US Medical Professional Liability Insurance Market Remains in Flux

Coming into 2020, US medical professional liability (MPL) insurers were looking ahead and focusing on strategies to address concerns about rate adequacy amid rising loss costs and the impact of social inflation on litigation-driven loss severity trends in the wake of diminishing reserve redundancies. AM Best is thus maintaining its Negative outlook on the segment for 2020, owing to these fundamental factors, as well as the COVID-19 outbreak, which is likely to pose additional challenges.

COVID-19 is now at the forefront of all our lives. The pandemic has struck at what may be the MPL segment’s weakest point in almost two decades. The number of confirmed cases continues to grow as more testing becomes available, and the healthcare community is doing its best to manage. However, inadequate supplies, staffing, and hospital space could presage additional risk and numerous liability concerns for all the professionals and facilities involved, including the medical professional liability companies that insure them. Furthermore, the areas most affected by the virus are the more densely populated cities, some of which are the least desirable when it comes to litigation venues. Federal and Executive orders are coming into play, state immunity bills being requested and passed, relief packages being distributed, and courts being frozen. However, what will be effective in protecting the healthcare community and their carriers from the eventual surge of litigation related to COVID-19 remains to be seen.

COVID-19 Entails a Plethora of Risks for MPL Insurers

Hospitals and healthcare providers may well be overwhelmed by the number of people needing in-patient care as COVID-19 continues to spread. The rise in the number of people seeking medical attention means more hospital overcrowding, a higher patient-to-medical personnel ratio, and greater risk of delayed procedures and hospital infections. Healthcare professionals are working extended hours while getting little rest. The strain of providing care for so many patients could lead to the kinds of mistakes that lead to lawsuits.

Additionally, with case numbers rising in tandem with the increase in diagnostic testing, a growing number of less experienced professionals are becoming involved in providing healthcare services. But any volunteering physicians and healthcare professionals who have not been professionally trained in infectious diseases may find themselves subject to liability. With the heightened volume of patients visiting hospitals and makeshift medical facilities set up to provide COVID-19 tests, an elevated number of claims of misdiagnoses is only too likely.

Furthermore, in some areas, hospitals lack medical equipment, testing materials, and supplies, and are running out of proper protective equipment to treat patients, which could also lead to a spike in unfavorable medical outcomes. There is also a shortage of staff needed, particularly in temporary, drive-through areas set up by state governments to accommodate the growing number of individuals seeking tests—a number that has been increasing dramatically every day.

The most acute need has been for the personal protective equipment healthcare professionals require to administer tests and treatments, along with respirators and other equipment to...
treat those whose diagnoses have been confirmed. Healthcare workers who treat patients out of need but without the necessary protective equipment could later be sued for negligence associated with contributing to the spread of the virus.

Telemedicine could help meet social distancing needs to limit the spread of the virus, although this could expose medical professionals to added liability and cyber risks as well. For actively practicing physicians, delays in non-pandemic-related medical treatments and elective surgeries, as well as the expanded use of telemedicine, could result in a rise in negligence claims, including “failure to diagnose”—an area that has always posed some of the greatest challenges when it comes to potential liability exposure.

**Immunity Protections for Healthcare Providers**

Providers are treating people while personally unprotected, exhausted, and in makeshift and overcrowded conditions, and are being placed in unprecedented situations (treating people in cars, over the phone, on a computer, and in parking lots). Even non-urgent medical providers are treating people in their cars (strep and flu testing, vaccinations for well children, etc.).

In response, some states, as well as the federal government, have acted to provide varying degrees of immunity to healthcare providers. On March 17, 2020, the Secretary of Health and Human Services issued a declaration under the Public Readiness and Emergency Preparedness (PREP) Act to provide liability immunity for medical countermeasures against COVID-19. This declaration is an effort to provide immunity from civil liability to individuals and entities (“covered persons”) such as healthcare professionals, against claim of loss caused by, arising out of, relating to, or resulting from the manufacture, distribution, administration, or use of medical countermeasures, with the exception of claims involving “willful misconduct” as defined in the PREP Act. However, the medical countermeasures it refers to are solely non-customary practices.

The degree of potential litigation will depend on whether a bill providing federal liability immunity to medical professionals courageous enough to risk their own lives for the sake of others will garner bipartisan support. Such a bill, the “Good Samaritan Health Professionals Act,” was introduced by Representatives Raul Ruiz and Larry Bucshon and is intended to protect volunteers and provide liability immunity for those assisting in patient care for COVID-19. Until such an act is passed, Good Samaritan laws would still apply and would be the mechanism states can use to provide much needed liability protection for those on the front lines. However, volunteer healthcare professionals who cross state borders are not protected under federal law and would fall under a patchwork of inconsistent state laws where large-scale pandemics are concerned.

Various states’ medical associations and societies have already sent letters to their states’ governors requesting legal protections for the response, treatments, and actions associated with COVID-19, drafting executive orders declaring civil and criminal immunity to healthcare providers that act in good faith while responding to the outbreak—excluding gross negligence or willful misconduct. A number of states appear to be establishing these immunities, among them, New Jersey, New York, Michigan, and Tennessee.

In the near term, few lawyers are likely to take on lawsuits against healthcare providers related to COVID-19, owing to healthcare provider sentiment and the difficulties of determining the standard of care in the current environment. These immunities may offer some protection from litigation related to COVID-19 over the near term, but immunities have
not been tested in the courts, and claims will likely come in years ahead, despite today’s positive healthcare provider sentiment.

**Profitability Prospects Are Dim**

The already dim prospects for the segment’s profitability have been clouded by COVID-19, given uncertainty about the impact on loss costs as well as premium refunds and the ability to put planned rate increases into effect. The majority of physicians in specialty areas, and even primary care, are not seeing patients. For small hospitals in rural areas that may have already been struggling prior to the pandemic, canceling non-emergency medical procedures cuts off their main source of revenue and premium paying ability. The bipartisan CARES Act (Coronavirus Aid, Relief, and Economic Security Act) signed on March 27, 2020, by President Donald J. Trump provides $100 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response. According to the act, the funding “will be used to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19.” It is not considered a loan and is not to be paid back.

The CARES Act includes “payments to practices that are part of larger medical groups” and aims “to provide relief to both providers in areas heavily impacted by COVID-19 and those providers who are struggling to keep their doors open due to healthy patients delaying care and canceled elective services.” At a time when many practices are on hold and revenue is stagnant for practices and hospitals, this may provide some relief in the short-term. However, it is uncertain if distributions based on an equation derived from medical providers who billed Medicare during 2019 will be enough to bail out physicians and rural hospitals who may see only a small percentage of Medicare recipients. Additionally, states such as California are enforcing premium returns, including for the MPL segment; other states are likely to follow suit and insurance premium refunds could be federally mandated. While considered fairly implemented and ethically appropriate, such mandates could be costly to carriers, who will still experience operational expenses and losses unrelated to COVID-19.

