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ANALYSIS OF MILLIMAN'S 2004 REPORT, "EFFECTS OF A CAP ON NON-ECONOMIC DAMAGES ON NEW YORK PHYSICIAN AND HOSPITAL MALPRACTICE RATES"

In early 2011, one of the proposals voted out of the Medicaid Redesign Team and placed in the Governor's Budget[1] and Appropriations bill,[2] was a $250,000 non-economic damages "cap" on compensation to victims of medical negligence. According to the limited public information available about this proposal, the MRT justified this cap's economic benefits as follows: "In 2004, Milliman estimated that a $250,000 cap would reduce hospital and physician premiums Statewide by 24%, which translates to a $384m savings for hospitals." Milliman is an insurance consulting firm and retained as consulting actuary for the Medical Liability Mutual Insurance Company (MLMIC).[3]

The cap was ultimately removed from the final 2011 New York State budget, as enacted. According to the Governor,[4] "There was disagreement on the net effect of the cap."

The Milliman report, on which the MRT relied to score this 24% "savings," was not publicly available at the time. However, the report has now been made available through media sources, providing an opportunity to analyze it.

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[1] Page 89 of the Budget said: (b) noneconomic damages suffered by the injured plaintiff, not to exceed two hundred fifty thousand dollars, provided, however, that such limitation shall be adjusted in accordance with the Consumer Price Index for all Urban Consumers (CPI-U), as published annually by the United States Department of Labor, Bureau of Labor Statistics.

[2] Page 47 of the Appropriation bill said: Provided, notwithstanding any other law or rule to the contrary, that in order to make expenditures from these appropriations and achieve savings necessary to meet the department of health state funds Medicaid expenditure cap as referenced above, a court shall issue an order in every medical, dental or podiatric malpractice action commenced during state fiscal year 2011-12 and state fiscal year 2012-13 pending before it, on its own motion or on the motion of any defendant in such action liable for damages arising from pain and suffering, loss of services, loss of consortium, or other non-pecuniary damages suffered by an injured plaintiff, limiting the recovery of such damages from every defendant liable for malpractice in such action, to no more than $250,000, provided that such sum may be adjusted in accordance with Consumer Price Index for all Consumers, as published annually by the United States Department of Labor, Bureau of Labor Statistics, and further provided there shall be established the New York State Medical Indemnity Fund, to provide a funding source for certain costs associated with birth related neurological injuries pursuant to a chapter of the laws of 2011 enacted as legislation submitted by the governor, which fund shall be contingent upon the enactment of a $250,000 cap on non economic damages pursuant to this appropriation or pursuant to such chapter.

[3] See, "Professional Services" section of the MLMIC 2010 Annual Report.

[4] http://polhudson.lohudblogs.com/2011/03/27/no-medical-malpractice-cap-in-budget/

OVERVIEW OF THE MILLIMAN REPORT

This report, "Effects of a Cap on Non-economic Damages on New York Physician and Hospital Malpractice Rates," ("Milliman report") was published on March 11, 2004 on behalf of what it describes as a "Tort Reform Coalition," of which MLMIC is a member. Milliman called the report a "confidential draft – for discussion purposes only." In this draft, Milliman says it developed an "actuarial model" to estimate the effect of a $250,000 cap on "losses and loss adjustment expenses." Based on its model, Milliman said that a $250,000 cap would yield a 24% reduction in the combined losses and LAE for hospitals and physicians for policies written in 2004. It relied on data provided by MLMIC, FOJP Service Corporation and the Combined Coordination Council (CCC), all members of the Tort Reform Coalition.

ELEMENTS OF AN ACTUARIAL REPORT

In order for an actuarial report to be truly complete, it must contain certain elements, including:

- The data used should not only be fully described but also fully displayed in the report so other actuaries can verify the data quality and understand how the data were used. ("In an actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report." American Academy of Actuaries Actuarial Standards of Practice "ASOP" at ASOP 41; Section 3.2)

- Each adjustment to the data must be shown, including the justification for each adjustment. (ASPO 23; Section 3.8) Data relied upon for making adjustments like developing losses to ultimate settlement value, should be also displayed.

- The credibility of the data (i.e., how believable the data are) should be calculated and discussed.

- If data has material limitations, the actuary must disclose those limitations. (ASOP 23; Section 3.1)

- The report should contain the actuary's review of the data for reasonableness and consistency. (ASOP 23; section 3.5)

- Any potential bias in the data should be disclosed. (ASOP 23; Section 3.7 and 4.1)

- Any limitations on the actuarial work due to uncertainty of the data quality or any concerns at all about the data should be disclosed and discussed. (ASOP 23; Section 4.1)

- Any mathematical work undertaken using the data should be part of the work so other actuaries can check the validity and reasonableness of the work.

