Pitfalls in Evaluating Proposed Tort Reforms

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Abstract

Motivation. To provide the ratemaking actuary with a description of typical medical malpractice tort reforms and issues involved in pricing these reforms.

Method. The paper draws primarily on the author's own experience with reform legislation.

Results. Ten pitfalls in evaluating reforms are described.

Conclusions. For educating non-actuaries, the most important is Pitfall #8, relating to the difference between indemnity savings and the expected change to current rates. Actuaries pricing malpractice tort reforms should be aware of the issues underlying all ten pitfalls. Some of these issues may also be relevant to pricing reforms for other lines of insurance.

Availability. No additional material is available online.

Keywords. Ratemaking; medical malpractice; tort reform.

1. INTRODUCTION

Actuaries are frequently called upon to estimate the impact of proposed legislation. This is an area where differing techniques can produce very different estimates. In this paper, I will discuss some of the pitfalls I have encountered in evaluating medical malpractice tort reforms. Many of the issues involved would seem likely to apply to more general tort reforms as well.

1.1 Research Context

A search of actuarial literature shows only a two panels and one paper on related topics. At the 1987 Casualty Loss Reserve seminar, there was a panel on Tort Reform moderated by Jeffery Mayer, with Thomas Grillo and Phillip Miller as panelists[i]. Topics included claim file analyses and impacts of tort reforms on loss reserves.

There was another panel on Tort Reform at the 1989 Casualty Loss Reserve Seminar[ii]. This panel was chaired by Fred Kist, and included panelist speaking on the following topics:

Claus S. Metzner: Tort Reform Reserving Issues

Phillip D. Miller: Use of Individual Claim File Studies

Gail E. Tverberg: Impact of Tort Reforms on Loss Reserves: Lessons from Medical Malpractice

Material relating to these sessions is available on the Casualty Actuarial Society website.

Also, a paper by Allen Kerin and Jason Israel entitled, "The Analysis of the Effect of Tort Reform Legislation on Expected Liability Insurance Losses" is included in the 1998 Casualty Actuarial Forum, Including the Ratemaking Call Papers[iii]. This paper provides a proposed Insurance Services Office approach to evaluating the non-behavioral impacts on losses of a hypothetical general liability reform. The paper includes a discussion of the difficulties encountered when evaluating the impact of reforms.

1.2 Objective

The paper is intended to provide insights into the difficulties involved in evaluating tort reforms from an actuarial perspective.

1.3 Outline

In the "Background and Methodology" section, I will describe some of the more common types of reforms, for the reader not familiar with tort reforms. I will then discuss ten potential pitfalls in the "Results and Discussion" section.

2. BACKGROUND AND METHODOLOGY

2.1 Frequently Used Reforms

2.1.1 Caps on non-economic loss

Such provisions restrict the amount a plaintiff may recover for damages other than medical expenses, loss of wages and other direct economic costs associated with the injury.

2.1.2 Collateral source offsets

These reforms provide that the amount of an award will be reduced by recoveries from collateral sources, such as disability and medical insurance policies.

2.1.3 Limitations on joint-and-several liability

Under joint-and-several liability, each entity that contributes to an injury is individually liable for all or any part of the award. Thus, if one defendant has inadequate assets or policy

limits to satisfy a judgment, a "deep-pocket" codefendant must pay a disproportionate share. Reforms limit the contribution of the deep-pocket defendant in certain situations.

2.1.4 Punitive damage restrictions

These reforms restrict the amount a plaintiff may recover as punitive damages to a multiple of the amount received for compensatory damages. In some instances, punitive damages are eliminated altogether or are limited to the most flagrant torts.

2.1.5 Periodic payments

For certain large awards, the portion attributable to future damages will be paid in regular installments over a fixed term or over the lifetime of the plaintiff.

2.1.6 Frivolous suit penalties

Typically, if a suit or a defense of a suit is found to be frivolous, the court may award attorneys' fees to the opposing party.

2.1.7 Limitations on attorneys' fees

In liability lawsuits, the plaintiff generally pays his attorney through a contingency fee, which is a percentage of the award or settlement. These reforms limit contingency fee percentages or provide for a court review of the reasonableness of fees.

2.1.8 Immunity statutes

Such statutes exempt certain individuals, institutions or public entities from tort liability under specified circumstances or place limits on the amount a plaintiff may recover from them.