**2019 Financial Results Driven by Leading Performers, Owing to Consolidation**

The P/C industry’s top 20 MPL writers (based on statutory data) accounted for 78.1% of direct premiums written (DPW) volume in 2019, up significantly from 69.9% in 2018. The noticeable increase in concentration was driven, in part, by industry consolidation, particularly the acquisition of Hospitals Insurance Company (HIC), a hospital-owned insurance company, by Doctors Company Insurance Group. The Berkshire Hathaway Insurance Group grew its direct MPL premium by more than 6% and remained the leading writer of MPL business (Exhibit 1), although its lead shrank considerably owing to the Doctors Company’s acquisition of HIC. Had HIC, the ninth-ranked MPL writer in 2018, been part of the Doctors Company organization coming into 2019, Doctors’ year-over-year growth would have been just 1.2%.

Three quarters of the top 20 MPL writers posted YoY premium growth in 2019, led by a rise of more than 20% by Liberty Mutual, Physicians Mutual, and W. R. Berkley Group (WRB) apiece. Both AIG and Curi Holdings, formerly Medical Mutual Group (NC), also generated double-digit direct premium growth, while Coverys Companies finished with just under 10%. Chubb Group was the only MPL underwriter in the top 20 that saw close to a double-digit drop in direct premium volume, although MPL business makes up less than 1% of the group’s direct premium.

**Consolidations Help Growth for Overall Group**

Liberty Mutual’s growth was spurred by the 48% YoY premium growth in its subsidiary, Ironshore Specialty. The MPL line accounts for only 12% or so of the company’s DPW, but
the line’s growth accounted for the majority of Liberty’s 2019 YoY growth, outside of its lead general liability line of coverage. Similarly, the almost 23% growth in MPL premium reported by WRB’s Admiral Insurance Company drove the MPL premium growth for the entire group, since Admiral generated 89% of the group’s MPL premium. MPL isn’t a leading line of business for Liberty Mutual or WRB, but both have seen the line grow through their efforts to expand their professional liability portfolios. The growth in premium reported by Curi Holdings was attributable to its lead insurer, Medical Mutual Insurance Company of North Carolina. A modest increase in the percentage of covered physicians and an impressive 96% policyholder retention rate helped the company grow its top-line MPL premium.

Consolidations are likely to continue to play a key role in the MPL insurance industry—specifically, in the composition of top 20 MPL carriers. MLMIC had been the sixth highest ranked MPL insurer by DPW in 2017, and its acquisition widened the disparity between its new parent company and the rest of the leading MPL insurers.

In February 2020, NORCAL Group and ProAssurance Corporation announced a definitive agreement whereby ProAssurance would acquire NORCAL in a $450 million deal. Some industry observers believe the deal could yield both strategic and financial benefits to ProAssurance, as the combined entity is likely to become the third largest MPL insurer in the US. However, as AM Best commented in February, the acquisition is likely to strain the risk-adjusted capitalization of ProAssurance, which was already contending with a deterioration in
The analysis in this section is based on data AM Best has received from nearly the entire population of MPL carriers. Exhibit 1 shows MPL premium volume for the 20 leading companies in the P/C industry. Data for Exhibits 2 to 9 comes from 2019 statutory statements filed with AM Best as of April 8, 2020, for a composite of carriers whose primary line is medical or hospital professional liability insurance. Note that one top ten MPL writer, which generated almost $340 million in MPL DPW in 2018, has not yet filed its annual statement with AM Best. As such, we have excluded it from this report’s exhibits for 2019 as well as prior years. The analysis also excludes or adjusts for aberrations in the reported financial results of MLMIC Insurance Company (for 2018) and Texas Medical Liability Insurance Underwriting Association (for 2015), whose results skewed the segment’s underwriting figures and loss reserve development for those specific years.

operating performance and a decline in capital adequacy driven by shareholder dividends and less embedded equity in loss reserves.

**Composite DPW Is Growing**

DPW for the MPL composite rose 3.7% in 2019 to $7.3 billion, after rising 3.3% in 2018 (Exhibit 2). The growth in 2018 and 2019 followed a prolonged period of soft market conditions and changing industry dynamics that dampened product demand. In recent years, hospital and other healthcare facility businesses provided growth; in 2019, however, overall premiums for physicians rose but declined for hospitals (Exhibit 3). Given the number of private practice physicians who have migrated to hospital employment, the growth in premium associated with physicians’ practices may indicate rate increases in the physicians’ business.

MPL insurers have been feeling rate pressure for several years, and the recent increase in premium likely reflects strategies by insurers whose bottom lines have been the most affected

---

**Exhibit 2**

**US MPL Composite – Direct Premiums Written, 2015-2019**

Note: Totals represent companies in AM Best’s MPL composite that have filed statements as of April 7, 2020.

Source: AM Best data and research
by inadequate rates. Rates in certain areas and markets remain pressured, but the portion of the MPL market affected by these market dynamics has contracted. In some instances, business is being fronted and then passed on to the alternative risk transfer (ART) market. Additionally, larger groups and hospitals are either self-insuring or using ART options.

Underwriting Loss Leads to Deterioration in Operating Performance

In 2019, the MPL composite’s pretax and net operating income declined (Exhibit 4) owing to a significant increase in underwriting losses. The deterioration in underwriting results was due primarily to a slight rise in underwriting expenses and losses and loss adjustment expenses (LAE), along with an 11% drop in net premiums earned (NPE). A decrease of almost $40 million in policyholder dividends paid tempered the underwriting loss.

Net investment income declined moderately in 2019, versus a more than 20% increase in 2018. MPL companies have been shifting some of their lower-yielding municipal bonds to higher-yielding corporates and equities for several years now. The composite’s 2.8% investment yield remained on par with the previous year, but that was still an improvement over the 2.2% yield each of the two previous years. An increase in other income from ancillary fee-based services also helped offset the underwriting loss, to generate pretax income. Also, a lower corporate tax burden attributable to the Tax Cuts and Jobs Act had a positive impact on net income.

The composite’s calendar year underwriting results continued to benefit from favorable development in 2019, albeit to a lesser degree than prior years. (The aggregate underwriting losses in the last four years followed an extended period of underwriting and operating profitability, during which the segment outperformed the P/C industry on key profitability measures.) Still, pretax and net income reflected the ongoing margin compression from the long-term loss of premium volume, despite the increase in investment income the last couple of years.
As Exhibit 5 shows, increases in incurred losses and underwriting expenses led to significant deterioration in the composite’s loss and LAE ratios, as well as underwriting expense ratios. Rising medical loss costs, along with relentlessly challenging and competitive market conditions, had pressured loss and LAE ratios over the last few years, before an even larger increase in 2019. Underwriting expenses had been relatively stable, before an increase of almost two percentage points contributed to the more than ten-point surge in the segment’s combined ratio.