- Any models used in drawing conclusions should be fully described, including each assumption used in running the model.

- Output from any models should be part of the report, including any statistical measures made by the model.

- "The actuary should complete an actuarial report if the actuary intends the actuarial findings to be relied upon by any intender user." (ASOP 41; Section 3.2; emphasis added)

- "If the actuary believes circumstances are such that including certain content is not necessary or appropriate, the actuary must be prepared to identify such circumstances and justify limiting the content of the actuarial report. (ASOP 41; Section 3.3)

- "An actuary who is not financially, organizationally, or otherwise independent concerning any matter related to the subject of an actuarial communication should disclose any pertinent information that is not apparent. This includes any situation where an actuary acts, or may appear to be acting, as an advocate." (ASOP 41; Section 3.4.3)

THE MILLIMAN REPORT OF MARCH 11, 2004 FAILS TO MEET THESE GENERAL ELEMENTS OF AN ACTUARIAL REPORT

The Milliman Report is a deeply flawed actuarial report. Here are some of the reasons why:

- No data or analysis is contained in the report. Nor is there any justification for the absence of real data within the report. The report says there are results from the model shown on Exhibit 1. Exhibit 1 was not attached to the publicly available version of the report and the document itself indicates an intent to limit distribution, to wit: "The Tort Reform Coalition has expressed its intention to distribute this report and, in particular, to distribute the Observations/Conclusions section of the report to interested third parties. Milliman agrees to such distribution…"

- The "actuarial model" used is not described adequately nor are the assumptions used in running the model complete and understandable.

- The data used in running the model were not contained in the report. Adjustments made to the data were not disclosed nor shown at all, much less in sufficient detail to test. No analysis of the credibility of the data is contained in the report. No discussion of data limitations or potential bias is contained in the report. The likelihood of bias is a significant risk in this situation, given the fact that the data are supplied by members of the "Tort Reform Coalition" who have a stake in the results of the analysis. This is not discussed in the report.

- The mathematics employed in doing this analysis, including by the actuarial model, are not shown in the report.

- The actuarial calculations, the model outputs and other work done to produce the report are missing from the report.

- No independent actuary qualified to analyze the report's findings could possibly test the conclusions of the report.

- Milliman has a financial interest in the outcome of the report's work as "Milliman, Inc. is retained as consulting actuary" for Medical Liability Mutual Insurance Company (MLMIC), as revealed in the "Professional Services" section of the MLMIC 2010 Annual Report. MLMIC is a primary member of the Tort Reform Coalition. The report does not disclose this conflict of interest.[5]

SPECIFIC PROBLEMS WITH THE REPORT BEYOND THE GENERAL ELEMENTS

Besides the general problems listed above, which make the report of no value in understanding the medical malpractice situation in New York, we found a number of specific issues with the report.

The data are too old to be relevant in 2011. The report was done in early 2004, at the height of the hard market. The data are likely much older than that, since these seem to be mostly paid claim data. A lot has changed since the 2000-2004 era. (For example, MLMIC released over three-quarters of a billion dollars from reserves to profit; rates have been flat to down. Any alleged crisis in 2004 to 2007 has melted away.)[6]

We do not even know the years of data used, the size of the sample, whether the data are adjusted and how, the accounting method followed for the data (calendar year, accident year or policy year?) or whether just paid claims or incurred claims (including reserves) were used. One thing we do know was that the data were provided by parties with a stake in the outcome so the potential for bias in the selected data is great.

The report concludes that results of imposing a cap on medical malpractice non-economic damages will be significant but shows no results from caps imposed on patients who suffered

[5] Technically, according to the Casualty Actuarial Society's "Code of Professional Conduct," at Precept 7, "Conflict of Interest," the actuary only need tell the principals (here the Tort Reform Coalition) of any conflict as long as the document is not sent to others for their reliance. But Milliman knew that the Tort Reform Coalition was going to provide the "Observation/Conclusions section of the report to interested third parties." We received the report from one of those third parties – a news organization - and we believe that the conflict had to be disclosed at the point of its use in such advocacy outside the TRC walls. How can the media and state legislators be allowed to see these conclusions without being warned of the clear conflict of interest Milliman had?