2.1.9 Changes in pre-judgment interest

Many states provide that a jury award will be increased by a specified interest rate, between some specified date (such as the injury date or the date the suit is filed) and the date of the award. Recent reforms reduce the interest rate to correspond more closely to current interest rates.

2.1.10 Establishment of pre-trial hearing panels

Such reforms require that before a suit can be taken to trial, it must first be heard by a pre-trial panel. Under certain circumstances, the results of the panel may be admissible in court.

2.1.11 Establishment of state-operated funds to handle certain claims

States may establish a state-operated fund to cover claims in excess of a specified dollar amount, or to handle certain types of injuries, such as birth-injury claims.

2.1.12 Changes to the statute of limitation or statute of repose

Depending on the state, the statute of limitations can run from either the date of injury or from the date of discovery of the injury. If the statute of limitations runs from the date of discovery, there may also be a limitation on amount of time permitted for discovery, which is called the "statute of repose". Reforms can reduce the length of time permitted for either of these events.

2.1.13 Mandatory mediation

These require that mediation be tried before a case can go to jury trial.

2.2 Types of Reforms Discussion

This list of reforms is by no means exhaustive. State legislators are very creative in coming up with new types of reforms and combinations of reforms. Quite often packages of reforms will include items to try to appeal to a broad range of constituencies. Thus, besides including what one would usually consider tort reforms, such as the items above, there are often several other changes, as well, such as:

- Changes to the claim filing process, or to expert witness qualifications
- Requirements that insurance companies have rates approved in advance, perhaps after a mandatory hearing
- Mandatory rate reductions, if certain provisions are passed
- Requirements that physicians with adverse claims experience be investigated
- Various safety provisions, sometimes with requirements that physicians get premium reductions for making the changes

Thus, the legislation that is enacted generally includes quite a number of provisions, designed to appeal to different interest groups. Most often, the entire package of provisions needs to be reviewed, not simply a single provision.

2.3 Methodology

This paper draws primarily on my own experience in reviewing proposed malpractice tort reforms, working with closed claim data bases, and talking to lawyers involved with malpractice litigation.

3. RESULTS AND DISCUSSION

3.1 Pitfall #1: Not Adequately Understanding the Proposed Reform

Lawyers and others working with tort reforms frequently compile summaries, listing the basic provisions in the reforms package. While such a listing is helpful for getting an overview of the proposed legislation, it is better to obtain a copy of the legislation as proposed, and read it carefully. Pay close attention to details: If a non-economic damage cap is proposed, does it apply per defendant or for all defendants combined? Does it apply per plaintiff, or for all plaintiffs combined? If periodic payment of awards is proposed, how are payments treated after the death of the plaintiff? Do they stop, or does a portion of the payment continue?

Quite often there is also the issue of how the proposed legislation differs from current practice. As a starting point, one can look at the existing statutes, to see how they differ from what is proposed in the legislation. Additionally, it is also helpful to talk to someone who is familiar with current practices in the state (perhaps a lawyer handling claims) to get their view of how the proposed legislation differs from the current practice. There are situations where part of the existing statute has been declared unconstitutional, so it no longer applies, even though the wording of the statutes suggests the statute applies as originally enacted. There may also be situations where the existing statute is not enforced, raising questions whether the new statute will be enforced, either. A person familiar with existing practices can point out such pitfalls, and may also be able to provide insight as to how the current process really works and the reasons for the proposed changes.

3.2 Pitfall #2: Thinking Economic Loss Is a Uniquely Defined Amount

One of the more popular (and evidence suggests, effective) malpractice reforms is capping non-economic loss at a fixed amount, such as $250,000 or $500,000. With such a cap, the amount a claimant can receive in a jury award is limited to the claimant's economic loss, plus the cap amount. The question then becomes: How much is the plaintiff's economic loss?

If a person has only a minor injury, and is out of work a short time, the amount of economic loss is fairly easy to determine in retrospect. An insurer can ask how much the claimant paid in medical costs, and the amount of lost wages. There may be additional economic costs, such as the cost of transportation to medical treatments, to consider as well.