The MPL composite’s average underwriting ratios for the last five years are slightly worse than the P/C industry’s, with some of that margin clearly affected by 2019 results. Pre-policyholder dividend underwriting ratios remain in line with the overall industry. Compared to other P/C lines, the MPL segment’s loss ratio benefits from not being subject to catastrophe losses. Still, the segment’s five-year average loss and LAE ratio remains on par with the P/C industry average—which includes the 2017 and 2018 calendar years, when P/C industry results were heavily impacted by natural catastrophe losses owing to hurricanes and wildfires.
Relatively favorable claims frequency has been partly counterbalanced by worsening claims severity, which led to a rise in initial accident year loss and LAE ratios to the low 90s, from the mid- to high 80s in 2010 and 2011. The rise in claims severity has, in some cases and jurisdictions, reflected jury verdicts in favor of plaintiffs and higher settlement amounts. Some MPL insurers have indicated that the rise in severity is attributable to growing defense costs, despite the positive impact on indemnity severity of the tort reform and non-economic damage caps enacted in more than half the states in the country.

One reason for the muted benefits from non-economic damage caps is that, because economic damages have been so high in many cases, the caps have not limited claims severity as they might have in the past owing to social inflation. Public and jury attitudes are increasingly trending in favor of larger damages awards for plaintiffs. Over time, this kind of escalation in awards can be considered the norm, with juries awarding ever larger damages, which will affect how legislators balance public policy needs. Plaintiffs seeking larger awards can mean that cases remain open longer, pushing up insurers’ court and defense costs, which has helped drive LAE ratios higher.

The segment’s prior accident year reserve development was less favorable than in 2018—excluding the 2018 MLMIC loss portfolio transfer to new parent National Indemnity Company (NICO). Including the impact of this transaction would skew several MPL composite metrics for both 2018 and the five-year average, particularly net premiums written growth, loss reserve development, and, to a lesser extent, underwriting profitability. From 2009 to 2016, the MPL composite’s favorable loss reserve development accounted for more than 20% on average of NPE annually, before declining to 17%-18% in 2017. Following the aberrant reserve development in 2018 attributable to MLMIC, the composite’s favorable prior year development declined to less than 10% of NPE in 2019. With just under 97% of the composite’s net reserve base comprising MPL Occurrence or MPL Claims-Made reserves as of the end of 2019, the development of MPL reserves has clearly driven the recent decline in favorable development of prior year reserves, which have an overriding negative effect on underwriting results.

AM Best will continue to monitor reserves for recent accident years. Loss frequency remained relatively benign in 2019, which helps diminish pricing pressure—which in turn helps carriers focus more on price adequacy. Favorable development on prior accident year reserves lowered the 2018 calendar year combined ratio by only 7.6 points in 2019, less than half the 15.6 point difference in 2018 (Exhibit 6).

Since 2010, the segment’s one-year reserve development has been running off redundant. The release of prior year reserves has been decreasing, but so has the amount released as a percentage of the prior year’s original

### Exhibit 6

**US MPL Composite – Combined Ratios, 2010-2019**

<table>
<thead>
<tr>
<th>Year</th>
<th>Original Accident Year Combined Ratio</th>
<th>Original Calendar Year Combined Ratio</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>111.3</td>
<td>84.1</td>
<td>27.2</td>
</tr>
<tr>
<td>2011</td>
<td>113.4</td>
<td>89.1</td>
<td>24.3</td>
</tr>
<tr>
<td>2012</td>
<td>118.1</td>
<td>93.6</td>
<td>24.5</td>
</tr>
<tr>
<td>2013</td>
<td>114.9</td>
<td>92.7</td>
<td>22.2</td>
</tr>
<tr>
<td>2014</td>
<td>116.1</td>
<td>93.2</td>
<td>22.9</td>
</tr>
<tr>
<td>2015</td>
<td>118.2</td>
<td>98.3</td>
<td>19.9</td>
</tr>
<tr>
<td>2016</td>
<td>118.6</td>
<td>102.4</td>
<td>16.2</td>
</tr>
<tr>
<td>2017</td>
<td>118.0</td>
<td>100.2</td>
<td>17.8</td>
</tr>
<tr>
<td>2018</td>
<td>117.9</td>
<td>102.3</td>
<td>15.6</td>
</tr>
<tr>
<td>2019</td>
<td>120.9</td>
<td>113.3</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Note: The 117.8 AY CR for 2018 excludes the MLMIC Loss Portfolio Transfer in that year. Accident year and calendar year ratios are based on 2020 special QAR 79654 values.

Source: AM Best data and research
calendar year reserves booked (Exhibit 7). Coupled with higher accident year combined ratios, these indicators signal the composite’s eroding reserve cushion, despite overall development remaining favorable.

Several factors have combined with social inflation to contribute to the worsening loss severity trends. For one thing, more companies are holding firm on renewals or pushing for rate increases, but rates in some territories remain under pressure. Further, medical loss cost inflation has outpaced consumer inflation, with more cases litigated rather than reaching early settlement. Soon, given the confluence of these factors, reserve releases will no longer be sufficient to prop up the segment’s calendar year results, which has been the norm for some time. That means more effective risk selection, risk classification, individual account underwriting and pricing will be needed to generate improved calendar year underwriting results.

*Insurers Still Paying Out Significant Dividends … but for How Long?*

MPL insurers continue to use policyholder dividends as a retention tool. Nonetheless, owing to increasingly challenging operating conditions, the level of these payouts has declined considerably in recent years, from approximately $341 million in 2015, to about $212 million in 2019, a decline of 38%. If negative loss cost trends, large plaintiff settlements, and the erosion of reserve redundancies continue, underwriting margins will be pressured further, which could further limit dividend payouts. Prior to the upheaval caused by COVID-19, AM Best already expected that, with dividends based primarily on the prior year’s income, insurers would pay out smaller dividends in 2020. Whether companies will implement even more conservative dividend strategies remains to be seen, given the numerous unknowns facing physicians, hospitals, and other healthcare providers, as well as their insurance providers.

Prior to 2018, annual shareholder dividends for the MPL composite had for some time averaged around $500 million, albeit with some year-to-year volatility—that is, before MLMIC paid NICO

**Exhibit 7**

**US MPL – Calendar Year Loss Reserve Development, 2009-2019**

[Graph showing US MPL – Calendar Year Loss Reserve Development, 2009-2019]
more than $1.9 billion in 2018, which skewed the composite average significantly. Strategically, insurers are still intent on returning excess capital to their shareholders whenever prudent, but ongoing profit margin compression could result in a decline in payout amounts, similar to what may happen for policyholder dividends.

