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Press Release

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Actuaries Find that Medical Malpractice Report Misled the Public

Rockville, MD –Independent actuaries with the firm Towers Perrin find that a July 2005 report released by the Center for Justice and Democracy and five other "consumer groups" is incomplete and unsound. Jay Angoff, an attorney employed by a personal injury law firm, performed the analysis for the six "consumer groups" and claimed that medical liability insurers have overcharged doctors and hospitals and accumulated record amounts of surplus over the last three years. However, an analysis of Angoff's report by actuaries James Hurley and Gail Tverberg finds that those claims are not supported by the data, nor do they pass a common sense test.

Towers Perrin's comments released today find Angoff's "analysis is incomplete and unsound" and his statistics "are:

1) meaningless and unsound in the case of paid loss to written premium comparisons;
2) materially incomplete, in the case of incurred loss to earned premium comparisons; or
3) incomplete and taken out of context, in the case of the change in surplus."

The Towers Perrin analysis documents that malpractice insurers have lost money in each of the years 1999 through 2003 even after considering investment income from their bond portfolios. In 2001, financial results were the worst in approximately 30 years. Hurley and Tverberg, through a succinct and thorough review, demonstrate that Angoff's conclusions cannot be supported by the facts.

Furthermore, Hurley and Tverberg find that Angoff's analysis fails the common sense test in that insurance regulators and analysts do not look at the statistics that Angoff derives because they are "meaningless, incomplete and inappropriate to form the conclusions made in the [Angoff] Report. If medical malpractice is as profitable as implied by the report, more companies would be competing to write the coverage."

PIAA President Larry Smarr applauded the actuaries' comments. "The Angoff report is a hoax and inappropriately twists numbers to claim that medical malpractice insurers have increased premiums at a rate more than 20 times the increase in claims payments. Towers Perrin has taken a critical step toward setting the record straight and stopping Angoff and these groups from further misleading the public."

Mr. Angoff's report is entitled, ***"Falling Claims and Rising Premiums in the Medical Malpractice Industry."***

The PIAA is an association of doctor/provider owned and/or operated medical liability insurance companies which insure over 60 percent of America's private practicing physicians as well as dentists, hospitals, and other healthcare providers.

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Comments on Report by Jay Angoff

"Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry"

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EXECUTIVE SUMMARY

Introduction

In July 2005, Jay Angoff authored a report commissioned by the Center for Justice & Democracy entitled "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry." This report seems to suggest that the malpractice insurance industry is making huge profits and that insurers are greatly increasing their net worth through these profits, but these assertions are not supported by the analysis provided.

The Physician Insurers Association of America (PIAA) brought the Angoff report to the attention of the Tillinghast business of Towers Perrin (Tillinghast), and asked if Tillinghast would be interested in providing an independent review of the report. Tillinghast provides actuarial consulting services to a wide range of clients, including malpractice specialty insurers, state regulators, self-insurers, state medical societies, and multi-line insurers writing malpractice coverage as one of their coverages. Because of our training as actuaries and our broad range of malpractice clients, we believe that we are well situated to provide an independent analysis.

We should note that while the PIAA inquired about a review of the Angoff report, we have prepared this analysis without compensation from any source.

Findings

The Angoff report ("Report") purports to analyze the 2000 through 2004 performance of the 15 largest medical malpractice insurers rated by AM Best. The analysis is incomplete and unsound. We believe the quoted statistics are:

1. meaningless and unsound in the case of paid loss to written premium comparisons;
2. materially incomplete, in the case of incurred loss to earned premium comparisons; or
3. incomplete and taken out of context, in the case of the change in surplus.

In contrast, under required accounting rules, medical malpractice has produced operating losses for the last several years ending 2003, with an expected better outcome in 2004. These results differ from the partial story based on selected statistics discussed in the Report by

more appropriately matching revenues with costs and taking into account the total cost of providing coverage.

The Report states that surplus has increased dramatically and exceeds "adequate" levels. For this portion of the analysis, the Report focuses only on 12 monoline companies and shifts the selected measurement period to 2002 through 2004 (rather than 2000 through 2004, as used for others). By using this time period, the report ignores the decline in surplus capacity between 2000 and 2002. The report also ignores the fact that several malpractice insurers have taken steps to shore up surplus, including the issuance of surplus notes and additional paid in surplus. Using the Report's criteria for surplus adequacy, these 12 companies have less surplus margin in 2004 than in 2000.

