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**Testimony of Jillian Aldebron
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Before the Committee on Consumer and Regulatory Affairs
Hearing on B16-334, "Medical Malpractice Insurance Reform Act of
2005"
March 20, 2005**

Chairman Graham and Members of the Committee,

Thank you for allowing me to testify today on behalf of Public Citizen's 800 members in the District and, in fact, for the benefit of all consumers of healthcare services and the professionals who provide those services in Washington, D.C.

As a leading advocate for consumer justice and improved patient safety, Public Citizen has conducted numerous studies that both directly and indirectly expose the fallacy of insurance industry claims used to justify excessive medical malpractice insurance premium rates. Last May, for example, we produced a report based on information filed with the National Practitioner Data Bank that unmasked as myth industry contentions that lawsuits against negligent doctors were to blame for sharp premium rate hikes in the District.¹ That report is appended to my testimony, for the record. We have also stood ready to challenge business and public policy developments that threaten to harm consumers. When Alabama-based ProAssurance Corp. swooped in to take over NCRIC, the District's largest medical malpractice carrier, Public Citizen, fearing that increased industry consolidation signaled even higher prices for physicians, petitioned the Insurance Commissioner to delay the deal to give it more time to

¹ "District of Columbia Medical Malpractice Payout Trends 1991-2004: Evidence Shows Lawsuits Haven't Caused Doctors' Insurance Woes," Public Citizen's Congress Watch, May 2005.

scrutinize the potential impact on physicians and patient care.² That petition, which was rejected, is also appended here, for the record.

Public Citizen believes that for too long, physicians and other medical professionals in the District have been held hostage to the whims of the insurance industry, its spurious claims, and questionable business practices. Our attempts to bring reason and fairness to the medical malpractice insurance debate, however, have been stymied by the District's limited regulatory regime in the insurance sector. Indeed, it is virtually non-existent. But this bold initiative, B16-334, which Chairman Linda Cropp and four other councilmembers, including you, Chairman Graham, had the vision to introduce, would transform the otherwise bleak regulatory landscape by erecting a structure that obliges meaningful oversight and gives the medical and patient communities a voice in the rate-setting process.

If enacted, B16-334 would bring much needed relief for District doctors, putting them on par with colleagues in neighboring states and across the country who can count on regulatory protections to keep their malpractice premium rates in check. It would empower the Insurance Commissioner to hold malpractice insurers accountable for proposed rate increases. It would give those most crucial but often taken-for-granted stakeholders—consumers, both physicians and patients—a say by affording them the opportunity to challenge a rate proposal. It would reinvigorate the market by establishing a web site where doctors could comparison shop for the best professional liability insurance rates. It would put cash back into doctors' pockets when they've been gouged by opportunistic insurance practices. And, very importantly, by making all rate filings public, it would bring greater transparency to a process that has been shrouded in actuarial esoteria and confounding rhetoric—resulting in widespread demoralization in the medical profession and a beleaguered patient population.

The timing of this legislation is fortuitous. The “hard” insurance market, characterized by a paucity of carriers, stingy coverage and galloping rate hikes, appears to be officially dead. Nationally, malpractice insurance premium growth rates came to more or less of a standstill in

² Motion to intervene in the matter of the proposed acquisition of control and merger with domestic insurer NCRIC Group, Inc., by ProAssurance Corp., May 2005.

the last quarter of 2005, plunging precipitously from a peak of 63 percent average increases in 2002. So the insurance cycle churns on, leaving us a decade or so of “soft” market calm before the next self-inflicted industry crisis sends premiums once more through the roof. We saw it in the mid-1980s, and in the 1970s before that, each time provoked by the insurance industry’s behavior during a strong economy. The most recent hard market was set off by its collision course during the economic boom of the 1990s, when interest rates and investment returns were highly profitable. Insurance companies took advantage of investment opportunities by slashing rates to grab market share and premium dollars at all cost, so that they could turn around and invest the float at great profit in stocks and bonds. The cut-throat pricing war that ensued found insurers selling at rates below what they needed to cover claims. Then, when the market turned sour in 2000-2001, insurers were forced to raise rates dramatically to recoup lost investment income.