The composite’s NPE has declined a little less than 9% over the last five years, with variability driven partly by fluctuating levels of reinsurance premiums. The decline largely reflects not only the impact of the highly competitive MPL market but also changes in the healthcare industry overall. During the last five years, the aggregate level of premium ceded to reinsurers has fluctuated somewhat, although the ceded total for the composite was relatively steady from 2015 to 2019 (excluding the MLMIC effect on 2018 ceded premium). Yearly fluctuations in the composite’s ceded premium totals have typically been associated with affiliated reinsurance agreements entered into by some companies. Non-traditional reinsurance has not had a direct influence on MPL reinsurance purchasing decisions.

Unrealized Gains/Losses Dominate Returns
Historically, MPL insurers have maintained relatively conservative, generally sound investment portfolios, with the vast majority of the holdings consisting of fixed income securities. Over the last several years, the composite’s return on invested assets (ROIA) has improved, excluding 2018 when extraordinary unrealized losses led to an almost 70% decline in the composite’s total return, which resulted in a considerable drop in ROIA. The unrealized losses were due to a significant decline in the value of unaffiliated common stocks during the substantial downturn in the equity market in the fourth quarter of 2018. Robust financial market performance in 2019 resulted in an almost 180-degree turn in the composite’s $1.1 billion unrealized loss in 2018 to a $1.1 billion unrealized gain in 2019. The robust equity market in particular provided opportunities that MPL insurers took advantage of to generate gains, for an increase of more than $1.0 billion in the composite’s total return (measured as net income plus unrealized gains).

The composite’s aggregate investment performance was generally solid for the year, although investment income declined about 8%, after rising around 21% in 2018, when investment income benefited from an unusually high amount of investment income from affiliated investments. Interest on fixed-income investments generated more than 68% of the composite’s gross investment income; dividends on preferred and common stock holdings accounted for less than 20%.

The substantial effect of COVID-19 on the global investment markets, concerns about additional spikes of global sell-offs, and declining interest rates have made the investment environment more challenging. The number of attractive investment alternatives will likely remain limited until the worst of the pandemic is over. These market realities will have their impact on the MPL composite’s ROIA, but proven capital preservation strategies and conservative investment portfolio management will likely remain the norm.

The allocation of non-affiliated invested assets has not changed significantly in recent years, although insurers have made strategic changes aimed at generating higher returns. Many MPL companies are leveraging their strong capital positions (as part of their long-term strategies), to take on a little more investment risk in exchange for higher returns. Common stock leverage has grown, from 18.2% of total admitted assets at the end of 2017, to 19.2% at the end of 2019, and has contributed substantially to the volatility in the composite’s total returns in recent years. Net earnings have largely been returned to shareholders rather than being used to fund asset investments. Taking on more equities can lead to investment performance volatility,
which will be reflected in insurers’ mid-year 2020 investment portfolio reports. Long-term bonds still constitute the largest portion of total assets, on par with the last few years, but lower than in 2017 (Exhibit 8).

The remainder of invested assets are mainly in cash and short-term investments, real estate, and other invested assets (including alternative investments). Other invested assets have fluctuated the past five years and remain a minor portion of segment portfolios, constituting 5.4% of total non-affiliated invested assets at year-end 2019. Dividends from other invested assets almost doubled, to $146.3 million, after remaining approximately $116 million the two prior years. These dividends accounted for 12.6% of the gross investment income generated by these assets for the year. Coming into 2020, segment liquidity remained solid and in line with total P/C industry liquidity. Although net investment yields are likely to remain low for the near future, operating cash flow should remain positive for some time, as the segment’s investment float remains attractive.

**Capital & Surplus Trends Remain Positive … for Now**

The MPL segment’s statutory surplus increased 4.3% in 2019, by about $783 million, to $18.8 billion (Exhibit 9), following the 10% decline in policyholders’ surplus in 2018 that was driven by MLMIC’s payment of more than $1.5 billion in dividends to its new parent. Still, despite the rise in 2019, the composite’s five-year CAGR declined from 1.7% to 0.1%. Solid net investment income and total investment gains, including the extraordinary $1.2 billion unrealized gain, modestly overcame the underwriting loss for the year, and $733 million in contributed capital resulted in the 4.3% increase in surplus.

Besides the $436 million returned to stakeholders through policyholder and shareholder dividends (excluding contributed capital), insurers also granted premium rebates, discounts, and credits, funded in large part by the release of redundant reserves for prior accident year claims. In 2019, favorable development on prior year claims amounted to $388 million,
far less than the $1.0 billion-plus in 2018 (excluding MLMIC). A few MPL insurers have formed policyholder loyalty programs that are bolstering policyholder retention. Under statutory accounting regulations, insurers do not have to segregate these programs from policyholders’ surplus. Only a portion of these funds is accounted for as disbursements through retained earnings.

A number of MPL insurers are using their excess capital to improve market share through strategic acquisitions, partnerships, alliances, co-branded programs, or innovation investments, or to provide reinsurance support for markets they are unable to enter directly. Some carriers will no doubt continue returning excess capital to their owners; others will use capital to remain competitive on pricing. The current soft pricing environment is a by-product of excess capital, redundant reserves, low claims frequency, and manageable claims severity—conditions that could hold for the near to medium term.

**Alternative Risk Transfer Vehicles Provide Options**

Alternative risk transfer (ART) vehicles provide healthcare organizations and hospitals an outlet to tailor their own insurance coverage to address business risk. These vehicles can provide access to different types of policyholders and can facilitate geographic expansion. Captives, risk retention groups (RRGs), and segregated cell captives offer well-capitalized stock and mutual companies the opportunity to service high-severity risks that may fall outside their core risk appetite. Hospitals and physician groups have become more aware of the benefits of captives and are similarly using them as strategically prudent options.

The use of RRGs continues to grow. MPL RRGs still generate the largest amount of RRG direct premiums written, at almost $1.5 billion (*Exhibit 10*)—about 21% more than the $1.2 billion generated via RRGs focused on the Other Liability lines (either Occurrence or Claims Made). Rate flexibility is the key reason that the use of ART vehicles will likely continue growing over the near term, especially given the low failure rate attributed to MPL RRGs. Where the premiums collected by a traditional MPL insurer include funds to cover the insurer’s profit
margin and overhead, ART structures allow large MPL groups to bank premium dollars and establish reserves for specific exposures, based primarily on their own loss experience.