From an industry perspective, surplus to write medical malpractice, which controls how much premium can be written, declined significantly over the last several years due, in part, to voluntary (e.g., St. Paul) and involuntary (e.g., Phico, MIIX) withdrawals of significant writers, compounded by operating losses noted above. Thus, the overall industry is also operating at a lower surplus margin in 2004 than in 2000 based on the Report's criteria.

Furthermore, the analysis fails the common sense test. If it was meaningful to compare Lexington's written premium of $778.6 million to its paid losses of $124.2 million, or its growth in written premium and paid losses over time, common sense says it would be done in regulatory reports and financial reports. Experts – regulators and insurance analysts – do not look at these statistics because they are meaningless, incomplete and inappropriate to form the conclusions made in the Report.

With respect to profitability and surplus growth, it is generally agreed that 2004 will produce better financial results than the last several years. It seems unlikely, however, that the malpractice line is unreasonably profitable. Common sense says if medical malpractice is as profitable as implied by the Report, more companies would be competing to write the coverage. For these reasons, the assertions of the Report do not pass the common sense test.

OVERVIEW

The medical malpractice line of insurance has been in turmoil for the last several years. According to AM Best data, malpractice insurers, considered in total, have lost money in each of the years 1999 through 2003, even after considering investment income. In 2001, financial results were the worst in approximately 30 years of separate record keeping for the line. The 2004 year is anticipated to produce improved results, and may even break the string of losing years. These results are based on operating ratios of insurers, reported in accordance with National Association of Insurance Commissioner ("NAIC") accounting standards and reflect consideration of all the costs associated with providing the coverage, including investment income related to the insurance transaction.

Associated with these very poor financial results is a material shift in the insurers writing the coverage. The largest insurer of medical malpractice coverage, the St. Paul Companies, voluntarily stopped writing the coverage. Two other large insurers, MIIX and Phico, stopped writing the coverage for financial reasons. Several other major insurers restricted the coverage they wrote to selected states.

Against this backdrop, the Center for Justice & Democracy has released a July 2005 report (the "Report") prepared by Jay Angoff, a lawyer with Roger Brown & Associates, which provides a review of several statistics for a selected group of companies. Specifically, the Report compares paid losses to written premium and compares incurred losses (which include required provision for future payments) to earned premium. It also looks at growth in surplus (i.e., capital). Based on a review of these statistics, the Report concludes (Executive Summary, pages ii and iii),

> "Because of the overall surge in malpractice premiums with no corresponding surge in claims payments during the last five years, the leading malpractice insurers have increased their surplus by more than a third in only three years, and they are now charging more for malpractice insurance than either their actual payments in malpractice cases or their estimated future payments in malpractice cases would justify." (emphasis added)

The analysis is inadequate to support the conclusion. The inadequacies are several and include:

- failure to adjust for the acknowledged delay in loss payments relative to premiums
- failure to adjust for change in number of insureds over time
- failure to adjust for the known unprofitable starting point
- failure to include all costs associated with providing the insurance coverage
- failure to adjust for bias in companies selected for review
- failure to consider changes in interest rates affecting investment income earned
- failure to adjust for other sources of/impacts on surplus/capital.

The Report reflects an unsound and incomplete analysis of the companies reviewed and ignores all other companies writing medical malpractice.

The author of the Report indicates that his analysis is of the 15 largest AM Best-rated medical malpractice insurers, based on 2004 malpractice premium. One might think this group of companies would provide a representative sample of industry results. In fact, because of the financial failures of some of the largest insurers and withdrawal of others, it includes many companies which were much smaller at the beginning of the analysis period, but have grown rapidly as they sold policies to insureds leaving other carriers. Because of the selection of the group, and the lag between the time premiums are written and claim payments are made, this group of insurers can be expected to have much lower ratios of paid claims to premiums than other insurers, and much higher increases in premiums than other insurers. A comparison of 2000 premium rank and 2004 premium rank of the 15 insurers selected by the author of the Report is shown below. In addition, we have noted the rank of several companies not included.

