FRONT LINE
MEDICAL MALPRACTICE INSURANCE NEWS

RICK'S CORNER

Are Med-Mal Premiums Set to Head Higher in 1998?

The Historical Prospective

Prior to the 1975-76 national medical malpractice insurance crisis, commercial insurance companies collected an estimated 80% plus of the premium dollars paid by health care providers for malpractice insurance. In swift response to the commercial insurers' demands for overwhelming premium increases, sought to off set huge underwriting losses suffered through an explosion in frequency and severity of claims reported and paid, doctors united state by state to form their own mutual's or reciprocal insurance companies and cooperative underwriting facilities. Overnight, the "bed pan mutuals" (so-called by their commercial carrier competitors at the time) captured the individual physician and small group market by convincing doctors to replace their expensive occurrence-type policies with the new claims-made coverage model. This new form offered very attractive initial rates. And combined with the lure of lower operating overhead and their non-profit status, "bed pan mutuals" gained rapid market share and 20 years later, respect of their peers in the insurance community.

Other than changing to the claims-made policy form and to doctor managed mutuals, by and large the new companies carried on the commercial underwriter's practice of catering to the needs of the individual physicians and surgeons who dominated the health care market place. When presented with requests for proposals from physician partnerships and other groupings, some struggled with the concept, and many continued to issue separate, stand-alone policies to each individual doctor, or refused the larger clinic opportunities. Carriers who specialized in covering corporate risks, hospitals and larger clinics avoided extending individual doctor coverage under their policies to independent physicians and surgeons who had been granted staff privileges by their hospital and/or clinic policyholders. At the time, many viewed these physicians as in-direct corporate risk of which they had no insurable interest or ability to manage their risk effectively.

The Evolving Market

The changes in the way health care insurance protection is purchased accelerated the growth of large group practices and managed care facilities and forced malpractice insurance underwriters to rethink the way they do business. Policies and services originally designed for individual practitioners and small groups do not fully meet the coverage needs of providers that require protection for their corporate interests. Particularly the new demands for creative financing options for larger numbers of physicians under one buyer. Many underwriters are beginning to recognize that the malpractice exposure can be more accurately quantified when significant numbers of doctors are required to conform to defined treatment standards and are paid based upon patient volume rather than for services rendered. However, with this change has come a trend towards increasing numbers of medical malpractice cases of failure to and/or delay to diagnose claims; which could be an out growth of managed care.

continued on page 4

QUOTABLES

"Nothing astonishes men so much as common sense and plain dealing"

~ Ralph Waldo Emerson

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Health Care Liability Trends: Implications "Captive Insurance

In recent years, medical malpractice has been one of the more profitable lines of business in the insurance industry (see Exhibit 1), with loss ratios of 77% to 85% from 1994 through 1996. With favorable results like these, ever more players are attracted to the market, adding more capacity to an already intensely competitive situation. However, captive owners and malpractice writers alike should approach this market with caution and look beneath the current financial results to the underlying trends.

Frequency, severity: Changes in claim frequency (number of claims per exposure unit) have been the key drivers in previous turns in the market cycle. Following the decline in claim frequency that occurred during the late 1980's, claim frequency has been relatively flat for the past 5 - 7 years, though results have been mixed from region to region and insurer to insurer. Signs of frequency increases are emerging. St. Paul, the largest medical malpractice writer in the country, saw its claim frequency increase roughly 20% from 1994 to 1996 (see Exhibit 2). Average claim sizes have continued the trend upward throughout the 1990's. The average annual increase is 6 - 8% per year, a rate that shows no sign of decreasing.

With managed care-related changes sweeping the health care industry, new exposures are emerging, causing upward pressure on claim frequency and costs. If claim frequency and security are increasing, shouldn't rates be increasing?

