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SENATE COMMERCE & LABOR
March 11, 2003
S.B. 122

TESTIMONY OF PHYSICIANS INSURANCE COMPANY OF WISCONSIN

We wish to express our appreciation to Chairman Townsend and members of the Senate Commerce and Labor Committee for the opportunity to testify this morning. My name is Bill Montei, and I am the President and CEO of PIC Wisconsin. I have been with PIC Wisconsin since its formation in 1986 and have been involved in medical professional liability insurance in various capacities since 1978. With me is Kerry Kravik, our Assistant Vice President of our Classic Insurance strategic business unit.

PIC Wisconsin is a privately-held, physician-owned and governed medical malpractice company, located in Madison, Wisconsin. We were formed by Wisconsin physicians as a result of the crises of the mid-eighties to assure the availability of medical malpractice insurance at the most reasonable cost possible. That remains our mission today. We currently write approximately $68 million in gross written premium, and have approximately $65 million in statutory surplus. In 2002, we wrote 318 physicians and 295 dentists in Nevada for a total of $5.8 million in claims made premium. Even as a fairly small company in the industry, our financial profile is one of the strongest in the industry. We are rated A- (excellent) by A.M. Best.

In our home state of Wisconsin, we have had reasonable tort reform since 1995, which has passed constitutional muster. We also have a patients' compensation fund that covers all claims above $1 million (the fund is currently 'solvent'), and a state-mandated primary insurer that must insure all applicants. Wisconsin, according to most experts, is considered a "white" state, that is, it is considered a very stable medical malpractice insurance environment. Competition operates freely, the market is healthy, and insurers have a stable litigation environment in which to protect healthcare providers. We view Wisconsin alongside California as venues where the right mix of tort reform, regulatory governance and healthy market competition serves healthcare providers in the best possible manner. Wisconsin, like Nevada, has a very strong but fair regulatory climate, but did not see the need for any insurance reform legislation.

We are particularly sensitive to the regulatory and legal environments outside of Wisconsin. We have extensive experience in some of the worst venues in the country, and are very careful to avoid participating in those environments. We simply do not have the surplus, nor is it in the best interest of our 8,937 insured physicians and dentists, to assume excessive risks created by regulatory or judicial sanction. As a company that always stands by our policyholders, we believe the first priority in that duty is to assure the financial health of the company.

It is for that reason that we are here to testify today, and that we speak in opposition to Senate Bill No. 122. We believe very strongly that the Commissioners office has done an excellent job of balancing the interests and needs of all the Nevada constituencies under very difficult circumstances, and that that regulatory stability has enabled the market to appropriately absorb the void left by St Paul. While rates have increased dramatically in the last twelve to fifteen months, it is our belief that the combination of the recent tort reforms and rate adequacy should

result in rate stability over time. We view Nevada similarly to Wisconsin from the mid-eighties to the mid-nineties, when rates rose dramatically and the marketplace was tumultuous.

Our comments related to specific elements of the proposed legislation are attached, but our position can be expressed generally in the following points:

- Any attempt to further statutorily limit the ability of insurers to charge adequate rates to cover their loss costs and provide a reasonable profit will result in fewer insurers willing to provide a market in Nevada with the likelihood that those who remain will be less stable and therefore less desirable to the physician community.
- As a physician-owned and governed insurer, PIC Wisconsin prices it products and manages its business as advocates for the physicians and health care providers we insure. Allegations that we would do otherwise are simply not true.
- Similarly, inferences that the crises in Nevada and elsewhere have been caused by irresponsible investments is unfounded and unsupported by any credible data.

PIC Wisconsin is proud of our record as advocates for the healthcare providers who put their trust in us. We view many of the provisions of Senate Bill No. 122 as being detrimental to a robust, competitive marketplace for professional liability insurance and would urge great caution before adopting it in its entirety. We would welcome the opportunity to answer any questions or to participate in the process that will produce legislation coming from the Committee. We would also be pleased to make available any data or information that would be helpful in the Committee's deliberations.

Discussion of Specific Elements of Senate Bill No. 122

1. <u>Section 1</u>: The amendment to Section 1 allows "any interested person or entity to intervene as a matter of right in any hearing or other proceeding." We are unclear on what powers are conveyed by the term "intervene" but we could not support an intent by this amendment to delay or have disallowed an otherwise appropriate rate increase. At PIC Wisconsin, the development of our rates is predicated on data and judgments that include actuarially determined projected loss costs as well as reasonable provisions for both expenses and profit. Any intervention, other than the regular and necessary approval process of the Commissioner's office could harm our financial stability that is ultimately not in the best interest of our insureds.

2. <u>Section 4, Par. 3(a)</u>: This amendment to Section 4 provides that the Commissioner *shall* disapprove the proposal (rate increase) if the premise of the proposal is due to certain factors (emphasis added). The first instance is when an insurer "has experienced or is reasonably likely to experience losses...as a result of the imprudent investment of money." All states have guidelines that insurers must follow for the investment of assets, which protects policyholders from specific investments or concentrations of investments. Further, there is no industry standard or common understanding of what is considered "imprudent". Given the lack of evidence in today's market that rate increases are due to imprudent investments, this provision seems an unnecessary addition to an aspect of insurance where regulation already exists.