GROSS WRITTEN PREMIUM RANK OF INSURERS

Company	AM Best 2000 Rank	AM Best 2004 Rank	Rank in Report
Lexington	26	1	1
Medical Protective	3	2	2
TDC	6	4	3
ISMIE	9	5	4
HCI	4	6	5
MAG Mutual	21	7	6
Medical Assurance*	11	8	7
FPIC	16	10	8
ProMutual	17	11	9
State Volunteer	18	12	10
NORCAL	10	15	11
ProNational*	8	16	12
Continental	25	17	13
AP Capital	15	18	14
Evanston	39	19	15
Excluded			
St. Paul	1	145	N/A
MLMIC	2	3	N/A
MIIX	5	N/A	N/A
Phico	7	N/A	N/A

* ProAssurance

Data is available from two different sources that provides a more complete picture of industry results. Both AM Best (the principal rating organization for the insurance industry) and the NAIC (the organization of insurance regulators from the various states) collect and summarize the data of most medical malpractice insurers. Two ratios viewed by these and other insurance organizations are the "combined ratio" and the "operating ratio". The combined ratio represents all the costs of providing medical malpractice insurance, including both losses and expenses, as a percentage of premiums. The operating ratio is the combined ratio, adjusted to

consider investment results on policyholder-supplied funds. Summaries by AM Best and NAIC indicate a combined ratio of 139% for the five year period ending December 31, 2003, and an operating ratio of approximately 118% for the same period. (Data for 2004 is not yet available.) Lower interest rates during the last few years have resulted in reduced offsets for investment income to the combined ratio, producing medical malpractice operating losses at record-setting levels.

The anticipated improved 2004 underwriting result reflects the rate actions taken – but if they are at a breakeven level, it suggests that the current rate levels are where they need to be – not good news for premium paying healthcare providers and not unreasonably profitable as implied by the Report.

ANALYSIS

This analysis discusses the three "methods" used to support conclusions in the Report and provides additional information intended to give a more complete picture of medical malpractice financial circumstances.

Method 1: Written Premium vs. Paid Losses

The Report compares written premium in a calendar year to paid losses in the same calendar year. For example, if a policy is written on December 1, 2000, and a claim is paid relating to this policy in 2004, all of the premium for the policy would be considered in the 2000 year, and the claim payment would be considered in the 2004 year. Besides the material omission of other costs to be discussed later, this comparison is flawed because it fails to account for changes in the number of policyholders over time and the delay in loss payments relative to premium payments. The Report's author acknowledges the latter problem (page 2 "... does not provide a complete picture, since claims paid out in a given year are typically covered by policies written in prior years."), but ignores or does not understand the former problem. Furthermore, the comparison ignores the recognized unprofitable level of premiums in the 2000/2001 period.

A. Knowledgeable reviewers of insurance financial results do not use this ratio. Further, the ratio of paid losses to written premium is not included in NAIC or GAAP reporting. This is because the NAIC and GAAP oversight bodies recognize that this statistic is not an effective indicator of financial performance. It represents a mismatch of premiums and losses and ignores other costs of providing the coverage.

B. Premium written is the amount collected when issuing a policy. However, because the policy is for a 12-month period, it must be earned over 12 months, not counted as income immediately. Increases in rates cause further distortions, since the higher premiums relate to coverage for the next 12 months while the paid losses relate to policies issued in prior years.

C. Additionally, this ratio is distorted due to growth in number of policyholders, which most of the Report's 15 companies experienced during this time frame. An example of this distortion can be observed in the following chart. It assumes new premium written of

$20,000, 50% of premium associated with loss payments and a typical payment pattern (and no trend):

WRITTEN PREMIUM VS. PAID LOSSES EXAMPLE

By Calendar Year

Year	Premium	Paid Loss	Ratio	Year	Premium	Paid Loss	Ratio
1	$20,000	$750	3.8%	6	$20,000	$9,100	45.5%
2	20,000	3,000	15.0%	7	20,000	9,450	47.3%
3	20,000	5,500	27.5%	8	20,000	9,600	48.0%
4	20,000	7,200	36.0%	9	20,000	9,750	48.8%
5	20,000	8,400	42.0%	10	20,000	10,000	50.0%

Pattern: .075, .225, .25, .170, .120, .070, .035, .015, .015, .025

As indicated, it takes the full duration of the payment pattern to reflect the impact of growth in business in this ratio, assuming there is no trend in loss costs. The ratio is clearly biased low due to the growth in business experienced by the companies.