One somewhat tricky area, even on short duration claims, is the treatment of collateral source payments, such as health insurance and disability insurance payments. Depending on state law, economic loss will be either gross (full amount before recovery) or net of collateral source payments. If collateral source offset is permitted, the types of payments that are eligible for collateral source offset will vary by state. Besides privately purchased health and disability coverage, collateral sources could, at least theoretically, include payments by state disability programs, life insurance payments, Social Security disability income payments, Social Security health insurance payments, and Medicaid payments, among others. If collateral source offset is permitted, very often the premiums a claimant made to purchase the collateral source are considered as an offset to the calculation. If there is not an offset for collateral source payments, quite often the payer of the benefits will be allowed to subrogate against any award the claimant receives (collect back payments from the claimant after the claimant receives the award).

Another issue that sometimes arises is what the gross cost of hospital care really is. Hospitals charge different patients different amounts, depending upon who is paying for the care. In some jurisdictions, a plaintiff's attorney will be allowed to build his case based on the highest hospital rate anyone is charged, while in others, costs are limited to the actual cost for the particular claimant.

On longer duration claims, and on permanent injuries, evaluation of economic loss becomes more difficult. First, consider medical treatment. Will the claimant receive the finest medical treatment available, or treatment that is cost-effective and not quite state-of-the-art?

If the patient requires around-the-clock-care, will the patient be provided with private nurses in his home, day and night, or will care in a state-run hospital suffice? If the patient requires some extra care, but not around-the-clock nursing, can one expect that family members will provide the extra care at little cost, or must someone be hired (perhaps all day, every day) to assist in the care? If a family member provides care, will there be compensation for the wage loss of the family member? If the claimant is unable to walk, what kinds of additional help will be provided — a special car every few years, wheelchairs, changes to the claimant's home to accommodate a disabled person? The Virginia Birth-Related Neurological Injury Compensation Program, in its initial years of operation, provided each claimant with a specially-designed new home to accommodate the injury — a high cost way of dealing with the need for modifications to permit mobility.

If the person is disabled for a long time, or permanently, the question arises as to how long the medical care will continue. If the injured person is disabled, should one use a disabled lives table to determine life expectancy, or should a normal life expectancy be assumed? As an extreme example, a very injured infant may have a life expectancy of only a few years, but could live to be more than 70 years of age in the absence of the injury.

There is also the question of what inflation rate to assume on future medical costs. If payments are expected for many years, whether an inflation rate of 3%, 4%, or 5% is chosen (or something else) can make a substantial difference. If costs are to be net of collateral source offsets, one must also consider future collateral sources, and whether they will increase at the same rate as future medical costs. A person must also consider whether future costs should be discounted, and, if so, what interest rate should be used.

Wage loss becomes an issue on long duration claims as well. If the person was not in the workforce at the time of the injury, can one assume that in the absence of the injury, the person would have gotten a job? If so, what type of job, and at what wage? This issue applies especially to injured infants, since one would expect that the in the absence of the injury, the infant eventually would become employable. Wage loss also has the same issues of inflation and discounting as medical costs.

All of these issues make economic loss difficult to evaluate. In a typical suit, each side will present its own life-care plan for the plaintiff, and the expected future costs presented are likely to be quite different. If state caps on non-economic loss are enacted, proving

economic damages becomes more important. Because of this, plaintiff's attorneys may apply more attention and creativity after caps become effective. Such changes may cause savings from the caps to be less than would be predicted based on the relationship between pre-reform loss payments and pre-reform economic losses.

3.3 Pitfall #3: Expecting Too Much of Closed Claim Data

Public databases, such as the National Practitioner Data Bank ("NPDB") and the Florida malpractice closed claim database, collect data from a variety of payers of malpractice claims: insurance companies, reinsurers, hospital self-insurance trusts, state joint underwriting associations, state excess funds, bankrupt insurers in runoff, and even individual physicians who do not purchase insurance. Trying to get everyone to report on a consistent basis is difficult, at best. For example, the NPDB summarizes claims by the year a closed claim report is received. The data at times appears quite "lumpy". Looking at the data, a person suspects that some organization has not been sending in reports, then sends in several years of back reports at one time. This kind of batching of claims can distort year- to-year comparisons and comparisons among states, especially if done on a single year basis. Averaging over a number of years tends to reduce this problem.

