



## **Discussion of SB-07-248 in re: Medical Malpractice Insurance Regulation in Colorado**

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July 20, 2007**

### **Introduction**

On April 4, 2007, Senator Joan Fitz-Gerald (D), President of the Colorado State Senate, and Representative Claire Levy (D), introduced SB07-248. The bill was assigned to the Senate Judiciary Committee and was heard on April 10. Following that hearing, the bill passed the full Senate on April 17, was sent to the House where it was assigned to the House Health and Human Services Committee. The House HHS Committee killed the bill at the request of the sponsors on April 26.

During the time that the bill was pending before the General Assembly, two special client newsletters were produced that analyzed the bill and its implications. Those newsletters were used by physician groups and medical malpractice insurers to develop their arguments against the bill. This discussion paper is a composite of those two newsletters and has been revised and edited.

### **GENERAL COMMENTS**

The bill originated with the Colorado Trial Lawyers Association. Members of the CTLA made presentations to various physician groups to explain both the bill and their organization's rationale for requesting it.

The CTLA said that the purpose of the bill was to establish an increased opportunity to review proposed premium increases by an insurance company that has a dominant position in the market and can exercise market power because of that dominant position.

While the explanations related to the bill emphasized medical malpractice, the bill actually would have applied to all Type I insurance. Under the Colorado statutes at 10-4-401 (3), Type I insurance is currently defined as being workers compensation, assigned risk motor vehicle insurance and such other lines of insurance as determined by the Insurance Commissioner. Medical malpractice is defined in statute as being a Type II line of insurance.

The bill, as introduced, would have added a new market concentration description to the criteria that define Type I insurance. That proposed market concentration description was any insurance (property and casualty) written by any insurer that accounted for more than 65% of the total premium written in Colorado for that line of insurance during the most recent calendar year for which information is available. At that time (and still), the only medical malpractice insurer that would have been classified as Type I is COPIC.

However, Colorado law at 10-4-403 (5) gives the Commissioner the discretionary authority to reclassify a Type II carrier to be a Type I carrier under certain market circumstances. This reclassification is for a period of one year and may be extended by the Commissioner. The relevant statute is quoted below:

“(5) Under the commissioner's power to review rates of all companies, if he determines, after a hearing and on the basis of findings of fact and conclusions, that, with respect to any territory or to any kind, subdivision, or class of insurance, competition is either insufficient to assure that rates will not be excessive, or so conducted as to be destructive of competition or detrimental to the solvency of insurers, he shall order that the rates for such insurance or territory shall be regulated as type I kinds of insurance as defined in section [10-4-401](#) (3) (a). Such order shall have a specified duration of not more than one year but may be renewed by the commissioner upon appropriate findings of fact, conclusions, and order.”

### **OPENING UP THE FILE AND USE PROCESS**

Colorado uses two forms of rate review. One is the regulatory doctrine of prior approval and the other is the regulatory doctrine of “file and use.” The bill, as introduced, was designed to remove medical malpractice insurance written by a carrier meeting the new market share test from file and use and to make it subject to prior approval.

As introduced, the regulatory oversight doctrine of file and use would have remained the regulatory doctrine for all medical malpractice insurers other than COPIC. The bill would have, through its market concentration criterion, statutorily declared COPIC to be a Type I insurer and subject to the doctrine of prior approval for its rates. Questions were raised whether singling out a specific company in a statute would violate the Constitutional prohibition against special legislation. It was generally agreed that the bill was structured to use its carefully crafted definitions to avoid the special legislation trap by defining a class. However, there was no independent legal opinion presented on the point.

The bill, as introduced, would have further required the Insurance Commissioner to place on file for public use all filings by an insurer that meets the market concentration standard.

### **THE NEW HEARING OPTION**

Under the provisions of the bill as introduced, a public hearing could have been requested by someone who would be subject to the premium increase that is part of the filing. In addition, a new category of intervener would have been created in the bill for persons who would be designated as being a “qualified person”. This new category will be discussed further on.

The bill set up a three-prong test that must be met before the hearing process is triggered. The first prong would be whether the insurer is a Type I insurer. The second prong would be whether the rate filing calls for a premium increase of 5% or more. And the third prong would be whether the person asking for the hearing is an affected insured or a “qualified person.”