How did this scenario play out in the District? From 1992 to 2001, medical malpractice insurance premiums for District physicians *decreased* nearly 32 percent, when adjusted for inflation, according to data from the National Association of Insurance Commissioners (NAIC). During that same period, healthcare costs, which are a major component of medical malpractice claim payouts, *increased* 47 percent nationally.³ Over 1997-2002, the Federal Employee Health Benefits Program (FEHBP), which covers more than 8.5 million federal employees nationwide, many of them in the District, increased its health insurance premiums 67.5 percent to cover the cost of medical inflation. By contrast, NCRIC, over this same period, raised its malpractice insurance premium rates an average of just 4.3 percent. In fact, in three of those six years, NCRIC did not ask policyholders for any increase at all.⁴ Medical malpractice insurance premiums were so low in 2000 that the District ranked 47th among states with the least costly professional medical liability insurance.⁵ But following the 2001 economic bust came a surge in premiums. Even as the value of medical malpractice payouts in the District declined 64 percent and their number dropped 35.6 percent over 2001-2004, according to NPDB data, NCRIC was

³ “Medical Malpractice Insurance, Net Premium and Incurred Loss Summary,” National Association of Insurance Commissioners, July 2001.

⁴ “FEHBP Average Premium Increases – OPM Press Release,” Office of Personnel Management/Office of Actuaries, April 2003. “Trends in Rates for Physicians’ Medical Professional Liability Insurance,” Medical Liability Monitor, issues 1997-2002.

⁵ “Medical Liability Report Card 2000,” NORCAL Mutual Insurance Company, November 2002.

forced to boost rates to catch up. For example, according to the Medical Liability Monitor, NCRIC raised rates for internists 21 percent in 2003, and another 25 percent in 2004. The startling disparity between NCRIC’s 2002-2004 premiums earned and direct losses paid out—more than a two-to-one ratio—as reported in its own annual statements, bears witness to the company’s attempt to make up for a decade of underpricing.

NCRIC: Direct Written Premiums vs. Direct Paid Losses, 2000-2004

Year	Direct Written Premium	Direct Paid Loss
2000	\$16,809,326	\$14,043,305
2001	\$17,412,277	\$12,677,500
2002	\$21,673,080	\$ 9,814,750
2003	\$23,126,708	\$11,645,740
2004	\$25,547,886	\$12,654,246

While the boom-bust insurance cycle phenomenon is not new, that does not make its repercussions for consumers any more tolerable. It is critical that now, during this breathing period, the D.C. Council takes stock of the situation and establishes a regulatory framework that can mitigate the burden of industry practices on both policyholders and patients. We have tangible evidence that this can be done in the example of California’s Prop 103, which in its nearly 20 years on the books has repeatedly proven successful in keeping medical malpractice insurance rates honest and prices under control.

When Prop 103 passed in 1988, insurance rates were so off the charts that the rollback provision of the measure had the immediate effect of returning \$1.2 billion in overpaid premium refunds to seven million consumers, of which some \$70 million went to physicians after California’s insurance commissioner determined that medical malpractice insurance rates were excessive. In subsequent years, Prop 103 forced SCPIE Indemnity to slash a proposed 2003 rate hike of 15.9 percent by a third and denied it a rate increase of 8.9 percent in 2004, saving 9,000 physicians insured by the company some \$27 million. It forced a 70 percent reduction in NORCAL Mutual’s proposed 9.9 percent premium increase at the end of 2003, saving policyholders an estimated \$11.6 million. In 2004, it gained \$3.9 million for doctors insured

with GE Medical Protective, whose 29.2 percent proposed rate increase was trimmed back to 11.8 percent following a consumer challenge and insurance commissioner review.

Prop 103 is also making insurers think twice before insisting on unwarranted premium increases. Last year, The Doctors Company withdrew a proposal to raise rates 5 percent as soon as consumers filed a challenge. National Union, an A.I.G. subsidiary, responded to consumer opposition to a 39.9 percent rate hike for certified nurse midwives in 2005 by rescinding its proposal altogether.

Prop 103's achievements demonstrate that we have the ability to make medical malpractice insurers responsive to the needs of policyholders and patients, and as a matter of public policy, we have an obligation to do. Public Citizen strongly endorses B16-334 as a giant leap in the right direction. The only modification we would recommend is to include a provision requiring insurers to report to the Insurance Commissioner, on an on-going basis, all medical malpractice claims that result in a settlement or judgment, with the amounts paid, as well as claims closed without payment. Currently, there is no such reporting requirement. But the advantages of having one were recognized and a similar measure recommended by the Health Committee Taskforce on Medical Malpractice, convened by Councilmember David Catania in mid-2005. Without mandatory claims reporting, it is impossible to know precisely the total value of malpractice payouts in the District compared to the premiums paid in. Reporting systems in Texas and Florida, for example, have made it possible to analyze claims trends in those states and provide accurate information on which to base insurance decisions. The potential benefits of such a system, however, extend beyond the realm of insurance to improved patient safety, as well. Claims analysis could tell us much about the frequency and severity of various types of claims, identifying the most urgent areas that need to be addressed. We would be glad to assist the Committee in drafting such an amendment to the pending legislation.

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