Testimony Before the Joint Subcommittee Studying Risk Management Plans for Physicians and Hospitals
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Mr. Chairman, thank you for the opportunity to address the committee today. I have been asked to focus on two specific areas: 1. How does The Doctors Company set its rates for Virginia physicians and 2. What is the potential impact if the MICRA reforms were enacted in Virginia? To address the second question first, MICRA would have a very favorable impact on the state's troubled malpractice insurance environment.

Now, I will address each question in detail.

Question: How does The Doctors Company determine premium rates for Virginia doctors?

First, Mr. Chairman, I refer you to a ratemaking primer presented by Mr. James Hurley before the United States Senate in testimony entitled "Causes of the Medical Malpractice Liability Crisis." He describes the process by which insurance companies determine rates in testimony prepared by the American Academy of Actuaries. This is an excellent general description of the challenges of making rates for a medical malpractice insurer.

To respond more specifically to your question in regard to The Doctors Company, I would note the following. TDC rates in Virginia are based on claims experience specific to Virginia. The rate process begins by accumulating historical

statewide claim data and calculates the overall annual loss amount per doctor, known as *loss cost*. This is defined as the sum of all payouts for settlements and awards incurred on behalf of TDC policyholders, plus associated legal defense costs.

The data includes information from all doctors, whether or not they have had a claim, and the resulting base rates are applied to our specific population of policyholders as a whole. Thus, the ratemaking process starts at an aggregate level, rather than at an individual doctor level. This is a basic principle of insurance. Were this not the case, then a doctor with no claims would have no premium and a doctor with a $1 million claim would have a $1 million premium. The fundamental notion of insurance is the sharing of risk.

The overall average loss amount is influenced both by the number of claims and the size of claims. Some specialties have a propensity toward a higher or lower than average number or size of claims. The number of claims is generally referred to as the *frequency* (number of claims per hundred doctors) and the size of claims the *severity* (the cost of the average claim). The product of frequency and severity for a given specialty, in turn, may drive that specialty rate above or below the average for the state or territory. In this way, rates for the individual specialties are calculated.

Once the average annual loss amount is determined, it is necessary to add an expense load that considers company overhead, business acquisition costs, taxes, licenses, fees, etc. Although TDC is a reciprocal company owned by its policyholders, a small amount of profit is necessary for two reasons. First, additional surplus is

necessary to support the premium of new policyholders. Without strong surplus, an insurance company cannot accept new policyholders. Second, adequate capital is needed to pay for losses that exceed expectations, precisely the situation we have witnessed in the current crisis. Moreover, surplus levels are highly regulated by state insurance departments. Companies lacking adequate surplus are simply not permitted to operate.

Moving to the underwriting of individual physicians, the primary factors considered include the doctor's practice profile, loss history, and the presence or absence of prior liability coverage. The practice profile includes the number and type of medical procedures performed compared to the average for the doctor's specialty, the number and nature of office personnel, the business structure of the practice, and any responsibilities outside of regular practice.

Generally speaking, surgical classifications necessitate higher premium rates than nonsurgical specialties. For example, historical claims data suggest that loss costs associated with obstetricians are, on the average, about four times the level of loss costs associated with internists. Neurosurgeons average roughly six times the annual loss cost of an internist. Conversely, low-risk specialties such as administrative medicine receive premium rates lower than the average specialty.

The venue in which the doctor practices also plays a critical role in determining the premium rate. As insurance is regulated on a state-by-state basis, TDC's ratemaking method utilizes state-specific information to develop loss cost projections as

a starting point for premium rates. In this context, the presence or absence of legal reform is critical in the ratemaking process. Other pricing considerations include whether or not a doctor practices full time, the policy limits, the number of allied health professionals supervised, the length of time in practice, and the specific territory within the state. Prior liability coverage is evaluated to make sure the doctor has not practiced without coverage in the past.

Claims history, of course, also plays a part for individual physician pricing. An individual doctor's claims history is compared to the average expected for the specialty. Doctors with no claims receive a claims-free discount. Doctors who have a worse than average liability history may receive a surcharge on their premium levels. In assessing the appropriateness of a surcharge, the company makes an effort to distinguish between adverse medical outcomes and medical negligence. Ultimately, however, there is a Solomonic issue of how to apportion the burden of premium among policyholders. In general, we ask those who have incurred losses to pay more than those who have not, even if we do not feel the doctor was negligent. Ultimately, the average rate for the state is the sum of the experience of the individual policyholders.

Question: What factors are causing increases in medical liability premiums?

Severity in Virginia has risen significantly in recent years. Between 1998 and 2003 severity in Virginia has increased at 167% of the rate of California severity. The increase is even greater in the most recent years. Severity in Virginia in 2003 is 15%

higher than in 2002 and nearly 30% higher than 2001. TDC's rates in this time frame were designed to produce an underwriting profit of less than 5%, but even this modest goal has not been met, i.e. claims losses have exceed projections.

Overall, since 1998, TDC has averaged an annual rate increase of 10.3% for Virginia, but much of this has been in the past three years corresponding with the sharp increase in severity.

Virginia's Tort Reform and the impact of MICRA

Virginia caps total damages at $1.75 M, but this figure increases by $50,000 annually until it reaches $2 M. This is a substantive reform and it has the effect of reducing the likelihood of a blockbuster verdict having an undue impact on overall rates. On the other hand, Virginia physicians generally carry coverage equal to the full cap, which means that virtually every physician carries a $2M/$6M policy. In other states, approximately 80% of physicians carry a $1M/$3M policy. This higher limit alone increases the average premium in the state by 25-30%.

Now let us look at MICRA (Medical Injury Compensation Reform Act). It has four principle provisions:

1. $250,000 no exceptions cap on non-economic damages only. California does not limit the total award. This is the single most important provision, but all four are important and MICRA should be thought of as a package.

2. Periodic payment of future damages in excess of $50,000. This allows the insurance system to accommodate even very large awards and assures that funds will be available as they are needed.

3. The collateral source rule allows introduction of evidence that the plaintiff has already recovered damages from third parties. This has the common sense outcome of limiting double–dipping and avoids the use of the incredibly inefficient tort system to cover basic benefits. The Department of Heath and Human Services calculates the transaction tax on payments to injured patients to be 72%.

4. Limitation on the contingency fee. This is a sliding scale that begins at 40% of the first $50,000 awarded and declines to 15% of awards beyond $600,000. This means a California personal injury lawyer still receives $221,000 (plus all expenses) for winning a single million claim. Under this statute, the injured plaintiff, on whose behalf we are expected to believe the trial lawyers are pleading, takes home $179,000 in larger indemnity in California than in a state with an average contingency fee of 40%. The Rand Study (2004) quantifies how valuable this provision is to the injured plaintiff. It reduces by half the impact of $250,000 cap on non-economic damages in the average case in which it is invoked.

Sources as diverse and independent as the American Academy of Actuaries, the Congressional Budget Office, the Department of Health and Human Services, the General Accounting Office, the Florida Select Commission on Malpractice, Standard and Poor's, Milliman and Robertson, and the National Association of Insurance Commissioners, all estimate that the MICRA reforms reduce malpractice premiums between 20 and 30%.

The same will be true in Virginia when the state enacts the MICRA reforms. If Virginia were to implement MICRA, and the prevailing policy limit in the state was reduced to $1 million as it is in the rest of the country, savings of 40% or more can be anticipated.

Mr. Chairman, that concludes my testimony. I would be happy to answer questions from you or the Committee and appreciate the opportunity to address you today.

Thank you very much.

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