D. The Report's selection of companies misrepresents the relationship of paid losses to written premium and the rate of change in the two, even if the comparison were meaningful. In the chart below, we have added just three significant (or formerly significant) medical malpractice writers – St. Paul, MLMIC, and SCPIE – based on data reported to AM Best to the totals in Table 2 of the Report for years 2000 and 2004.

GROSS WRITTEN PREMIUM VS. GROSS LOSSES PAID

2000 & 2004

Company		($millions) 2000	2004	Change
Prior Total	GPW	$2,259.6	$5,298.3	+134.5%
	GPL	1,550.0	1,698.8	+9.6%
	Ratio	68.6%	32.1%	—
MLMIC/St. Paul/SCPIE*	GPW	1,407.5	1,074.1	-23.7%
	GPL	1,346.3	1,486.6	+10.4%
	Ratio	95.7%	138.4%	—
Revised Total	GPW	3,667.1	6,372.4	+73.8%
	GPL	2,896.3	3,185.4	+10.0%
	Ratio	79.0%	50.0%	—

* Direct business from AM Best database for group

Including just these three companies exposes the importance of the Report's selection of companies by cutting the criticized increase in premiums by nearly one-half.

E. It is not possible to accurately assess the growth in business experienced by active writers. However, it is clear that much business moved from former major writers of medical malpractice to current active writers. In 2000, St. Paul wrote approximately $650 million in premium and two other companies that are no longer active (Phico and MIIX Group) wrote premium totaling about $400 million. Thus, approximately $1 billion in business (about 15% of premium reported to Best in 2000) shifted from these three insurers to others during this period, contributing to the distortion in paid to written relationships of the active writers.

F. The Report's focus on the reduction in the so-called "paid loss" ratio has the implicit assumption that the ratio in 2000 or 2001 was at an acceptable level. The 2000 ratio of 79%, as recalculated in the table above, is unacceptably high and implies unprofitable results. This will be discussed further in the next section.

Method 2: Earned Premium vs. Incurred Losses

In this analysis, the Report compares earned premium to incurred losses. This is an improvement over the paid-to-written comparison commented on in the previous section because there is a better matching of the time period of premium and losses. Earned premium used in this method reflects the portion of premium earned during the year, based on the effective and expiration dates of policies. Losses include a provision for future payments (reserves), as required in insurance accounting. However, this ratio is still an inadequate and incomplete measure of performance because it omits significant other costs – both the cost of defending claims and other costs of operating the company. Additionally, the comparisons made in the Report fail to recognize that the 2000 through 2003 period was an unprofitable one. Finally, while earned premium and incurred losses represent a better matching than paid losses and written premium, this comparison is still not appropriate for rate determination. For this type of analysis, more refined data is needed.

A. Although more meaningful than the Report's paid-to-written comparison, this comparison fails to consider the costs associated with defending claims and with providing and servicing the coverage. The chart below shows total underwriting costs for the last ten years ending 2003 as contained in the NAIC Profitability Report.

NAIC PROFITABILITY RESULTS (COUNTRYWIDE)

(Ratios to premium earned)

Year	Losses	Loss Adjustment Expense	Other Expenses	Underwriting Profit/(Loss)	Investment Gain on Insurance Transaction	After-tax Profit on Insurance Transaction
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1994	59.3%	26.2%	18.5%	(4.0%)	25.3%	17.7%
1995	59.3%	30.1%	19.5%	(8.9%)	28.8%	16.4%
1996	62.9%	28.4%	19.6%	(11.0%)	32.3%	17.3%
1997	57.8%	29.2%	22.0%	(9.0%)	32.3%	18.5%
1998	73.0%	32.4%	23.4%	(28.7%)	33.2%	5.7%
1999	73.9%	32.4%	23.6%	(29.8%)	26.8%	0.6%
2000	80.9%	32.5%	22.5%	(35.9%)	32.0%	0.0%
2001	100.0%	34.2%	21.8%	(56.1%)	24.1%	(18.8)%
2002	93.0%	31.7%	18.9%	(43.6%)	14.7%	(17.6)%
2003	80.7%	31.9%	16.1%	(28.6%)	16.6%	(6.3)%
2004	N/A	N/A	N/A	N/A	N/A	N/A