Economic and non-economic loss data collected through closed claim data has particular problems. One of the issues is the complexity of the calculation. If a claim has been settled prior to trial (and most are), there may not be enough information in the claim file to do a complete calculation of economic loss. Furthermore, as we saw in Pitfall #2, a person can get a very wide range of answers when calculating economic loss, depending on the assumptions used. If the completion of the closed claim form is assigned to a clerk, there is a significant possibility that shortcuts will be taken in completing the economic loss data. One of the more likely shortcuts is to include only past economic loss, and not try to estimate future economic loss. Another is to record a $0 or leave the field blank whenever the correct economic loss amount is difficult to determine. If either of these actions is taken, the amount of economic loss will be understated in the closed claim report.

Besides not having proper information to prepare economic cost estimates on claim settlements, there is also the issue that settlements reflect a variety of factors, besides the economic loss of the plaintiff. If the plaintiff has only a weak case, the settlement is likely to

be lower than if liability is clear. It is not clear how one should apportion economic and non-economic loss, if liability issues are affecting the amount of the settlement.

When economic loss is collected on claims, one might think that the sum of the economic loss and non-economic loss recorded on a single claim (where there is only one payer) would add to the total amount of the claim. For the Florida closed claim data, this relationship rarely seems to hold (Exhibit 1). When we looked at the "current" Florida database, 1,304 out of 4,962 claims with indemnity payment showed neither economic nor non-economic loss, suggesting that no coding of economic or non-economic loss had been done. Another 1,774 out of the 4,962 claims showed some non-economic loss, but no economic loss. It would seem hard to believe that economic loss is absolutely $0 on these claims, since the average indemnity cost of these claims is $228,482, and most claimants have at least some economic loss. Of the 4,962 claims, 325 showed only economic loss. The economic loss on these claims amounted 1.85 times the claim amount. Only 1,255 out of the 4,972 claims showed both economic and non-economic losses. If an actuary uses this data to try to estimate the impact of caps on damages, he should be aware of its limitations. One approach might be to calculate a range of indications, with some of the indications excluding claims for which no economic loss is coded.

Very often, there are a number of different insurers or other entities making payments with respect to a single medical injury. This might happen when there are multiple defendants, such as a hospital and a number of physicians. It may also happen if there are layers covered by different organizations — for example, a self-insured hospital layer at the bottom, with a layer covered by insurance in the middle, and an excess insurer or an excess state fund on the top. In order to get a proper matching of indemnity with economic and non-economic loss, a person needs to be able to add together all the indemnity payments from various sources relating to a single medical injury and compare this amount to a single estimate of the economic loss. This is necessary since the plaintiff has only one economic injury, regardless of the number of organizations making payment of the claim. Getting everything matched together properly is tricky, and it is not clear that closed claim analyses can get all the pieces matched together properly.

There can also be medical injuries with more than one claimant. Such medical injuries would typically involve a mother and infant. Matching these, as well as the multiple defendants and multiple insurers, adds a further level of complexity to closed claim data.

3.4 Pitfall #4: Misunderstanding the Phase-In Implications of the Reform

Reforms are likely to be effective on one of three bases:

1. Court awards after a certain date
2. Suits filed after a certain date
3. Claims arising from medical injuries after a certain date

The actuary needs to consider how the proposed effective date will co-ordinate with the type of malpractice coverage sold. If a reform is effective on claims arising from medical injuries after a certain date, this is equivalent to the reform being effective on an accident year basis. If the malpractice coverage is sold on a claims-made basis, the effect of such a reform will take several years to phase in, since the first year it will affect only claims with the accident year equal to the report year. Each year, a larger proportion of claims will be affected by the reform.

When a reform is effective with suits filed after a certain date, theoretically such a reform would match up fairly well with claims-made coverage, especially for an insurer that does not consider a claim to be reported until a suit is filed. The issue that one quite often encounters, however, is that lawyers have some discretion over when a suit is filed. Prior to the effective date of the reform, there may be a rush to file as many suits as possible. After the effective date of the reform, there may be relatively few suits filed for a while, since the "pipeline" has been emptied.

After a reform has been in effect for a while, it is possible that impact of the reform will change. This change could be in either direction. If the reform is one that trial lawyers can partially circumvent, it is possible that the reform will reduce in effectiveness over time. In the case of caps on non-economic loss, it sometimes appears that the reform reduces the annual trend increase in losses, and thus in some sense the reform tends to increase in effectiveness over time.