**Reserve Redundancy – Ending the Decade Dramatically Weaker than it Started**

Historically, the MPL line of business has shown that it has been subject to wide swings in ultimate loss and LAE ratios. What makes the last ten years different is that the deterioration has been gradual rather than sudden, not only for the ultimate accident year loss and LAE ratios, but also for the industry’s net loss and LAE reserve position. The calendar year-end reserves booked ten years ago have run off $8.6 billion favorable. However, AM Best believes the industry’s 2019 calendar year-end booked net loss and LAE reserves will ultimately run off redundant only $1 billion including the effect of $0.5 billion of statutory discounting (Exhibit 11). While this estimated redundancy is only $0.6 billion lower than the redundancy estimated for the 2018 calendar year-end reserves, it is more than $7 billion lower than the amount of redundancy that was realized from the reserves booked ten years ago. The dramatic decline in the estimated redundancy over the last ten years is a result of higher indicated ultimate loss and LAE for the most recent accident years, lower booked net reserves for the most recent calendar year end, and a payout pattern that appears to be slowing down.

**Exhibit 11**


($ billions)

<table>
<thead>
<tr>
<th>Reserves as of</th>
<th>Excluding Discount</th>
<th>Statutory Discount</th>
<th>Total Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2019</td>
<td>-1.5</td>
<td>0.5</td>
<td>-1.0</td>
</tr>
<tr>
<td>December 31, 2018</td>
<td>-2.1</td>
<td>0.5</td>
<td>-1.6</td>
</tr>
</tbody>
</table>

Note: Positive values indicate deficiency, negative values indicate redundancy. AM Best treats all discount as deficiency.

Source: AM Best data and research

**Exhibit 12**

**US MPL – Ultimate Incurred Loss & DCC* Ratios, 2018-2019**

Ratios (%)

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>Initially Booked</th>
<th>Developed Through 12/18</th>
<th>Estimated Ultimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>78.7</td>
<td>57.7</td>
<td>58.0</td>
</tr>
<tr>
<td>2010</td>
<td>79.9</td>
<td>60.6</td>
<td>60.4</td>
</tr>
<tr>
<td>2011</td>
<td>79.9</td>
<td>54.1</td>
<td>63.7</td>
</tr>
<tr>
<td>2012</td>
<td>82.2</td>
<td>67.9</td>
<td>66.3</td>
</tr>
<tr>
<td>2013</td>
<td>79.5</td>
<td>71.8</td>
<td>68.1</td>
</tr>
<tr>
<td>2014</td>
<td>80.0</td>
<td>75.0</td>
<td>68.8</td>
</tr>
<tr>
<td>2015</td>
<td>80.1</td>
<td>78.2</td>
<td>71.4</td>
</tr>
<tr>
<td>2016</td>
<td>80.1</td>
<td>78.5</td>
<td>75.2</td>
</tr>
<tr>
<td>2017</td>
<td>80.9</td>
<td>80.0</td>
<td>78.2</td>
</tr>
<tr>
<td>2018</td>
<td>79.2</td>
<td>79.2</td>
<td>77.0</td>
</tr>
<tr>
<td>2019</td>
<td>--</td>
<td>--</td>
<td>77.8</td>
</tr>
</tbody>
</table>

* Defense and Cost Containment.

Source: AM Best data and research

**Exhibit 12** shows the gradual deterioration in selected ultimate accident year loss, and defense and cost containment (DCC) ratios. The increase from one accident year to the next never exceeds four points, but the cumulative increase over the last ten years is almost 20 points. We are projecting that the MPL industry will book a 2019 calendar year loss and LAE ratio slightly lower than the 2019 accident year estimated ultimate loss & LAE ratio of 84.9% (the sum of the 77.8% estimated ultimate loss and DCC ratio for the 2019 accident year plus 7.1 points for Adjusting & Other expenses). When the calendar year loss & LAE ratio is lower than the accident year ultimate loss & LAE ratio, the reserve position gets weaker.

Industry reserves overall appear to be redundant, but reserve positions will vary greatly by insurer. As reserve margins decline, AM Best expects that a number of insurers will report adverse development in 2019 and 2020. For those insurers still reporting favorable development, the margins from earlier accident years will likely be greater than the adverse
development coming through from more recent accident years. Overall reserves will run off
deficient if management is not proactive in strengthening reserves. AM Best will continue to
monitor insurers individually through the use of our internal loss reserve analysis, which is
based on Schedule P paid and case incurred loss and DCC development. We will also consider
each insurer’s reserving history throughout the underwriting cycle, conduct a diagnostic
analysis of Schedule P, and make a qualitative assessment of the insurer’s current operating
environment. Insurers can supply reserve reviews from internal or external actuaries, which
we will also take into consideration.

Adverse reserve development is one of the leading causes of insolvency among insurers, and
an insurer’s reserve adequacy remains a critical rating component. As Exhibit 13 shows, the
industry’s loss and DCC reserves have experienced large swings in its reserve position, as
reserves booked in the late 1990s and early 2000s ran off deficient, whereas reserves booked in
2003 later ran off redundant. Reserve margins have been declining and AM Best believes that,
at the current rate of decline, current reserve redundancies will allow the industry to continue
to report favorable reserve development for the next one to two calendar years.

NPE per Claim Remains Low

Net premiums earned (NPE) have been relatively flat over the last five years, so changes in the
amount of NPE per reported or paid claim will occur only if the number of reported claims
changes. For the claims-made business, the number of claims reported has been increasing,
which explains the decline in NPE per reported claim. Exhibit 14 shows NPE available
for reported and paid claims by accident year for the claims-made business. Accident year
means the year in which the premiums were earned and the losses were incurred, which
for the claims-made form of coverage occurs primarily on a claims reported basis. As the
exhibit shows, after 12 months of accident year development on the claims-made business
(which constitutes about two thirds of total MPL premiums, the remaining third being the
occurrence business), NPE of $83,000 were available per reported claim in 2017, $81,000 in
accident year 2018, and $80,000 in accident year 2019. Although these amounts have been
fairly flat the last few years, the 2019 amount is at a level that is 25% below the 2010 amount.

Exhibit 13
US MPL – Cumulative Reserve Development, 2001-2018
As a % of Original Booked Reserve

Source: AM Best data and research
The trend for the amount of NPE per reported claim at 24 months of development is similar. NPE per paid claim trend is theoretically the better indicator of NPE needed per claim, as NPE per reported claim can be distorted by changes in the proportion of claims that close without payment. However, paid data takes longer to produce reliable trends since the true NPE per paid claim isn’t known until the vast majority of claims have been settled for the accident year. Despite volatility at earlier ages of development, NPE for each paid claim after 12 months of development for the 2019 year dropped to $3.5 million, the lowest level in 10 years. This amount is 16% lower than the amount for the 2018 year, driven by an increase in the number of claims closed with pay. Furthermore, this amount is 37% lower than the amount for the 2010 year. NPE per paid claim after 24 months has been flat at $1.2 million for accident year 2018, which is 26% lower than the 2010 amount.