3. <u>Section 4, Par. 3(b)</u>: This subsection denies a rate increase for certain acts of an insurance company, or any director, partner, officer, employee, agent or contractor. This seems overly broad. If a company is in good standing in the marketplace, acts of its employees or agents shouldn't be a part of the ratemaking process. It seems to us that if those acts are detrimental to Nevada policyholders that there are other more effective avenues of recourse against the insurance company.

4. <u>Section 4, Par. 3(c)</u>: This subsection requires the disapproval of a proposed rate increase if the insurer has experienced or is reasonably likely to experience losses as a result of the insurer engaging in litigation "unreasonably or vexatiously after one or more opposing parties have made a reasonable offer of settlement."

   This amendment has a number of troublesome components. First and foremost, the question of whether engaging in litigation was unreasonable or vexatious seems to us a legal question, not a regulatory issue. The provision seems to penalize through the ratemaking process determinations that are currently dealt with through the judicial process of bad faith litigation.

   The second problem with this amendment is that it *requires* the disapproval of the proposed rate increase if the Commissioner determines that the pursuit of any claim was unreasonable or vexatious, regardless of whether any such losses are a material component of the rate increase. If this amendment becomes of the final legislation, we

would hope at a minimum that the Commissioner would have some flexibility in its application.

Finally, the wording of the amendment implies that it may be unreasonable to pursue litigation in the face of a settlement offer, which is not always the case. The question is "what is the reasonable pursuit of litigation?" We feel strongly that if an insurer believes that the physician-defendant did not breach the standard of care, the insurer and the insured physician should have the right to defend the claim regardless of whether the plaintiff attorney believes a reasonable offer has been made.

5. Section 10: This section discusses the offering of tail insurance. We would support legislation that governs the issuance of a tail policy, or an extended reporting endorsement. We would also support guidelines for disclosing to the insured the expected cost of the extended reporting endorsement, as well as the formation of guidelines by the Commissioner regarding circumstances in which the tail charge might be limited.

6. Section 12.1: This section provides that terms within an agreement to settle a claim are not confidential. While we support efforts to collect data for data evaluation and general risk management efforts, the effect of this amendment will likely be to discourage settlements.

7. Section 13: This section discusses protocols for exiting a market based on a percentage market share within a specialty. We don't really have much objection to this section, but it may not resolve the problem it is intended to fix. Our understanding is that a withdrawal already requires 120 day notice to the Commissioner and also must be conducted in an orderly fashion with appropriate notifications to the insureds based on the renewal dates of their policies. The issue appears to be how to handle the perceived abandonment of a medical specialty, like obstetrics-gynecology, which could result from an insurers exit from Nevada. Certainly, the tail provisions of Section 10 will help this, but more importantly, a robust and competitive marketplace for medical malpractice insurers is the most effective long-term solution.

8. Section 14: This section establishes the right of a defendant policyholder to obtain independent counsel at the expense of the insurer whenever the defendant receives a settlement demand that is equal to the limits of the insurance policy of the defendant. This provision is particularly difficult for us, in that it brings the specter of bad faith into the defense process before bad faith could even exist. For PIC Wisconsin, the development of defense strategies is a collaborative process with the defense counsel, the insured physician and the company. Introducing an independent counsel at an inappropriate time places a burden on the defense strategy process that is not in the physician's best interest. The vast majority of physicians in the vast majority of cases want to defend a case if there is no merit. Bad faith issues always influence decisions in ways that are detrimental to the defense of any claim. We believe, since we close almost 90% of all claims without indemnity payments and win between 75 and 85% of cases we

take to trial, that bad faith is rarely if ever present because of our defense strategy process. Specifically, we believe the provision does the following:

- Increases the cost of defense dramatically
- Forces insurers to pay for potential merit less legal action against itself
- Increases premiums by forcing settlements in situations that otherwise would not call for settlement
- Establishes a barrier between the insurer and the insured when in fact their interests are very much aligned

The underlying purpose of this provision appears to be to pressure insurers to make settlements they otherwise wouldn't make, which is not in the best interest of the policyholder. Besides, common law in Nevada and other states already provides for bad faith actions when appropriate; the imposition of this amendment between the insurer and the insured will do more harm than good.

Finally, we believe that this provision will be a serious disincentive for insurers to participate in the professional liability market in Nevada.

9. Section 15: This section essentially requires a rate rollback of 25% of premiums upon rates effective July 1, 2002. We find this provision particularly onerous for the following reasons:
   - It falsely presumes that rates already approved by the commissioner are excessive.
   - Should the assumptions regarding current tort reform inherent in this section prove false, the surplus of companies who remain in the market would be harmed. Those who are smaller, like Nevada Mutual Insurance Company and to some extent PIC Wisconsin, would be harmed more than others. We suspect that the new mutual insurer would be irreparably harmed by this provision.
   - The message from this provision will likely resonate throughout the industry, making Nevada an unattractive market for medical malpractice insurers to participate.