The constitutionality of many reforms is challenged in the courts. Until the constitutionality is upheld, a reform may not be fully effective. This seems to be the case with the set of reforms enacted in California (Medical Injury Compensation Reform Act or "MICRA") in 1975, but not upheld in the courts until 1985.

There have also been a number of instances where reforms were enacted (Texas, Illinois, Ohio, and Oregon, for example), and were at least partially effective. The reforms were later found to be unconstitutional, and malpractice costs in the state increased significantly after the constitutionality test.

3.5 Pitfall #5: Missing Indirect Impacts

Most reforms apply only to court awards, not to settlements. Clearly, if a reform results in lower awards, there will be at least some indirect impact on settlements. For example, if a state reduces the pre-judgment interest rate from 12% per year simple interest to 5% per year simple interest from the date a suit is filed to the date of the award, and average lag between suit and award is 4 years, the amount of prejudgment interest will be reduced from 48% of the award (on average) to 20% of the award (on average). The claims adjustor will consider the amount of the likely award (among other things), when making a settlement, so a change in award plus interest is likely to have an impact on settlements. It is not clear, however, that the percentage impact on settlements will be the same as on awards, since there are other factors affecting settlements. There may also be some other indirect impacts, such as a change in the willingness of the insurer to settle.

Other indirect impacts are less clear. For example, if a reform makes it much quicker and easier to pursue a claim, there are likely to be more people willing to pursue malpractice claims. For this reason, total malpractice costs may increase, even if the cost per claim is lower. Mandatory mediation is sometimes considered to have the potential to increase costs, because it makes settlements quicker and easier.

Changes to the compensation of lawyer through caps on contingency fees will increase the proportion of the award a plaintiff receives. It will also reduce the amount of payment the lawyer receives, and make him less willing to take on suits for which his compensation is likely to be too low. This may make the attorney less willing to take on suits for small dollar amounts, or suits where liability is unclear.

If a state establishes a state fund, and requires that health care providers purchase $250,000 limits from private insurers, private insurers may behave differently if they are providing $250,000 limits of coverage than if they are providing $1,000,000 limits (or more) of coverage. With low limits, the insurer may be less willing to defend the claim, and more willing to settle, since taking a suit to trial is likely to incur substantial attorney fees, and not save a large amount of indemnity payment.

3.6 Pitfall #6: Expecting a State Fund to Behave Like a Private Insurance Company

Quite often, states create state-operated excess funds to provide coverage in excess of some required primary limit. Florida and Virginia have also established state-sponsored birth injury funds. On paper, these funds look much like private insurers, but in practice they often behave quite differently. Some of the differences include:

- Adequacy of Funding. Some state funds are pay-as-you-go by design. Others are intended to be fully funded, but may not be as fully funded as an insurance company, because of the pressures to keep rates low, and because of the uncertainties of funding for excess limits.

- Expenses and other costs. Expenses of state funds may be significantly lower than for an insurer, particularly if there is no commission expense. Also, state funds generally do not pay federal income tax. Funds may not to have the equivalent of shareholders' equity, and even if they do, are not likely to be concerned about making an adequate return on equity.

- Willingness to settle. Without a profit motive, some state funds may be more willing to settle than a private insurer would be. The willingness to settle may also be related to a desire to help the injured person.

- Background of employees. If wages are constrained by state budgets, the employees may be less experienced than their counterparts at private insurers.

3.7 Pitfall #7: Missing Additional Expense Resulting from the Reform

There are several types of reforms that are likely to results in extra cost because of additional administrative expense and other factors. It is possible the same reforms will result in some savings as well, but the actuary will want to consider both when estimating the net savings or costs. Some reforms that are likely to result in addition expense are the following:

- Pre-Trial Hearing Panels. In many cases, the insurance company will need to present its case twice: First to the pre-trial hearing panel, and second at the trial itself. Thus, there may be additional legal expense because of the additional work involved. If there are no incentives built into the program to hear cases quickly, the pre-trial hearing panels may significantly delay the regular trial. If the jury trials are delayed, there could be other additional costs as well—higher indemnity costs because of the delay, and possibly issues of witnesses no longer being available, because of the delay.