**Case Incurred and Paid Development Still Increasing**

Case incurred development factors for the loss and DCC expenses for the claims-made business have been rising steadily over the last four years for the 12- to 24-month development period (Exhibit 15). This is significant for the claims-made business because the largest proportion of loss and DCC is reported within the first 24 months (from the start of the accident year), and a significant amount of development occurs in the 12-month period following the end of the accident year. A smaller amount of case incurred development occurs during the 24 to 36 month development period, although the last three accident years are showing a higher level of development (1.137 average) than the prior five accident years (1.092 average). Nonetheless, the case incurred development at the 24 to 36 month looks to have peaked with the 2016 year, which had the highest level of development compared with the previous seven years.

Even though the vast majority of case incurred development takes place within 36 months, Exhibit 15 shows that paid loss & DCC development for claims-made business continues beyond 72 months. As with the case incurred development, the paid development factors for the 12- to 24-month period have been increasing over the past few years. However, unlike the case incurred development factors, which are at historically high levels for that 12- to 24-month period, the paid development factors are not outside the historical range of factors. Although the most recent paid development factors for the 12- to 24-month period are within the historical range, the most recent factors for the 24- to 36-month and the 36- to 48-month periods are higher than their historical averages, which implies a lengthening of the payout pattern.

**Loss and DCC Reserves Appear Less Conservative**

After years of large releases of prior accident year loss and LAE reserves, overall loss and DCC reserves now seem weaker than in prior years, a situation that can be analyzed in various
ways. One way is to divide the accident year case reserves by the number of open claims to obtain an average case reserve. This can be calculated at each stage of claim development, such as 12 or 24 months. As Exhibit 16 shows, the average case reserve for open claims in both the claims-made and occurrence business continued to decline at both 12 and 24 months. The average case reserve for the two most recent accident years is either at its lowest value over the period or at the low end of the historical range.

A decline in average case reserves alone doesn’t necessarily imply that total reserves are weakening, as companies can book higher incurred but not reported (IBNR) reserves to offset a decline in average case reserves. The IBNR as a ratio to NPE did increase for the claims-made business at both 12 and 24 months of development (Exhibit 17), and since premiums have been flat the past five years the higher ratio implies that the dollar amount of IBNR was increased at calendar year end 2019.

Adding IBNR to case reserves and then dividing by the number of open claims will calculate an average total unpaid reserve per open claim. Exhibit 18 highlights the decline in this average total unpaid reserve per open claim at both 12 and 24 months of development. Although the most recent average unpaid values are higher than the prior year values for the claims-made business, these most recent values are well below the levels for older accident years at the same stages of development. Given the large redundancies in older years, there does not appear to be a need to return to those historical levels, but the recent increases in the total unpaid per open claim indicate the industry has hit a low point.
Declining average reserves would be acceptable if claim severities were also declining at the same rate, but paid loss and DCC severity trends do not appear to be declining at nearly the same rate, if at all. Therefore, the declining average reserve is a clear indication that reserves are weakening and that case incurred loss development factors will begin to increase at later stages of development, assuming a constant number of paid claims. *Exhibits 19* and *20* show that the average closed claim and average closed-with-pay claim at the later stages of development for the claims-made business have been relatively flat the past few years. Approximately 77% of claims reported are closed by 36 months; 87%, by 48 months; and 92%, by 60 months.

**Opioid Abuse Continues Nearly Unabated**

The medical profession is contending with two national public health emergencies—not only a pandemic, but an opioid crisis as well. In 2018, according to information from the National Center for Health Statistics at the Centers for Disease Control and Prevention, 46,802 people died owing to opioids, while nearly 67% of drug deaths were related to opioids. Over 2.1 million people have reported an addiction to pain medication, although more than 11 million Americans reportedly misuse opioids each year. The economic burden of the opioid crisis amounts to more than $78.5 billion a year. Opioids include synthetics such as fentanyl and natural or semi-synthetics such as oxycodone and hydrocodone (legally obtainable by prescription), as well as the illegal drug, heroin.

Calendar year 2018, represented the first time in 20 years that the number of opioid-related deaths did *not* increase. Since 2013, the number of opioid prescriptions has declined by more than 80 million, or 33%; in 2018 alone, they declined 20 million, or 12.4%.
In 2019, the American Medical Association’s (AMA) Opioid Task Force recommended that physicians take six important actions to address the opioid crisis—and hopefully lower the number of malpractice claims:

- Register and use state prescription monitoring programs: In 2019, almost two million healthcare providers used state prescription drug monitoring programs—up 290% from 2014.
- Enhance continuing medical education and training provided by the AMA: In the past year, more than 700,000 physicians have completed continued education training and accessed other educational resources related to the issue.
- Support comprehensive treatment for pain and substance disorders: More than 66,000 physicians are now certified with the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide Medication-Assisted Treatments to patients with opioid disorders.
- End the stigma: More comprehensive treatment and greater support and compassion for patients with substance abuse disorders would help eliminate the stigma related to opioid addition.
- Co-prescribe Naloxone to counter the effects of an opioid overdose: Naloxone has become a critically important drug in combatting the opioid crisis; in 2018, the number of Naloxone prescriptions in the US reached an all-time high of 598,000, up 107% from 2017.
- Encourage safe storage and disposal of all unwanted or unused medication and drugs: This includes educating patients on the safe way to take these drugs.

These six recommendations may help prevent litigation (which has generally favored plaintiffs). Studying legal cases and developing a deep familiarity with AMA prescription recommendations could help physicians mitigate some opioid-related risks.
Another issue is doctors’ ability to continue to effectively treat patients for whom they have prescribed opioids as part of their treatment. The COVID-19 outbreak is already disrupting recovery routines and treatment for some and limiting patients’ access to treatment in general. Lockdowns for social distancing are forcing doctors, support services, and social groups to cut hours, move services online, and in some cases shut down.

Furthermore, limitations on the supply of opioids owing to COVID-19 could lead to even worse outcomes. For example, if supplies diminish, black market opioid dealers could look to cut available drugs with potentially dangerous substances, which could spiral into more people needing treatment and result in a heightened level of risk for physicians and the insurers providing their professional liability coverage. On the positive side, SAMHSA, in a somewhat surprising move in mid-March, relaxed restrictions on medication-related treatments. The relaxed guidelines allows doctors to prescribe opioids via telemedicine and advises methadone clinics to give stable patents take-home doses. The guidelines also recommended deliveries to patients in quarantine.

Telemedicine Continues to Expand
The remote delivery of healthcare services has increased substantially in the past few years, and has the potential to be a real game-changer. Telemedicine (or telehealth) allows patients to speak to healthcare experts 24/7 for treatment, and has reportedly resulted in cost savings and higher productivity; has reduced the amount of time patients spend in transit to different locations for medical care; and offers better work-life balance for doctors. Given the rising number of complaints about healthcare costs and of healthcare workers who are burning out, telemedicine has become a critical option.