These are results for the medical malpractice industry as reported in statements filed with and summarized by the NAIC. Results for the 2004 year are not yet available. A few observations –

i. The Report discusses only column (2). Clearly this omits significant costs related to this coverage. The cost of defending claims that close with loss payment as well as those that close with no payment (column (3)) averages about 31% of premium. In addition, other operating expenses average approximately 21%. These affect financial performance and impact the adequacy of rates.

ii. This data indicates that the deterioration in financial results is primarily due to increased losses relative to collected premium (the ratio in column (2) averages 62% for the first five years and 86% for the second five years). The other expense ratio has declined and the loss adjustment expense ratio has been fairly stable.

iii. The data also shows clearly that the Report's use of the 2000 through 2003 period as its basis for comparison represents a biased high and unprofitable period. In order to avoid further losses, the industry needed to take steps to lower the ratio in column (2). In fact, a lower loss ratio is required now for profitability than was required when interest rates were higher, because of the smaller investment income offset (see column (6) in the chart above).

iv. The after-tax profit (including consideration of investment income) calculated by the NAIC is shown in column (7). The years 1994 through 1997 are profitable; 1998 through 2000 reflect deteriorating results; and 2002 through 2003 reflect significant losses with improvement in 2003. The 2004 results, when available, will likely produce a profitable result.

B. The complete calendar year results summarized by the NAIC shown above, or by AM Best, are not well-suited for a formal determination of rates. A better basis for this would be coverage year data (e.g., calendar-report year or policy year data for claims-made rates).

Method 3: Surplus Analysis

The Report states the selected medical malpractice insurers have substantially increased their surplus (capital) by reducing losses and increasing premiums. The support for this conclusion is a comparison of surplus of the 12 selected monoline companies from 2002 through 2004 which shows a 34% increase. The Report further states that "... the surplus of each of the twelve monoline medical malpractice insurers now substantially exceeds the surplus the NAIC deems adequate for the company" (emphasis added). In a change from prior sections, the Report shows the 2002 through 2004 period. Results for the comparable 2000 through 2004 period produce half the growth rate over a longer period, even for the selected companies. Adding omitted carriers will reduce it further. For these 12 companies and the industry in general, operating income does not explain the change in surplus; other changes impact surplus. Finally, surplus controls how much business insurers can reasonably write. The growth in business and increases in rates has strained these relationships.

A. The Report shows the change in surplus between 2002 and 2004 for 12 selected companies and notes a 34% increase. To provide a more complete, longer-term picture and be consistent with prior sections of the report, the following chart adds the 2000 year

to Table 5 and calculates the four year dollar and percent change in surplus. For these companies, this produces a cumulative 17% change over the period, averaging 3.9% per annum.

CHANGE IN SURPLUS, MONOLINE MEDICAL MALPRACTICE INSURERS
($millions)

Company	2000 Surplus	2002 Surplus	2004 Surplus	Change 2000 – 2004 Dollar	Change 2000 – 2004 Percent	Change 2002 – 2004 Dollar	Change 2002 – 2004 Percent
HCI	$542.9	$482.5	$767.8	$224.9	+41.4%	$285.3	+59.1%
Med Pro	372.8	401.7	510.8	138.0	+37.0%	109.1	+27.2%
MLMIC	1,500.5	993.0	478.1	-1,022.4	-68.1%	-514.9	-48.2%
TDC	381.1	341.4	405.6	24.5	+6.4%	64.2	+18.8%
ProMutual	398.6	300.3	378.5	-20.1	-5.0%	78.2	+26.0%
NORCAL	272.3	204.2	309.1	36.8	+13.5%	104.9	+51.4%
Medical Assurance	208.8	193.3	276.9	68.1	+32.6%	83.6	+43.2%
ProNational	253.5	197.0	241.8	-11.7	-4.6%	44.8	+22.7%
ISMIE	225.7	170.5	212.5	-13.2	-5.9%	42.0	+24.6%
AP Capital	229.7	163.5	200.1	-29.6	-13.9%	36.6	+22.4%
MAG Mutual	150.1	142.9	194.9	44.8	+30.0%	52.0	+36.4%
State Volunteer	138.2	129.3	167.9	29.7	+21.5%	38.6	+29.8%
FPIC	91.6	110.8	145.4	53.8	+58.7%	34.6	+31.2%
Total (x MLMIC)	$3,265.3	$2,837.4	$3,811.3	$546.0	+16.7%	$973.9	+34.3%
Total	$4,765.8	$3,830.4	$4,289.4	-$476.4	-10.0%	$459.0	+12.0%