As introduced, the Type I insurer would be subject to the doctrine of prior approval on all rate increases whether a hearing were requested or not. The bill incorporated the 5% increase and the request as the triggers for a public hearing. If the rate increase was less than 5% and no one requested a hearing, the Type I insurer is not released from the prior approval requirement.

Among the things that make this hearing process unique is that the insurer that is the subject of the hearing would be required to bear all reasonable costs of the hearing. Those costs would be determined by the Commissioner. It is not clear whether the insurer would have been required to pay the costs incurred by any interveners. It should be noted that there was no limit on the number of “qualified” persons who may intervene.

### **WHO IS A “QUALIFIED PERSON”**

The bill would have required the Insurance Commissioner to establish the qualifications of persons who would be allowed to intervene as a “qualified person”. While the Commissioner would be the person who would establish the qualifications, the bill set forth certain criteria which must be among those set by the Commissioner. The Commissioner may set additional criteria, but the following criteria must, at the minimum, be met:

- \*The person must be familiar with the insurance laws of Colorado;
- \*The person must have an understanding of the actuarial principles employed in establishing rates and rating systems;
- \*The person must have sufficient expertise to conduct a technical examination of a rate filing;
- \*The person must have sufficient resources to intervene in the rate filing process; and,
- \*The person must display the willingness and ability to represent the interests of insurance consumers in Colorado and must accept a “duty of fidelity” to so represent them.

As the bill was written, a “qualified person” is essentially a consumer advocate by his or her own declaration, and does not enjoy the status of having been appointed by a public official such as the Governor, the Attorney General or the Insurance Commissioner. By comparison, the fixed utilities industries that are regulated by the Public Utilities Commission are also subject to having their rates and service policies scrutinized by the Office of Consumer Counsel. The OCC is an agency of state government, and must adhere to the various state processes and oversight controls. The bill would have created a new specialty of ad hoc interveners.

The bill did not have a conflict of interest disqualification criterion so an attorney who is in an adversarial role with the insurer could have intervened in a rate filing. The bill did not require a qualified person to have a nexus with Colorado. As written, a person who met the qualification criteria but who lives in, say, Washington, DC could force a hearing. These provisions would have allowed any number of self-styled consumer advocates to intervene in Colorado rate filings.

On the other hand, the bill did not require that the intervener necessarily be opposed to the rate filing. An intervener who met the qualifications for being a “qualified person” may have intervened in support of the rate filing. As a strategic defense, an insurer which had been the subject of a request for a public hearing under the bill may have arranged for qualified persons to intervene on its behalf to not only support the filing but also to challenge and discredit qualified persons who were intervening in opposition to the filing.

The bill did not set a limit on the number of interventions that could be filed by qualified persons. As the bill was written, every request for a hearing would have to be honored by the Insurance Commissioner. Moreover, the bill did not provide for consolidation of interventions into one single hearing.

The easiest way for an insurer to have avoided the public hearing was simply to file adjustments that were less than 5%. There is no limitation on how often an insurer may file rate increases. A 12% increase could simply have been accomplished with 3 separate filings for a 4% increase. In fact, that is most likely what would have happened. An insurer seeking to avoid a public hearing and taking into account time frames for filing, approval and notifying insureds would be motivated to be in continual filings rather than waiting for one large filing.

### **THE PUBLIC POLICY RATIONALE IS NOT CLEAR**

The bill as written did not have a clear or concise public policy rationale, or a definitive description of the market failure that the bill presumably addressed. The bill did contain one odd repealer that did not seem to be warranted. Under current file and use standards, the Insurance Commissioner is tasked with the responsibility of determining that rates are neither excessive nor inadequate and that they are not discriminatory. Current law then clarifies that a rate will not be held to be excessive unless it is unreasonably high for the insurance being provided and *a reasonable degree of competition does not exist in the area with respect to the classification to which the rate would be applicable*. The bill would have repealed the noted latter criterion that addresses market competition.