[6] See, Testimony of J. Robert Hunter, Before the New York State Department of Health Medicaid Redesign Team: Medical Malpractice Reform Working Group, OCTOBER 27, 2011, found at http://www.consumerfed.org/pdfs/Testimony%20NY%20MM.pdf

harm in other states. There is no mention of research that concludes caps do not result in significant savings to doctors and hospitals.[7]

The assumptions that Milliman used that are disclosed are questionable.

- One key assumption is that a cap would apply "per person" injured rather than "per wrongdoer". So, if a $250,000 cap was adopted, Milliman assumed that that is all a victim would get, even in a case where the harm came from several sources, say a hospital and two doctors. This extremely harsh type of cap is *not* how the cap was proposed in the Governor's Budget, which proposed "limiting the recovery of such damages from every defendant liable for malpractice in such action, to no more than $250,000."

- Milliman also assumed that hospitals would pay unlimited losses, "amounts in excess of insurance limits from operating funds." Then they applied that "savings" in a way as if those were savings in insurance prices. It is plain wrong to calculate savings in insurance based on lower out-of-pocket payouts made by insureds over their insurance limits!

- The report assumes the claims they used as a sample "accurately reflected" statewide experience" although the three samples they selected showed "significant differences." How they 'judgmentally selected averages" is unexplained.

- An "important assumption" Milliman made was that the cap would have the "same proportional effect on settlements as it does on verdicts." No explanation of that choice is made other than that Milliman assumes "it follows." There was no examination of data from other states with damage caps. But more importantly, it is common knowledge that in New York State, settlements are never related to verdicts. Settlements are related to what the Appellate Division has allowed to stand.

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[7] For example, at the time the Milliman Report was written, Weiss Ratings, an independent insurance-rating agency, had already done a study in June 2003, which found that between 1991 and 2002, states with caps on noneconomic damage awards saw median doctors' malpractice insurance premiums rise 48 percent – *a greater increase than in states without caps*. In states without caps, median premiums increased only 36 percent over the prior decade; states with caps saw median doctors' malpractice insurance premiums rise *faster* than states without caps. Moreover, according to Weiss, "median 2002 premiums were about the same" whether or not a state capped damage awards. Weiss Ratings, "Medical Malpractice Caps Fail to Prevent Premium Increases," (2003). See also, *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices*, Center for Justice & Democracy (1999). This view was confirmed by numerous studies and books issued just a year after the Milliman Report was published. See, e.g., Tom Baker, *The Medical Malpractice Myth*, University of Chicago Press. 2005; Amitabh Chandra, Shantanu Nundy, Seth A. Seabury, "The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank," *Health Affairs*, May 31, 2005; Jay Angoff, "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry," July 2005, http://www.centerjd.org/ANGOFFReport.pdf. A study by law professors at the University of Texas, Columbia University and the University of Illinois based on closed claim data compiled by the Texas Department of Insurance since 1988 concluded that "the rapid changes in insurance premiums that sparked the crisis appear to reflect insurance market dynamics, largely disconnected from claim outcomes." Black, Silver, Hyman, and Sage, "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002," *Journal of Empirical Legal Studies* (2005).

- Defense costs are lowered under an assumption that such costs "tend" to go down with claims but "the reduction is not to the same extent." The report does not tell us even to what extent this is reflected; much less show us the math used to drop these costs.

The cumulative effect of these assumptions makes it impossible to believe the results of the analysis, particularly without the actual data and the actual application of assumptions shown in the report.

To Milliman's credit, the report almost begs us to not believe its results. It notes limitations on accuracy due to judgment, "numerous" assumptions, uncertainty, statistical fluctuations, unanticipated insurance and legal events, economics, "social" inflation and "numerous other social, political and economic factors." Milliman admits that its model cannot "reflect all of the forces underlying a complex insurance process." Their simulation model reflects "numerous (undisclosed) assumptions." Their estimated distributions may "be significantly different " than the "true" distributions. The data, they admit, was "not audited, verified or reviewed…for reasonableness and consistency." Therefore their results have "a substantial amount of uncertainty" and may be substantially different than what actually would happen if New York enacted a cap.

Milliman knew that third parties would receive parts of this report but also knew enough about the risks of such distribution given the clear conflict of interest Milliman had, plus all the errors and doubts about the quality of the work. Milliman knew this and thus said that the report did not create any legal duty vis-à-vis the third parties and that such parties should not "rely on the work or conclusions contained herein. We recommend that any recipient have it's own actuary or economist review the work and form an independent opinion." The problem is the report has insufficient material to allow review.

We do agree with Milliman on one thing, however: that no third party, be it a legislator or the media should rely on the report's work or conclusions in any way, as the report specifically states. The work is shoddy and the conclusions are biased and unreliable.