Exhibit 1

General Liability and Medical Malpractice

Loss Ratios 1949-1995

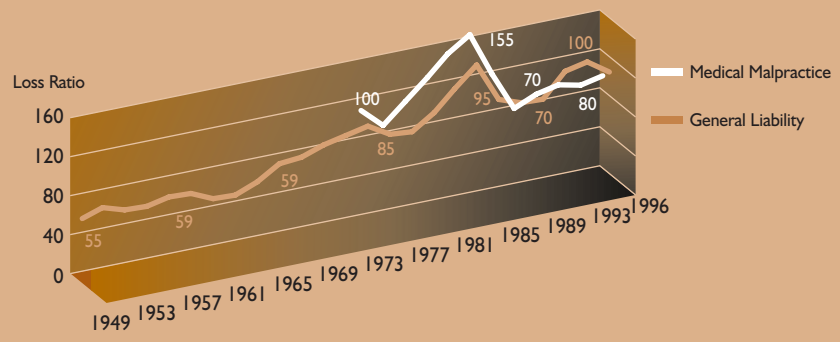
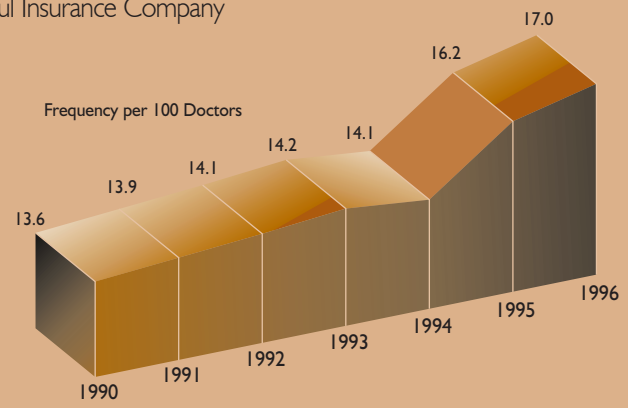


Exhibit 2

Physician Liability Claim Frequency

St. Paul Insurance Company



Rates and premiums: Rates and premium levels, meanwhile, have been relatively flat over the past few years. We see more instances of companies selecting rate levels at the low end of, or below, the range suggested by actuarial indications. Companies appear to be making liberal use of schedule rating premium credits, thereby reducing premiums charged. This is one way to attract physician groups and their business managers.

Downgradings: A.M. Best recently downgraded seven strong, otherwise healthy medical malpractice specialty insurers from A+ to A, not because of negative changes in their financial results, but because of Best's concern about the severe price competition and the uncertainties relating to managed care. The companies in question also specialized in this one line of business, as do health care captives.

If rate levels are considered inadequate, and Best is downgrading companies' ratings, why does this medical malpractice line of business look so profitable? It's because of the significant reserve redundancies left over from policies written in the late 1980's and early 1990's. At that time, loss costs unexpectedly turned favorable, and rate levels didn't react for a period of years. We are concerned with the present state of rates and premiums. Here's why: when premium levels decrease or remain flat, and underlying loss costs increase, at some point the lines cross and the business becomes unprofitable (see Exhibit 3).

We are at or beyond that juncture in many medical malpractice insurers and captives.

for Captives
Company Reports"

TILLINGHAST - TOWERS PERRIN actuary Ed Wrobel, our expert in medical professional liability for health care insurers, including captives, has written an important analysis of the current trends. They are not as favorable as published results would make them appear.

Appearance vs. reality: A comparison of calendar year loss ratios (i.e. the typical published financial information) with policy year loss ratios (i.e. the estimated results of policies written in a given year) illustrates this situation (see Exhibit 4). Consolidated published results from a sample of physician insurers reveal a 1996 calendar year loss ratio of 85%. This is the appearance: the reality is that the expected 1996 policy year loss ratio is 128%. Why such a big difference? The difference between the two is the release of the redundant reserves from prior policy years into the 1996 results. Won't these same redundancies continue year after year? Those crossing lines shown in Exhibit 3 indicate that they won't. When the redundancies dry up, so will the rosy financial results.

Health care captive owners need to make strategic decisions with their eyes wide open. It may not make sense to try and compete in such a difficult market, depending on the particular jurisdiction. Key requirements for captive players in this market are rational pricing, patience, and a long-term view.