B. Further, the analysis gives an incomplete picture of the change in surplus for the medical malpractice line because it does not consider the reduced surplus available to write premiums due to losses experienced by St. Paul, insurers taken over by regulators (e.g., Phico and MIIX Insurance Company) and other insurers. The impact of some of these insurers cannot be reasonably incorporated in a change in surplus calculation, but MLMIC can be added to the Report's Table 5. (The Report notes that MLMIC's surplus is not available; this is not true.) As noted in the chart above, this results in a net surplus reduction over the four year time period.

C. Expected improved 2004 industry operating results are likely to contribute to industrywide surplus growth in 2004 (and apparently did for the selected companies). After several years of net operating losses, this turnaround is needed to keep premium written and surplus relationships reasonable. However, this overlooks other components of increased surplus over this period. A number of companies obtained additional paid in surplus and surplus notes (e.g., State Volunteer, MAG Mutual, NORCAL). In addition, the accounting change allowing insurers to book the net deferred tax asset (a change under codification) contributed to statutory surplus increases.

D. Surplus capacity of active medical malpractice insurers is still constrained based on AM Best data through 2003 as these insurers have absorbed much of the business previously written by St. Paul, Phico and MIIX. The following chart shows the net leverage (sum of net premium written plus net liabilities divided by surplus) of 54 organizations whose primary business is medical malpractice insurance over the period 1999 through 2003 as summarized by AM Best.

AM BEST'S NET LEVERAGE

Year	Ratio
1999	2.7
2000	2.9
2001	3.5
2002	4.8
2003	4.5

Although there is no "correct" ratio, the increase in this ratio reflects the increased risk of adverse reserve development or inadequate premiums as the surplus available relative to loss exposure is substantially lower compared to earlier years. Rating agencies, if not regulators, are monitoring these levels and insurers have taken several steps, as noted in C., to improve such leverage ratios.

E. The Report states that insurers "now" have substantially more surplus than regulators deem "adequate". This is based on Table 6 of the Report, comparing the actual surplus to

the company action level ("CAL") Risk Based Capital produced under a regulatory formula. First, this is not "adequate" surplus; it is minimum surplus. If an insurer falls below this level of surplus, regulators will require a rehabilitation plan to increase surplus to get it above the minimum required level. More serious actions are authorized or required if surplus drops to certain levels further below the minimum. Insurers of this coverage, and throughout the insurance industry for all coverages, recognize this as minimum surplus and maintain surplus well above the CAL level.

Second, the comment that these 12 companies "now" have more surplus than deemed "adequate" misrepresents the facts. These companies have had more than required surplus over the entire 2000 – 2004 period. In fact, the ratio of surplus to CAL Risk Based Capital is lower in 2004 than it was in 2000 for eight of the 12 companies in the chart below, despite the increases cited in Table 5 of the Report.

RATIO OF SURPLUS TO COMPANY ACTION LEVEL RISK BASED CAPITAL

Company	2000	2004
HCI	152.1%	183.5%
Med Pro	198.3%	239.6%
TDC	441.6%	250.4%
NORCAL	245.1%	257.6%
Med Assurance	245.7%	185.8%
ProNational	306.6%	191.0%
AP Capital	273.2%	233.6%
MAG Mutual	404.2%	216.2%
ISMIE	229.3%	191.9%
FPIC	178.5%	295.9%
State Volunteer	318.0%	207.4%
ProMutual	208.0%	125.1%

Said differently, these companies have become more leveraged over this period – writing more premium and holding more reserves per dollar of surplus. Thus, there is not evidence that company surplus level is excessive, as suggested by the Report.