This repeal was odd. The bill did not abolish file and use as a regulatory process for Type II insurers. It is not clear why the market competition criterion would be abolished since it would be one of the guiding principles for the Insurance Commissioner to make his or her determination by in the event that the filing was made by a Type II insurer. The repeal would have denied the Commissioner use of the market competition criterion.

The bill did not establish a threshold case that a strong market penetration is linked to market abuses. Nor is there any indication that if an incumbent insurer with a strong market penetration were to engage in predatory market conduct that the State of Colorado would not be able to correct the abuse using existing tools. In fact, current law expressly allows the Insurance Commissioner to gain control over rates that are so low that they would have the effect of injuring competition.

A problematic aspect of the bill was that there did not seem to be any proponents who were actually affected by medical malpractice insurance. There were no physicians insured by COPIC who publicly stated that there is a lack of adequate information available to them that the bill would have corrected. Nor had either the Attorney General or the Division of Insurance come forth and asked for more investigatory powers or regulatory tools. And, there were no known complaints from COPIC's competitors that COPIC had used its market power to injure competition. In fact, Colorado enjoys some of the lowest medical liability premiums in the nation which is an indication that the market is working.

Simply because an entity has a strong market presence is not in and of itself a market failure. If the entity achieved that status through the normal workings of the market and the entity does not exercise its market power to impair competition, there is nothing inherently wrong with the market. In many cases, such a market may be extremely stable and that stability may provide the customers of the entity with many advantages. Medical liability is a different set of

circumstances than other lines of insurance or products. Because there are long periods of time associated with statutes of limitations and statutes of repose, stability in the market together with long business relationships between the insurer and the physician should be considered positive market conditions. Physicians would be harmed by an unstable market in which insurers regularly enter and exit the market with volatile premiums.

### **THE BILL AS AMENDED BY THE SENATE**

As the bill passed the Senate, it would have classified medical malpractice insurance as a Type I line of insurance thereby affecting all licensed carriers the same. However, the reclassification of medical malpractice as a Type I line of insurance would only have become effective on May 1, 2008 if the Health Care Task Force issued a report based on a summer 2007 study that the reclassification would be warranted. However, the actual language of the bill did not preclude the regulatory change from going into effect if the Task Force delivers a negative report.

### **CLARIFYING THE ISSUES**

It is a frustrating experience when testimony given before legislative committees fails to inform or clarify important public policy issues. Such was the case when SB07-248 was heard before the Senate Judiciary Committee, was subsequently debated on the Senate floor and as passed on Senate 3rd reading. Many of the following discussion points rely on economic theory because the issues raised in committee and on the floor were largely about market domination and market power that COPIC is presumed by the bill proponents to both possess and use.

Even though many of these discussion points refer to COPIC, please bear in mind that the bill was amended to apply to the entire line of medical malpractice insurance written by all carriers doing business in Colorado.

### **IS COPIC A MONOPOLY PROVIDER?**

It was frequently asserted in committee and on the floor that COPIC is a monopoly provider of medical malpractice insurance and because of that monopoly power can adjust its rates unilaterally to the great disadvantage of its physician insureds.

The assertion is not true. COPIC is not the only medical malpractice carrier writing insurance in Colorado. According to public information gathered and published by the Colorado Division of Insurance for the year 2005 (the most recent full year available), there were 107 insurance companies authorized to write medical malpractice insurance in Colorado. That number is, however, misleading. The data base does not distinguish among the types of licensed professionals who are insured by the various carriers. While some of the carriers insure physicians, other carriers insure podiatrists, optometrists and other licensed health care professionals. The use of direct written premiums is a dollar value, and there is no good way of adjusting the data for the more expensive lines of insurance vis-à-vis the lower premium lines. As a general characterization, physician malpractice premiums are higher than those for nonphysician professionals. Moreover, some of the carriers have not written any coverage even though they may be authorized to do so. Of the 107 carriers, a total of 60 actually wrote policies and collected premiums in 2005.

The market for medical malpractice insurance in Colorado is an oligopolistic market, not a monopoly market. Oligopoly (dominated by a few providers) markets take on many forms and characteristics and are a very common market structure in the United States. There is nothing inherently wrong with oligopolies although it is generally considered that they exhibit several types of inefficiencies. What is important to understand is that firms in an oligopolistic market *cannot* exercise unilateral market power as a monopolist can. Firms in oligopolistic markets must take into consideration what the reaction of their competitors may or may not be, and whether the firm making the market move (e.g., increasing prices) can do so no matter what its competitors might do to react.