CICR comment,: New health care captives are still being formed, in spite of these trends. The driving force appears to be the providers and physician groups. Not to mention the promoters of captives, of course.

The Bottom Line

by Rick Mortimer

We concur with Ed Wrobel's view. Although we have a slightly different vantage point as brokers/consultants designing and securing risk transfer plans for medical providers with the 60+ qualified medical malpractice underwriting facilities doing battle with one another today. It is still a buyers market in nearly every state when it comes to medical malpractice coverage. However, we do here rumblings from top executives at some of these companies that prices and coverage (such as prior acts so freely given over the last 20 years) will both need to be adjusted. But with competition as intense as it is, few carriers have the nerve to be the first and lead with price hikes fearing significant loss of market share to their aggressive new competitors.

Tillinghast, in February of 1994 warned in their monthly publication, "Emphasis", of the looming hard market forces the numbers were suggesting. They have been silent until now, watching price fall even further and competition increase. Nearly four years later, they warn the markets again to take stock that sooner than later the premium will rise and the coverage restrict as the number of markets are forced to over react to the trends they have been ignoring.

Exhibit 3
Premium vs. Losses

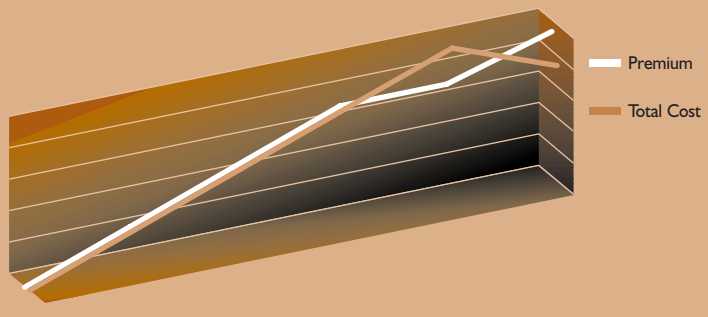
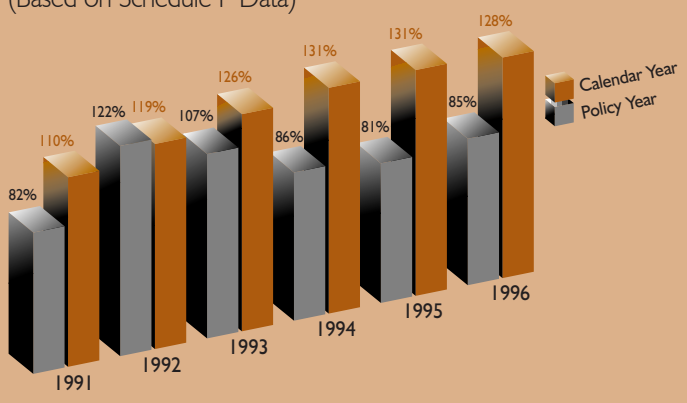


Exhibit 4
Comparison of Calendar Year/Policy Year Loss Ratios

(Based on Schedule P Data)



CLAIMS CORNER

Is California really the bell weather state?

	CA Average Large Loss*
1990	$ 811,280.00
1991	$ 997,343.00
1992	$ 734,665.00
1993	$ 623,131.00
1994	$ 818,400.00
1995	$ 957,717.00
1996	$ 840,219.00

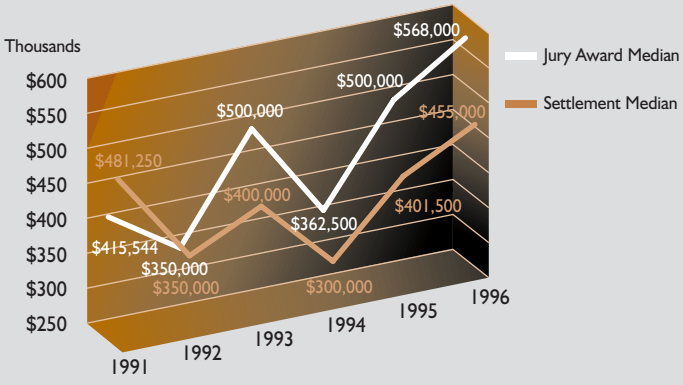
*MIEC Large Loss Study

For a complete copy of MIEC's Large Loss Study (20 pages), please call or write HCP attention Ruth Ann Saine at (714) 990-4430 or email us at HEALTHPROS@aol.com.

