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Private Responses to the Crisis

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SESSION 2: PRIVATE RESPONSES TO THE CRISIS

PROF. BLUM: Our next speaker with an insurance perspective is Robert Mulcahey.

MR. MULCAHEY: I think that the keynote speakers did an excellent job of outlining what the issues are in the insurance industry. However, as far as characterizing the current situation as a crisis of large financial proportions, it is important to understand that professional liability, from the insurance premium perspective, encompasses only about two percent of the total direct premiums paid in the property casualty line of insurance in 2002; $9 billion in premium was paid for professional liability insurance, medical malpractice insurance specifically.[1] Nine billion is a lot of money, but from the insurance industry's perspective it's a small slice. However, because this small slice is in a very specialized area of insurance, it has had a disproportionate effect. The reason for the impact is that there are two types of carriers that write professional liability insurance in the medical malpractice area. There are specialty carriers who [only] write medical malpractice insurance. Many of these are mutual companies. Some of them are publicly traded companies. About forty percent of the premium is written by multi-line carriers[2]—carriers who write all kinds of property and casualty [insurance]—and maybe even other insurance and it is these multi-line carriers that are exiting the business because it is too volatile and not as profitable as other lines. The specialty carriers do not have the option of leaving the market, but they also do not have the capacity to fill the void left by the multi-line carriers.

The declining number of companies offering professional malpractice insurance forces a loss of availability, which is what I am going to talk about—a loss of availability and the reaction to that in the market. Loss of availability occurs because companies like St. Paul, or Farmers, or some of the other companies who are multi-line carriers, are businesses. They are in the business of making money for themselves and their shareholders. These carriers are looking to make a fifteen to twenty percent margin off each line

1. Chad Karls, Principal & Consulting Actuary, Address to McFarland Clinic Board of Directors (Nov. 12, 2003).

2. *Id.*

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they offer. [T]hey look at all the other lines that they provide and they compare their other lines with medical malpractice and they say "this is a line that doesn't generate fifteen to twenty percent predictably over a period of time," because it goes dramatically up and down, more so than the other lines. In fact, the earlier speakers demonstrated the losses this past year, which were the second worst in history for the professional liability line of business.

The impact of poor performance is that St. Paul's and others multi-line carriers pull out of the market, which leaves a huge void. It's very difficult for the specialty carriers to come in and fill that void and it is particularly difficult to fill a void without dramatically raising their premiums in order to take on the additional exposure in an era when the returns of investments are greatly diminished. [A] long list of multi-line carriers have left the professional liability market, and even some specialty line carriers have pulled back and have stopped writing in some states. [The result is] a crisis of availability, which as the earlier speakers pointed out, will eventually go away, because as premiums get high enough, other carriers will come into the market.

A second issue is that both the multi-line carriers, who have stayed in the business, as well as the specialty carriers have greatly increased their premiums. In addition, they have also increased the self-insurance portion required of insureds in either the form of deductibles or self-insured retention (SIR). This is effectively an additional increase in the cost of insurance, but it is a hidden increase. Retention levels for both hospitals and physicians are going up into the astronomical levels and yet you have to ask yourself—at what point can an individual physician or individual group of physicians or a hospital take that kind of risk? [I]t's definitely happening in the market today. You are seeing dramatic increases in both premium and SIRs and deductibles.[3]

Premium increases range from fifteen to one-hundred percent, depending on which state you are in. Again, these high-level rate increases may be a short-term event, but over the long run it has a greater impact because the base premium never goes back down again and the provider community's revenue is not increasing to match the increase on the expense side.

The next thing that's happening in the industry is there are new entries [into the insurance market]. Again, when there are premium increases, new people will come in to take advantage of that opportunity. There are newly formed physician-owned mutuals and there are some state-supported

3. U.S. DEP'T OF HEALTH & HUMAN SERVS., CONFRONTING THE NEW HEALTHCARE CRISIS: IMPROVING HEALTHCARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 1 (July 2002), *available at* http://aspe.hhs.gov/daltcp/reports/litrefm.htm.

hospital association writers coming into the market to try to fill the void. They are not going to fill the void at lower premiums; they are going to fill the void at the level that the premiums are currently at. They are going to try to provide better availability over the long run, but that availability will be at a higher price.

