe they can save money by changing carriers. The safe course is to avoid the consequence of venturing outside their market segment by leaving the tougher and more complex risks to commercial markets.

The quest for profits is insatiable, even for the non-profit provider operated carriers. Because the allure can be mesmerizing and often clouds the judgment of otherwise prudent people, it becomes obvious that the roster of top players will continue to change as underwriters expand and contract their facilities. The task currently confronting buyers is to become reasonably certain that the carriers they select will remain in the market and not engage in an underwriting retrenchment. More than ever, buyers are cautioned to seek the advice of a qualified experience insurance broker that specializes in medical malpractice insurance.

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One final thought: Although it is flattering when your work is cited as a reference, it is important that proper context be maintained. Insurance market cycles are created by underwriters who, over time under-price their product. Premiums, combined with investment income, have been inadequate to cover the claims costs and expenses insurance companies have incurred. In an over reaction to the long term under-pricing, the market swings wildly to correct in the short term. The result; market chaos as we just witnessed over the past three years. ◆

FRONTLINE

This newsletter is for general informational purposes only. It is intended to provide a limited overview of the market and to provide thought provoking ideas for our readership to consider when arranging for risk transferal programs and insurance.

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