In the 1996 survey, managed care was mentioned in 16 of 147 cases. Three threads ran through these cases:

- Treatment was delayed or inadequately performed due to economic constraints imposed on health care professionals.
- Inadequate staffing led to monitoring lapses and injury.
- Failure to transfer a patient in a timely manner to a hospital better equipped for special care.

National Jury Award and Settlement Medians for Medical Malpractice Claims



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Med-Mal

Progressive underwriters are willing to gamble a share of their surplus to capture the premium pool and related services paid by large managed care companies, group practice and integrated delivery facilities. Others are more cautious about taking on large groups of physicians at discounted rates, as losses are growing disproportionately to historical trends and premiums continue at eight year lows, largely ignoring the trends and their actuary's minimum suggested rate levels. (see related article page 2).

New commercial carriers are reentering the physicians market and existing commercial are more aggressive. As well, an increasing number of doctor-owned companies previously committed to underwriting primarily individual practitioners and small groups in single states are now willing to innovate and tailor their policies and services to the specific needs of large groups, hospitals and integrated systems in multiple states. If they do not, they face declining market share to the big commercial underwriters who are better situated to meet the needs of larger corporate risks in health care.

Financing the Medical Malpractice Risk

During the past ten years, most group administrators have relied primarily on the purchase of insurance to finance the business risk associated with medical malpractice claims.

Balancing

They have focused on reducing costs through mergers, acquisitions and internal growth, and by expecting their underwriter to discount the rates charged for individual medical specialties simply because of the large numbers of doctors available to insure from a single buyer

For the most part, they have given only passing consideration to risk management methods, such as; loss prevention, mitigation, and risk retention to reduce the cost of claims and insurance. This approach has worked well, largely because of the continued soft market pricing and abundant capacity from dozens of underwriters willing to discount prices for business.

Between 1990 and 1997 group practices consistently negotiated rates which were 10% to 45% below the standard (solo practice) premiums charged by their carriers. These deep discounts turned the underwriter's actuarial tables upside down as time passed. While the loss experience of solo practitioners and smaller groups (those paying under $250,000 annual medical malpractice premiums) remained largely within expected ranges, underwriters began to realize they had overestimated their ability to quantify and accurately price the exposures of larger groups over time. Many have suffered greater than anticipated losses on their discounted group accounts before recognizing that they must tighten the underwriting tourniquet to stop the financial bleeding of eroding loss ratios.

But they quickly learned that higher rates lost accounts to new markets with deep pockets. Because new underwriters are willing to take the business at less premium. Thus, the continued soft market marches on…

Note: In 1990, 29% of cases arose from failure or delay in diagnosis, and they represented just 19% of total indemnity. By 1995, these cases comprised 40% of the total and accounted for 32% of all 1995 indemnity. Average indemnity in failure to diagnose cases grew from $550,973 in 1990 to $775,123 in 1995. Of the indemnity awards of more than $1,000,000 only 2 involved diagnostic errors in 1995 compared to 13 in 1994, according to MIEC's 1995 California Large Loss Study.

Still, during the past two years several prominent carriers have tried playing catch-up by increasing premiums for their larger group policy holders, in some cases by as much as 100%. Faced with intense price-driven competition for health services, CFO's were pressured to find ways to mitigate the upward move in the cost of insurance and have sought new relationship with carriers who emphasis risk management over the simple risk transfer to insurance. Many commercial insurance markets are responding as are a number of larger "bed pan mutuals" who have grown to become key national players.