It is true that COPIC is the largest carrier in what is a concentrated market. According to the DOI statistics, COPIC had a market share of 57.62% for the year 2005. The closest competitor to COPIC was The Doctors Company with a market share of 7.55%. The third largest carrier was Preferred Professional Insurance Company (which is affiliated with the Exempla system) with a market share of 4.77%. The fourth largest carrier was Lexington Insurance Company (which is a member company of the AIG Group) with a market share of 4.37%.

These market shares were calculated by the Division of Insurance as a percentage of direct premiums written. While an insurer may restrict its coverage to a certain profession (physicians, podiatrists, etc.) the percentage calculated by the DOI was across all direct premiums written across all professions. However, this does not have a material effect on the calculations since only COPIC has a market share in the double digits. All other carriers have market shares of less than 10%. The overwhelming majority of the carriers have market shares of less than 1%. Adjusting for nonphysician coverage would not affect the statistics significantly.

It should also be kept in mind that all licensed health care professionals are included under the Health Care Availability Act limitations on damages and other provisions. The only exception to the coverage by the HCAA is for health care professionals who are under Colorado Governmental Immunity. Even if a carrier does not insure physicians, it is highly likely that the carrier's insureds are licensed health care professionals subject to the HCAA. Thus, any manipulation of the data to exclude nonphysicians from the medical malpractice data base would be inconsistent with the HCAA.

A concentrated market is not a monopoly market.

There are three commonly used ratios to determine the degree of concentration in a market. They are the Four-Firm Ratio, the Eight-Firm Ratio and the Herfindahl-Hirschman Index.

In using the Four-Firm Ratio, the four largest firms in the market are aggregated to determine what percentage of the market they represent. In the Colorado medical malpractice market, the four largest carriers collectively accounted for 74.31% of the market as demonstrated by the 2005 data.

In using the Eight-Firm Concentration Ratio, the top eight carriers in Colorado had a collective market share of 82.36%.

These two ratios indicate that the medical malpractice market in Colorado is a concentrated market, bordering between being considered on the high end of being moderately concentrated to the lower end of being highly concentrated. The groupings for determining market structure using these ratios is that if the concentration ratio is greater than 40%, the market is determined to be oligopolistic. The break point between being classified as moderately concentrated and highly

concentrated is a ratio of 80%. The Colorado medical malpractice market is just above that ratio using the Eight Firm calculation and just below that ratio using the Four Firm calculation.

The third most commonly used analytical tool, and the best, is the Herfindahl-Hirschman Index used by the Department of Justice and the Federal Trade Commission when evaluating potential horizontal mergers that might result in greater post merger market concentration. The HHI is a very simple formula that aggregates the squares of the market shares. When applied to the Colorado market the HHI also shows that the medical malpractice market is concentrated.

However, simply because a market is concentrated does not *a priori* indicate that it is not competitive or that it fails to function adequately. In a recent study of medical malpractice insurance markets in the states conducted by economists at George Mason University, it was shown that in the particular case of medical malpractice insurance that premiums are actually demonstrably lower in concentrated markets than in unconcentrated markets.

The more relevant question than whether COPIC is a monopoly provider or that the market is characterized by oligopoly is whether COPIC can exercise market power to either increase premiums without regard to what its insureds and its competitors will do or whether COPIC can exercise market power to undercut competitors and force them into a loss situation and out of the market.

If the assertion advanced by the proponents were true, we would expect to see as a result of the highly concentrated market with a dominant incumbent market leader that premiums would be among the highest in the country. Colorado premiums are in actuality among the lowest in the country.

The proponents failed to substantiate a case that COPIC can exercise monopoly power in the Colorado market.