- Patient Compensation Funds (PCFs). PCFs are state-operated funds that provide excess coverage over required underlying insurance, purchased in the regular marketplace. Typically, the required underlying coverage is in the $200,000 to $1,000,000 range. One issue that arises is the additional administrative cost of the PCF. In the absence of the PCF, the underlying insurer would write higher limits, so that only one insurer would be needed. In these cases, having the PCF means there will be an additional set of expenses arises because both entities will have their own administration and claim-related costs, even if they are not entirely duplicative In addition, these entities will need to prepare their own financial statements, and will need to made their own investment decisions.

- Higher policy limits. Any change that causes physicians to purchase higher policy limits is likely to result in higher costs. For example, a cap on total damages that is higher than

physicians the policy limits physicians traditionally purchase can result in physicians purchasing higher limits, either by choice, or as a result of a requirement of a hospital in which the physician practices. Higher policy limits mean higher costs for two reasons:

— Because of the increased limits factor differential an actuary would expect.

— Because of a change in the economics of the situation. If policy limits are raised for a significant share of insureds, the change in policy limit may change the claim environment as to what is an appropriate settlement or award, and may result in higher payments to claimants for the same injury. This impact is the reverse of the capping effect of policy limits that sometimes occurs if policy limits remain at a relatively low level, in comparison to awards.

- Added features to make the program more balanced. Very often, if a reform gives some benefit to insurers, there will be other provisions added to make the bill more balanced. For example, malpractice insurers may be required to submit data for a closed claim study, or malpractice insurers may be required to obtain prior approval for any rate increase. In one proposal, malpractice insurers were required to notify insureds of any potential rate increase, and to have a hearing and approval before any rate increase could be implemented. These changes could make it difficult to collect adequate premium for the coverage sold.

3.8 Pitfall #8: Forgetting the Difference between Anticipated Indemnity Savings and Expected Change to Current Rates

An actuary will want to look specifically at what types of changes are expected: indemnity, legal expense, or both. For many types of reforms, including caps on non-economic loss, requirements for periodic payments, and changes in pre-judgment interest, the change will be predominantly affect indemnity costs.

The actuary will want to consider how the change to indemnity costs can be expected to affect overall costs. Suppose indemnity costs before a tort reform are $100, and are expected to be $90 after the tort reform. Suppose legal costs are $30, both before and after the

reform, and suppose other costs are $20, both before and after the reform. Total costs are then $150 before the reform, and decrease to $140 after the reform. The percentage savings are then $10 / $150 or 6.7%, rather than the 10% some non-actuaries might expect.

A related issue is the adequacy of the current rates. If rates are quite inadequate, prior to the tort reform, the tort reform may bring the rates closer to an adequate level. The actuary will want to consider the impact of the tort reform in determining the appropriate rate change. In some cases, a rate increase may still be needed, even with the reform. This idea is easy for an actuary to see, but may not be as obvious to legislators.

3.9 Pitfall #9: Failing to Consider Differing Impacts by Policy Limit and by Direct Insurer vs. Reinsurer

A wide range of medical providers purchase professional liability insurance. Besides physicians and surgeons, dentists, chiropractors, nurses, optometrists, physical therapists, and many other health care workers purchase malpractice coverage. Many types of institutions including hospitals, nursing homes, assisted living centers, clinics, and surgical centers also purchase malpractice coverage. Each of these types of providers has a different mix of claims, with the average size of claim varying with the type of provider. For example, dentists and physical therapists typically have quite small claims, while physicians and hospitals have larger claims.

Policy limits also vary greatly. In a few states, policy limits as low as $200,000 to $500,000 per claim are common for physicians. In other states, $1,000,000 limits are common for physicians. Hospitals, nursing homes groups, and others that have significant assets to protect very often have much higher policy limits, as much as $20,000,000 or more per claim.

When legislators enact a package of reforms that is expected to have a significant impact, such as a cap on non-economic loss, legislators may consider requiring insurers to reduce malpractice rates by a selected percentage, such as 10% or 20%, to reflect the expected cost savings of the reforms. Because of the diversity in types of malpractice coverage sold and policy limits, insurers are likely to be impacted differently by a proposed cap, so this flat percentage reduction is not very equitable. For example, a $500,000 cap on non-economic loss is likely to provide much more benefit to a hospital with a $20,000,000 policy limit than

to a physician with a $200,000 policy limit, since the low policy limit already provides some capping effect on claims.