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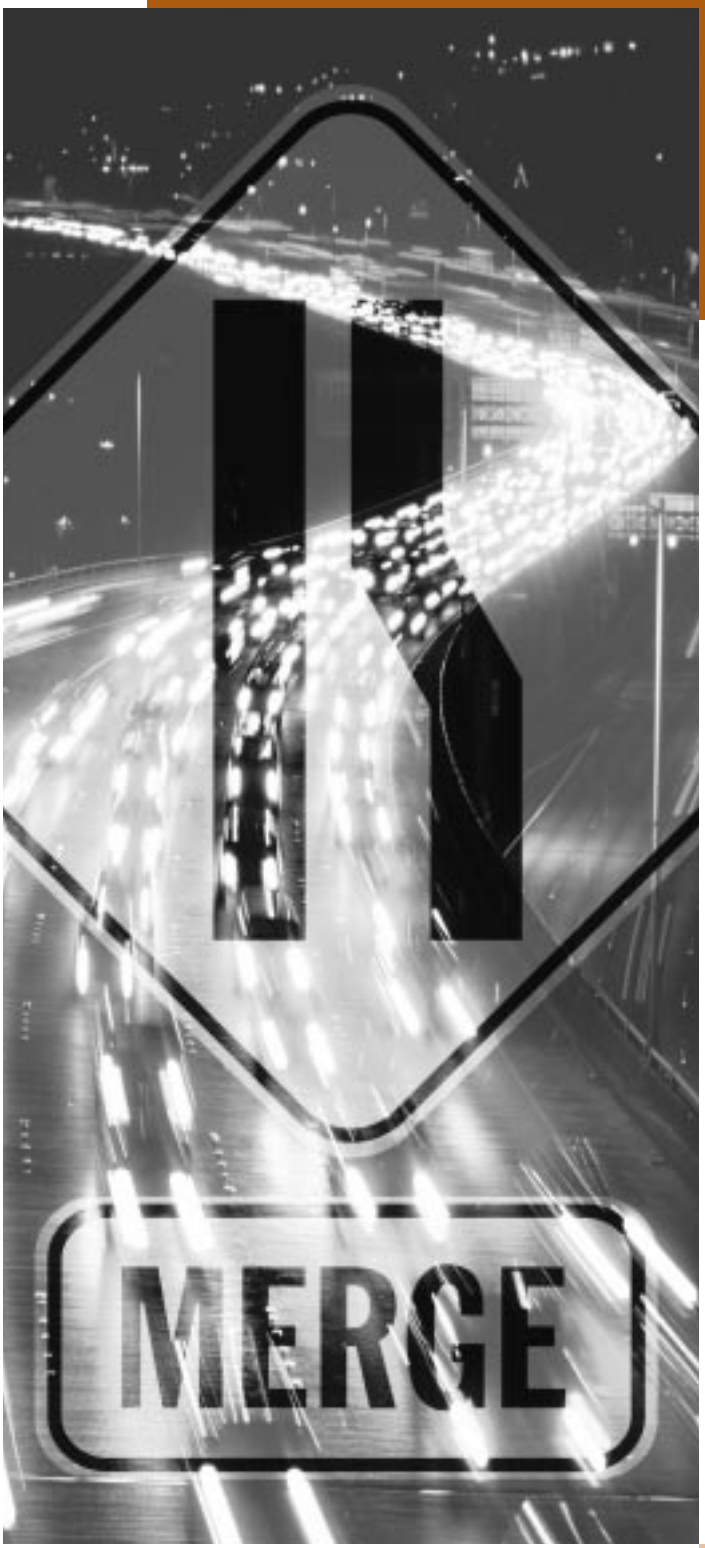
Risk Retention With Insurance

How prepared are you for the changes affecting malpractice insurance?



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Med-Mal

Conclusion

Those seeking to grow by acquisition, merger and internal growth can no longer always count on increasing their profits by reducing their consolidated medical malpractice premiums through size discounts alone as some carriers begin to tighten rates. Rather, they are faced with either: a) absorbing the premium increases, b) moving into the unfamiliar world of alternative risk financing, c) jumping at temporary price reductions offered by the vast array of new markets seeking large accounts (often attached to self-insured retention SIR) or, d) a combination of the various approaches.