The other thing that's happening is effectively lower coverage, not just excess coverage. Many physician groups, and I know hospitals have faced this also, have eliminated their excess coverage or dramatically lowered their excess coverage, simply because they can't afford it. On the primary layer, you have carriers, often times risk retention groups, sometimes multi-line carriers, that are effectively coming into markets saying, "we are only going to charge you ten percent more than your current premium," which appears to be a great deal on the surface, but underneath that, they have lowered the coverage because they have included defense costs within that $1 million level of insurance while most current policies provide defense costs outside of the $1 million level.

This lower level of coverage is creeping into the market. The introduction of effectively lower levels of coverage will have a ripple effect down the road because you will have physicians practicing who believe they have a million dollars worth of coverage similar to the coverage they previously had, but in effect they have purchased lower limits of coverage for more dollars. [I]t doesn't equate one for one. We are seeing that happen quite a bit in the marketplace. I expect that it will come back to haunt some of us in this room in the next year or two.

The next area I would like to cover is the insurance industry's reaction to risk management. I see risk management becoming more important in the eye of insurance carriers. Ten years ago, even five years ago, many insurance carriers evaluated whether they were going to take a risk from the underwriting standpoint and paid little or no attention to risk management activities. This was even more so in the reinsurance area. Reinsurers seldom looked at risk management programs because they just didn't see that as an area that was going to have a great impact on the risk that they were taking. Now you are seeing a lot of activity in risk management. You are seeing primary carriers looking at risk management, evaluating risk management activities of a prospective client before they write a case, and in some instances you see reinsurers asking for a copy of a risk management plan.

I think this is a positive impact. Again, it's only a positive impact if you are not a party that's going in and out of the market and always looking for the lowest bidder, but [rather] you are in a market and you are going to say, "we are going to stay committed to this market, we are going to stay committed to risk management for a period of time, and not just for the

years that the current prices last."

I think risk management overall is very positive. [R]isk management takes a lot of forms on a day-to-day basis. For me, who is in the business of looking at physicians and multi-specialty physician group liability, I preach to my groups that the best risk management you have is the first risk management. This includes credentialing and privileging when you make that hiring decision for a physician to come into your multi-specialty group. Because my groups are by and large in more rural areas, they may be more desperate for a neurosurgeon, or some other sub-specialist that the community needs. But many neurosurgeons or other sub-specialists don't necessarily want to practice in Taylorville, Illinois or Ames, Iowa. When the group has a candidate that comes along, they have a tendency to overlook a past history that wasn't as glorious as it might be. I am constantly pounding away on that issue—you wait and wait until you get the right person. They are out there. If you get the wrong person, a four or five year stream of revenue from that person is not going to pay you back for the $10 million or $20 million malpractice claim that comes out of it.

[R]isk management is getting the physicians' attention and they are looking at it [risk management] more seriously. In that way, I welcome this crisis in the sense that it focuses the physician groups' attention on the fact that they have to pay more attention to screening the people coming into their group and taking professional responsibility for correcting the misbehavior of physicians in their group. [A] lot of times it is misbehavior that leads to these malpractice cases, as well as injury.

The next area is the alternate risk financing area. This gets more directly to the issue of addressing availability. The first step, the most obvious one, in the way of alternately financing your premiums is one I have already mentioned—taking a higher SIR or deductible. Many hospitals, physician groups, and multi-specialty groups get forced into the situation of higher retentions. They really don't have a choice. They don't have a system in place to manage claims internally, but at the same time the only coverage they can get is with a very large deductible or SIR. As a result they are in the claims management business by default.

Higher SIRs and deductibles are a reality; most providers do not have a choice. That's the only coverage that is available to them. They have to prepare to take risk and look at claims and develop an infrastructure. That's happening today, but there is going to be a long learning curve for some of those groups to get up to speed who are used to having first dollar coverage. There is a huge difference between having first dollar coverage and having the first $100,000 of each claim [covered]. [T]hose of you who are doing this everyday know that may seem like a small amount, especially for the hospitals, but for a physician group it would be an astronomical issue to

manage.