### **IS COPIC'S AFFILIATION WITH THE COLORADO MEDICAL SOCIETY A BARRIER TO MARKET ENTRY?**

It was frequently asserted that the long-standing relationship between COPIC and CMS acts as a barrier to market entry for competitors and allows COPIC to maintain its market domination. This issue was debated quite extensively. The proponents claimed that the relationship does pose a barrier to market entry. The opponents claimed that market incumbency does not constitute a barrier to market entry. Generally, it is considered that there are five market conditions which individually or collectively can be considered to be barriers to market entry: economies of scale, the special advantages provided by geographic location, the importance of sunk costs of the entity seeking entry, a dominant position in the ownership of resources or other production inputs, and governmental restrictions through law and regulations. It is possible, and perhaps quite likely, that COPIC has managed over the past 20 years to achieve a strong market position because of economies of scale and its geographic location, but that is not the same thing as saying that there are significant barriers to market entry that protect COPIC from competitors.

The data compiled by the Division of Insurance shows clearly that there are several alternative carriers available to physicians. Given that there are 107 such carriers, and even adjusting for the professions insured and the fact that not all of the carriers are actually writing insurance, it seems fair to conclude that the market is not all that hard to enter. Undoubtedly COPIC's long-standing relationship with CMS provides them a strong competitive position. However, COPIC does not have the luxury of being able to disregard existing or potential competitors. Recent history has

shown that other markets that were characterized by a dominant incumbent provider have broken down under pressure from competitors. AT&T was a strong monopoly protected by governmental barriers yet advances in technology and the relaxation of governmental regulations resulted in a highly competitive market. Even the monopoly granted the US Postal Service has eroded in the face of competition from FedEx.

While COPIC may enjoy a large number of insureds due to its long-standing relationship with the CMS, that relationship is not tantamount to being a barrier to market entry. Many market options exist and may be exercised in the event that insured physicians become disenchanted with COPIC's premiums or services. The CMS might open its endorsements to other carriers as well as to COPIC. The CMS might discontinue endorsements of any carriers. National physician specialty organizations might begin to provide strong endorsements of other carriers on a national basis. Physicians might turn to risk retention groups as an alternative to COPIC. There are many options which if employed could overcome COPIC's market share.

It should also be noted that a physician is not required to be a member of the Colorado Medical Society to secure malpractice insurance or to practice medicine in this State. Nor is a physician who is a member of the Colorado Medical Society mandated to have COPIC as his or her insurer.

### **DOES THE DIVISION OF INSURANCE HAVE ADEQUATE TOOLS TO REGULATE COPIC?**

There were many assertions that the DOI does not have the regulatory tools necessary to review the pricing and behavior of COPIC. However, no evidence was put forward to demonstrate that the assertion is true and no description of the regulatory tools currently available was presented. The assertion went unchallenged. To a large extent this assertion has been the foundation for the argument that COPIC needs to be regulated as a Type I line of insurance which gives the Insurance Commissioner increased oversight of a carrier's premiums and policies before they become effective.

As noted in a preceding section, Colorado employs two regulatory schemes in insurance. There is the doctrine of "prior approval" employed for Type I lines of insurance and there is the doctrine of "file-and-use" for Type II lines of insurance. As amended, SB07-248 sought to reclassify all medical malpractice insurance as being a Type I line of insurance thus increasing the Commissioner's jurisdictional reach. Under current Colorado law, Type I insurance is listed as being workers' compensation, assigned risk motor vehicle insurance and such other lines of insurance as determined by the Commissioner. Currently, Type II insurance covers all others including medical malpractice.

However, Colorado law allows the Commissioner at his or her discretion to reclassify any Type II insurance to being a Type I line of insurance. The Colorado law also gives the Commissioner considerable authority to pursue predatory practices that might be engaged in by a carrier. Generally, these practices are analogous to the antitrust violations found in federal and state law, and the statute provides injured parties a right of private action in addition to regulatory relief.

### **DO PHYSICIAN INSUREDS HAVE REGULATORY RECOURSE AGAINST A CARRIER?**

Several individuals mentioned that they did not believe that physicians insured by COPIC have adequate recourses under Colorado's Insurance Code. However, no information was supplied that

would lend credence to the assertion. Whether COPIC's insureds have open or restricted access to COPIC's internal data is a matter between COPIC and its insureds. Colorado law allows an insured to file complaints with the Division of Insurance which then get investigated. The DOI has numerous options to both investigate complaints and to order various corrective actions against an errant carrier. No information was presented that any physician had ever filed a complaint with the DOI that the DOI had refused or was unable to pursue an adequate inquiry under current Colorado law. It must be concluded absent any information to the contrary that this assertion is without substantiation.