Many CFO's are, for the first time, embracing the alternative funding mechanisms which have been used for decades by their counterparts in large industrial organizations. They are realizing that, in general, first dollar insurance is (in an increasing premium market) the most expensive way to finance risk. Rather than looking solely to insurance companies for protection, they are implementing loss prevention programs, exercising greater control over the management of claims, and reducing costs through a combination of risk retention and the purchase of excess insurance, among other loss sensitive plans.

Balancing risk retention with sound risk control practices and risk transfer/stop loss coverage provides the game plan for medical groups, clinics and integrated systems in the new millennium. By implementing this strategy now, while near the bottom but upward curve in the next increased premium market, forward thinking CFO's and risk managers will be ahead of those who ignore these trends.

Medical Malpractice or E&O?

Managed care services Errors & Omissions insurance coverage is rapidly becoming a hot topic in medical group practice settings. Simply stated; medical malpractice policies are primarily designed to cover clinical issues such as failure to diagnose or failure to render adequate care. Where as E&O excludes medical care and steps in to pick up credentialling, peer review, utilization review and management, and should include vicarious liability to medical malpractice. For a white paper on this subject, E&O, Medical Malpractice and D&O, call or write HealthCare Professionals' Insurance Services.

Terms to be Familiar With:

RISK CONTROL

encompasses the avoidance or elimination of risk and risk eduction through loss control. Loss control reduces the probability that loss will occur and also reduces the magnitude of losses that do occur. Risk control, however, only addresses a portion of the risk management process and is not a complete solution in itself.

RISK FINANCING

involves various techniques to pay for losses that occur in spite of risk control techniques that are utilized. It involves assumption of risk and risk transfer. Assumption or retention of risk, either wholly or partially, means that the risk is borne or financed internally.

RISK TRANSFER

can mean either a contractual transfer of risk or transfer through the purchase of insurance.

Trivia Q&A

QUESTIONS

1. What insurer recently had AM Best down-grade their rating from B- to D?

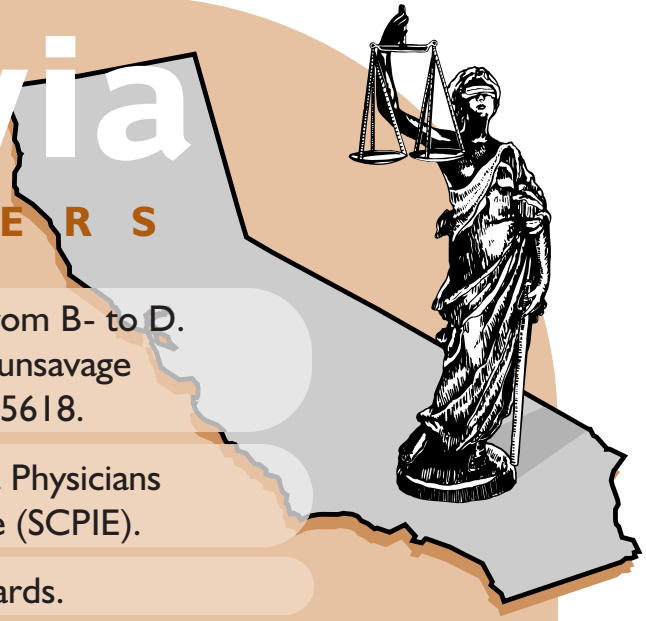
2. What mutual company went public in 1997?

3. How many awards over $1,000,000 were there in California in 1996?

Answers on back page.

Trivia

ANSWERS



1. P.I.E. Mutual Co., from B- to D. 11/17/97, Jeffrey Dunsavage 908-439-2200 ext. 5618.
2. Southern California Physicians Insurance Exchange (SCPIE).
3. There were 28 awards.

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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.

"Please let us know if you have any suggestions or items of interest for upcoming newsletters. Your input is valuable to us."

How to reach us:

HealthCare Professionals' Insurance Services
Risk Finance Consulting & Insurance
475 S. State College Blvd.
P.O. Box 9699
Brea, CA 92822-9699
714.990.4430 • 714.255.0872 Fax
HEALTHPROS@aol.com E-Mail

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Rick Mortimer, Editor