Not Just Doctor Calls
Telemedicine isn’t limited to healthcare delivery, however. Telehealth services are allowing healthcare professionals to develop more evidence-based solutions via collaboration with other healthcare providers to create even more informed care plans. Individual and group practices as well as hospitals are achieving greater success harnessing available technology to improve care outcomes.

As both demand and availability rise, new developments will further the evolution of telemedicine. The aging Baby Boomers require more at-home care, and the vast majority of Millennial and Generation Z patients want telemedicine capabilities from providers. With retail clinics at CVS, Walmart, and Walgreens offering telehealth services to satisfy patient demand, conventional healthcare providers and networks are likely to expand their telehealth services as well. Direct-to-customer telemedicine models were once limited to video calls with doctors that patients did not know. Virtual services have now evolved to the point where CVS and Amazon are making home deliveries of prescriptions and medical devices, and digital assistants such as Google Home and Amazon’s Alexa are helping coordinate care as well. Healthcare providers are also using telehealth software to ease the transition once a patient is discharged from the hospital, by collaborating with home healthcare nurses and conducting timely follow-up visits to better support patients.

Telemedicine will grow significantly as more people become comfortable using it, and as technologies and methodologies mature, especially in the wake of COVID-19. According to American Well's Telehealth Index Survey, physicians' use of telemedicine grew 390% from 2015 to 2018; by 2022, 590,000 physicians are expected to be using this medium.
Expanding Government Guidelines/Greater Regulatory Flexibility

The COVID-19 outbreak has made telemedicine a vital tool to help contain the spread of disease. On March 17, 2020, under the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Trump Administration called on insurance companies to expand their policies and guidance on telehealth. The Centers for Medicare and Medicaid Services (CMS) broadened access to Medicare telehealth services via the CMS’s 1135 waiver authority, allowing beneficiaries a wider range of services from doctors without having to travel to a medical facility. This includes granting doctors the ability to take video appointments across state lines even if they are not licensed in the given state. Under the waiver, Medicare can pay for any telemedicine visits, starting March 6. In the past, telemedicine was used mainly for routine check-ups.

Greater regulatory flexibility will allow for three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries:

- Telehealth visits: Any kind of office or hospital visit and other services that generally occur in person
- Virtual check-ins: Brief virtual communications initiated by the patient via telephone, video or image, and a few other communications technology modalities (not limited to rural settings)
- E-visits: Patient-initiated communication with doctors without having to go to the doctor’s office or a hospital (also not limited to rural settings)

On March 30, the CMS further expanded services to help with the COVID-19 outbreak. One of the most crucial changes was to promote telehealth in Medicare. This second expansion now allows 80 additional services to be treated via telemedicine, to minimize the risk that patients seeking healthcare will contract the virus. These are only short-term changes to keep patients safe in their home and still allow them to be treated. As stated earlier, the increase in additional services will increase the liability exposure as telehealth was originally designed for low liability risks. Telehealth visits now include emergency department visits, hospice, home visits, rehabilitation facilities and therapy services.

Clinicians will now be able to monitor patients remotely, whether due to COVID-19 or other conditions. One of the benefits of this system is that patients who are exhibiting COVID-19 type symptoms and have been tested do not need to risk being in a hospital while they await those results. Patients who physicians determine should not leave their homes due to COVID-19 or any other medical-related issue will qualify for the Medicare Home Health Benefit.

CMS also loosened many restrictions to make sure that healthcare workers are able to see as many patients as possible. Before the COVID-19 outbreak, telemedicine was available only to patients who already had relationships with their doctors, to make sure that doctors knew their patients and their needs, and were able to properly evaluate their health before switching to telemedicine.

As the spread of COVID-19 necessitates the sudden expansion of telehealth usage and acceptance by a greater swath of the population, questions remains as to how many of these changes are temporary and whether growing usage of telemedicine opens up providers to more liability claims. Experts in the field increasingly believe that, although some of the policy directives encouraging usage will be dialed back after the virus, the pandemic has opened people’s eyes as to telemedicine’s potential, which can lead to long-term changes.
As telemedicine becomes more mainstream, a number of risks and legal issues may emerge, particularly with regard to kinds of mistakes that could have been prevented during an in-person visit—such as standard of care issues, miscommunication, or equipment malfunctions that would be evident during an in-person visit. Claims relating to COVID-19 are currently protected by different levels of immunity at the federal and state levels. As for claims outside of COVID-19, exposures could grow, as almost all states currently hold telehealth to the same standard of care as in-person visits. This is central to the challenge MPL insurers face, as telemedicine capability evolves and becomes more pervasive in everyday healthcare.

**Cyber Remains a Significant and Growing Risk**

Cyber criminals continue to target hospitals, doctors' offices, and other healthcare organizations. The vast majority of healthcare organizations, approximately 90%, consider themselves vulnerable to cyber attacks. According to a November 2019 report from the anti-malware firm, Malwarebytes, cyber attacks against healthcare organizations increased 60% year over year during the first nine months of 2019. Data breaches can make patients wary of sharing personal information and can damage a healthcare provider’s reputation and bottom line.

Risks range from breaches that compromise the integrity of systems and the privacy of patients, to ransomware that infects systems and files, rendering them inoperable until a ransom is paid, to distributed denial of service (DDoS) attacks designed to overwhelm a network to the point where it is inoperable. Primary MPL Insurers continue to offer cyber policies as an add-on to standard policies and typically do not retain any of the risk, with most choosing to cede the risk to reinsurers that specialize in cyber insurance.

Cyber risk will only continue to grow, as COVID-19 spurs the expansion of telemedicine, which is vulnerable to cyber threats just like any other information technology service. Data may become easier to access owing to the growing usage of wireless and mobile networks. Information technology teams must create an infrastructure that allows for the safest communications between telemedicine providers and their patients—one that allows for remote interactions in a securely encrypted environment.

The COVID-19 outbreak has already led to a number of cyber attacks. In late March, a major hospital in Brno, the Czech Republic’s second largest city, was hit by a cyber attack that resulted in postponing some surgeries, re-routing some acute patient to other hospitals, and reducing other medical activities. The hospital was critical to testing for COVID-19 in the city, and the disruption delayed the processing of tests for several days. In the US, the Health and Human Services Department was recently hit by a cyber attack aiming to undermine the country’s response to COVID-19. US Secretary of Defense Mark Esper has warned employees to watch out for phishing attempts and other types of attacks.