The second area is dropping or limiting excess coverage. This has become a huge issue for the large multi-specialty group. When coverage was more affordable, most of the large multi-specialty groups carried an excess policy on top of their one/three limit or two/four limit for each of their physicians or another $30 million or $40 million on top of their coverage. That dropped down to $10 million or $15 million, then down to $5 million. Now, many groups are making the economic decision not to buy that coverage, with the full knowledge that this could mean bankruptcy for the organizations at some point in time. If you can't afford it or it's not available, you just don't buy it. That's what is going on out there. [W]hether that's good or bad for the industry, good or bad for the tort system, we will find out in four or five years down the road when cases come forward and you find out that there really is no coverage available for these very bad cases, very bad outcomes.

The next area where you will see a tremendous amount of growth is in risk retention groups. These premium dollars are not seen in the numbers we are talking about today for direct premiums because they are not with regular insurance companies that are licensed companies. Risk retention groups have taken a gigantic leap in the last year or two. In 2003, the projected premiums for risk retention groups for medical malpractice were $1.7 billion, which is a $460 million increase over the previous year.[4] Seven out of nine new risk retention groups that were registered last year were in the healthcare industry.[5] Not just in hospitals, but also in nursing homes and other related facilities.

[Y]ou are seeing a large portion of the industry that previously didn't have any experience in insuring themselves moving to an alternate financing vehicle. Whether that risk retention group has the infrastructure to manage claims, whether it has the underlying risk management program to identify issues properly, look at patient safety in their facilities, that's a question that's out there. [A]gain, for financial reasons a lot of providers are skipping over that question and just jumping into risk retention groups and saying, "We will fix the other issues on the back side." [T]hat, again, may have some serious consequences for us in the next four or five years.

The last area I will address is captive [insurance companies]. I represent a captive insurance company that provides professional liability insurance for multi-specialty groups. A captive is not the solution to the tort problem.

4. *RRG 2003 Premium to Climb to $1.7 Billion, RRR Survey Finds*, RISK RETENTION REP. (Oct. 2003), *available at* http://www.rrr.com/news/index.cfm.

5. *Number of Risk Retention Groups Swells To All Time High*, RISK RETENTION REP. (Oct. 2003), *available at* http://www.rrr.com/news/index.cfm.

It's not a solution to the medical care problem in this country, but what it does do is provide, to those participating physician groups, a leveling of premium increases. We tell all of our groups, "you are going to pay for your own claims. You are going to pay for the defense costs and the liabilities out there for the actions of the professionals in your group. You can go to the market and buy insurance premiums that are below what the actual costs will be from time to time, but then when the market turns the other way, you are going to pay much higher amounts."

[A] captive is a methodology to actuarially fund the liability, to put up the infrastructure to have a good claim system, to have a good risk management system, and then stick with it over the long haul, not a year or two, but a five, ten, fifteen-year platform at a minimum. [Y]ou, the doctor or physician group, are going to pay higher premiums this year, or next year, or when the market is soft, but overall you are going to pay more level premiums. That's really the pitch that we make for our captive.

[M]idway through 2003, there were forty-three new captives formed in the Cayman Islands, thirty in the healthcare field.[6] There were seventy licensed captives in the Cayman Islands that are segregated portfolio companies, and they had a total of 330 portfolios.[7] [Not] only are the number of captives growing, but by using segregate portfolio companies, there are even larger numbers of premium dollars going into the captive market for healthcare. There are also a growing number of captives in the United States, and again, with the majority of these new captives being in the healthcare industry.

[C]aptives can be a great solution, if you have the right attitude and long-term view going into them. However, like the other forms of insurance, captives are having problems getting fronting carriers because fewer multi-line companies want to get into the fronting business at all. [Captives are] also having issues with reinsurance, which is a whole new topic. [T]he reinsurance market is just as hard, if not harder, than the primary market. If you are going to form a captive and use that as an alternate way of financing, you better have your ducks in a row if you expect to get reinsurance coverage. It's not something you walk done the street and obtain readily without having a good infrastructure in place. Thank you.

6. Captive.com, *2003, A Continuing Trend of 2002* (July 2003), *at* http://www.captive.com/showcase/cayman/FirstHalf2003.html (Mar. 29, 2004).

7. *Id.*