A related issue is the impact of reinsurance. An insurer that writes coverage on a direct basis will be the one affected by a mandatory rate reduction. A reinsurer is free to charge whatever rate it chooses. In the case of caps on non-economic damages and other reforms affecting large claims, the most significant benefit will be with respect to layers which are typically reinsured. Therefore, a rate rollback, even if theoretically correct in total for a direct insurer and its reinsurer, may result in too little money for the direct writer of the coverage if the reinsurer is not willing to reduce its rates.

3.10 Pitfall #10. Special Considerations for One Line / One State Insurers and Self-Insurers

When a state passes tort reform legislation, the exact amount of the benefit is not clear in advance. There is also often a question of whether the reform will be upheld in the courts, as mentioned in Pitfall #4. If a reform is found to be unconstitutional several years after it is passed, an insurer may find it may have to pay more indemnity than planned on several past coverage years. The insurer cannot retroactively raise rates, and will need to cover any losses from such a change with its surplus.

A number of medical malpractice insurers are provider-owned insurers, writing coverage primarily (or entirely) in one state. The question arises: How optimistic should these insurers be in reflecting the expected benefit of the tort reform changes in their rates? These companies typically pay dividends to their policyholders, so have the option of returning extra premium later, if it is not needed. Since the company is provider-owned, any overcharge will remain in the company, and will be owned by the physicians (or others) who paid a higher-than-necessary premium. These companies were formed by physicians (or other providers), for the purpose of providing coverage to their members, because other coverage was not readily available. Continuing to provide a market for malpractice insurance is thus one of the primary purposes of these companies. If the company should overestimate the impact of the reforms, or have the reforms overturned in the courts, it could find itself in serious financial difficulty, since it cannot spread its risk to other lines or other states.

Given these consideration, one-line, mostly one-state companies often choose to be cautious in recognizing the benefit of tort reform. Because of competition, these insurers cannot ignore the impact of tort reform. But given the serious difficulties that could result if the rates are set too low, and the possibility of returning funds later through dividends, taking a cautious approach may seem best. Otherwise, these companies may find themselves in financial difficulty and because of this, cease to provide the malpractice market for which they were established. The physician-owners would not find this an acceptable outcome.

4. CONCLUSIONS

Because the many potential pitfalls in evaluating tort reforms, the actuary will want to evaluate any proposed reform carefully, and consider the many issues involved. Actuaries who evaluate the expected costs impact of proposed malpractice tort reforms should be aware of the issues underlying all ten pitfalls. Some of these issues may also be relevant to pricing reforms for other lines of insurance.

Of the various pitfalls discussed, probably the most important from the point of view of the non-actuary is the difference between expected indemnity savings with the expected change to current rates (Pitfall #8). If the legislature of a state enacts a reform that is expected to result in a 10% reduction in indemnity, it is easy for a legislator to jump to the conclusion that rates should be reduced by 10%. The actuary needs to be careful to explain the various issues involved, including the importance of the adequacy of current rate level, and the need to adjust for other components of rate level.

In this paper, I have discussed only pitfalls closely related to actuarial analyses of tort reforms. There are closely related areas, each with their own pitfalls. For example, there are a number of studies relating to the frequency of iatrogenic (caused by medical practice) injuries and iatrogenic injuries caused by medical negligence. Looking at the pitfalls of these studies is outside the scope of this paper.

5. REFERENCES

[i] 1987 Casualty Loss Reserve Seminar, Session 1D, Tort Reform, 104-137.

[ii] 1989 Casualty Loss Reserve Seminar, Session 2E, Tort Reform, 299-339.

[iii] Kerin, Allan and Jason Israel, "The Analysis of the Effect of Tort Reform Legislation on Expected Liability Insurance Losses," Casualty Actuarial Forum, Including the Ratemaking Call Papers, Winter 1998, 153-192.

Abbreviations and notations
PCF, patient compensation fund

Biography of the Author

Gail Tverberg is a consulting actuary for the Tillinghast business of Towers Perrin. She is a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries. She has a B.A. in mathematics from St. Olaf College in Northfield, Minnesota, and an M.S. in mathematics from the University of Illinois. Ms. Tverberg's primary area of expertise is medical malpractice. She is located in Atlanta, Georgia.

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