**MPL Innovation Initiatives Lagging Other Lines**

Some insurance lines of business lend themselves more readily to innovative strategies than others do. Where competition is fierce or regulation has undergone significant change, innovation provides a way for a company not just to survive but also to gain a sustainable advantage. The degree of complexity and scalability also affect how much a particular line can be transformed by innovation. Many innovative tools and techniques already available can be easily applied to less complex underwriting and claims processes. Much of the innovation in the MPL segment has been in response to competitive market threats, as companies respond with changes to their business models and alternative strategies to remain relevant.
Based on AM Best’s Innovation Assessment testing results, the MPL segment lags the overall property/casualty industry, as 95% of rating units in the segment scored in the bottom two innovation assessment profiles (90% Moderate, 5% Minimal) (Exhibit 21). The MPL segment scored lower than most of the other P/C segments, with the large majority of MPL rating units scoring in the lower half on several innovation components, particularly on the output side (Exhibit 22).

AM Best expects the output of the innovation process—in the form of new or significantly improved products, processes, services, or business models—to have a measurable impact on a company’s bottom line. Reinventing how insurance products and services are sold in the future will no doubt have an impact on bottom-line profitability. The MPL segment has yet to demonstrate any significant results.

MPL companies realize that disruption to their business model and underwriting risk selection are areas for innovation, given that one of the biggest threats to the MPL segment has been depressed demand due to consolidation in the healthcare industry and the rise in hospital employment of physicians. Some MPL insurers have leveraged data to develop predictive modeling capabilities, using either their own data to build data warehouses or even publicly available data, much of which is unstructured and requires AI and business intelligence tools to adapt it to usable formats. Some companies are also leveraging data and technology to provide a form of signal intelligence, providing the insurers and their policyholders insight as to the causes of preventable adverse events and outcomes.

Like many other segments in the P/C industry, the MPL segment has been affected by legacy IT systems and their impact on the speed at which companies can respond to emerging threats. Many MPL companies have been upgrading their IT systems or plan to do so in the near future. AM Best considers these infrastructure upgrades more of a competitive necessity rather than truly innovative, but any initiatives that measurably enhance customer experience and risk selection and transform the company would be positive.

Exhibit 21
MPL Segment Innovation Assessments

Source: AM Best data and research
A vast majority of MPL companies have begun to see a rise in “nuclear” verdicts and average indemnity losses that are much higher than historical averages. No longer are customary defense tactics applicable in certain situations. As such, claims settlements and legal costs have been rising at alarming rates and underwriting results have been weakening. Given the nature of the business, the loss adjustment expense ratios for MPL insurers are considerably higher than those of most insurance segments. MPL insurers pride themselves on claims defense, which may be ripe for new techniques and processes that can improve outcomes and cut defense costs, such as new litigation technology that allows them to better manage claims costs by controlling litigation expenses.

Not all innovation initiatives need to be “purchased.” Some can be developed in-house, although MPL insurers note that talent-related concerns are the biggest challenge to developing an innovation process (Exhibit 23). When MPL companies see the benefits of customization but do not have the in-house expertise, partnering with insurtech firms provides the opportunity to access externally developed information and techniques.

MPL insurers are always searching for more ways to help their insured physicians practice better medicine. Solutions driven by medical research, advanced analytics, and predictive modeling can enhance patient safety, promote better outcomes, and prevent or minimize future claims and legal costs. Certain companies have reported using simulation training for healthcare insureds to help improve patient safety, courtroom science in jury trials, and NLP—natural language processing—in claims management.

Not all innovation needs to be technology-focused. Many companies have found ways to be nimble and react quickly to changing market dynamics without relying on technological innovations. They have adapted business models to respond to competitive market challenges, whether through collaborative partnerships with other carriers or by providing non risk-
bearing products to insureds. Like other P/C insurers, MPL insurers are working to become more consumer-focused and improve the overall customer experience. Some MPL companies have also responded quickly to meet market demand by providing enhanced products and services.

A considerable amount of consolidation has taken place in the MPL segment in the last few years. Technological advancements and innovation capabilities may become more appealing characteristics for potential acquirers that want to leverage technology without using the resources to build in-house. Alternatively, they may decide to form strategic partnerships with a university or healthcare insurtech firm, although integrating their systems could be another hurdle, depending on the type of technology acquired.

The MPL segment continues to face a very challenging and dynamic market. The long-term survivors will be those companies that can effectively use innovation to gain competitive advantages, find efficiencies, and identify and react quickly to emerging risks.

Exhibit 23
US MPL – Biggest Challenges to Developing the Innovation Process

Source: AM Best data and research
Best's Financial Strength Rating (FSR): an independent opinion of an insurer’s financial strength and ability to meet its ongoing insurance policy and contract obligations. An FSR is not assigned to specific insurance policies or contracts.

Best's Issuer Credit Rating (ICR): an independent opinion of an entity’s ability to meet its ongoing financial obligations and can be issued on either a long- or short-term basis.

Best’s Issue Credit Rating (IR): an independent opinion of credit quality assigned to issues that gauges the ability to meet the terms of the obligation and can be issued on a long- or short-term basis (obligations with original maturities generally less than one year).

Rating Disclosure: Use and Limitations
A Best’s Credit Rating (BCR) is a forward-looking independent and objective opinion regarding an insurer’s, issuer’s or financial obligation’s relative creditworthiness. The opinion represents a comprehensive analysis consisting of a quantitative and qualitative evaluation of balance sheet strength, operating performance, business profile, and enterprise risk management or, where appropriate, the specific nature and details of a security. Because a BCR is a forward-looking opinion as of the date it is released, it cannot be considered as a fact or guarantee of future credit quality and therefore cannot be described as accurate or inaccurate. A BCR is a relative measure of risk that implies credit quality and is assigned using a scale with a defined population of categories and notches. Entities or obligations assigned the same BCR symbol developed using the same scale, should not be viewed as completely identical in terms of credit quality. Alternatively, they are alike in category (or notches within a category), but given there is a prescribed progression of categories (and notches) used in assigning the ratings of a much larger population of entities or obligations, the categories (notches) cannot mirror the precise subtleties of risk that are inherent within similarly rated entities or obligations. While a BCR reflects the opinion of A.M. Best Rating Services, Inc. (AM Best) of relative creditworthiness, it is not an indicator or predictor of defined impairment or default probability with respect to any specific insurer, issuer or financial obligation. A BCR is not investment advice, nor should it be construed as a consulting or advisory service, as such; it is not intended to be utilized as a recommendation to purchase, hold or terminate any insurance policy, contract, security or any other financial obligation, nor does it address the suitability of any particular policy or contract for a specific purpose or purchaser. Users of a BCR should not rely on it in making any investment decision; however, if used, the BCR must be considered as only one factor. Users must make their own evaluation of each investment decision. A BCR opinion is provided on an “as is” basis without any expressed or implied warranty. In addition, a BCR may be changed, suspended or withdrawn at any time for any reason at the sole discretion of AM Best.