It should be noted that under Colorado insurance law all filings to include all supporting information and data become public record and accessible by the public upon the receipt of the filing by the DOI.

### **IS FILE-AND-USE OR PRIOR APPROVAL THE BETTER REGULATORY DOCTRINE?**

SB07-248 as amended would have mandated the application of the doctrine of prior approval to medical malpractice insurance. There seemed to be a presumption that prior approval is a better regulatory practice than file-and-use. However, no information was presented which shows that file-and-use is not adequate or that prior approval would be better. Nor was any information provided that showed that if, in the judgment of the Commissioner a reclassification from Type II to Type I is warranted, that the reclassification from Type II to Type I could not be accomplished in an expeditious manner. Moreover, Colorado law allows the Commissioner to continue the reclassification on a year-to-year basis.

The answer to the rhetorical question is most likely, "It depends." A more useful inquiry would be to survey the other states to see which rely on file-and-use or prior approval for medical malpractice insurance. And, a very enlightening piece of information would be whether there is a trend toward file-and-use or prior approval. If, for example, the use of prior approval is declining in the other states, the obvious question would be why the provisions of SB07-248 were moving against the trend.

Under Colorado law, a medical malpractice insurer must give 90 days notice of a unilateral premium increase or benefit decrease by first-class mail to the affected insureds, and that notice must contain the reasons why the change is being made.

In direct discussions with senior staff at the DOI it became clear that the file-and-use process in Colorado is quite structured. As described by the staff, once a carrier submits a rate increase filing with the DOI, a number of flags and reviews are set in motion. If the carrier is a domestic insurer, such as COPIC, the filing is automatically flagged for a thorough review of the proposed rate increase to see if it meets the statutory criteria for fairness, nondiscrimination, adequacy, etc. This review may also trigger an automatic review by the DOI actuaries who apply the same actuarial principles to the review whether the filing is governed by prior approval or by file-and-use. Generally, the DOI has 15 business days to determine whether the filing is complete and to identify deficiencies. If deficiencies are found, the DOI contacts the carrier for corrections. The Commissioner has the authority to take any filing to a public hearing, and as noted previously the Commissioner can also elect to reclassify the request so that it is reviewed under the doctrine of prior approval. Very often the DOI will enter into a process of alternative dispute resolution with the carrier to negotiate a rate lower than that which was proposed in the filing.

This description is somewhat superficial but it is a fair representation of the process of review that is employed under file-and-use.

What is important is that the proponents did not create a threshold case that file-and-use regulation is inadequate or that prior approval would be better. And, even if prior approval is a better regulatory process for medical malpractice, the proponents did not put forward a threshold argument that the Commissioner has failed to exercise his or her prerogatives to reclassify the line of insurance as a Type I insurance.

### **IS COPIC'S SURPLUS TOO HIGH?**

The bill proponents argue that COPIC's surplus is too high and is an indication that its premiums are too high. Insurance is replete with industry specific terms of art the meaning of which may not be clear to a person with little contact with the industry. "Surplus" is such a term of art. It means the amount of money that is available to protect policyholders in the event of unusually high claims. It is determined by subtracting liabilities from assets. The proponents of the bill continually asserted that COPIC's surplus was far in excess of any regulatory standard and could not be justified.

The chief witness for the Trial Lawyers, Mr. Jay Angoff (a personal injury lawyer and former Missouri Insurance Commissioner) made the surplus issue the cornerstone of his testimony. Mr. Angoff, while attacking COPIC's surplus, maintained strongly that surplus is an indispensable part of a carrier's financial solvency and must be adequate and strong. Mr. Angoff stated that the National Association of Insurance Commissioners has established a percentage for insurance surplus and that COPIC's surplus was many multiples above that standard. Mr. Angoff also asserted that he believed the NAIC ratio was too low and that surplus should be considerably more. He was, however, unable to provide any kind of guidance or standard to determine what is an appropriate surplus.

Unfortunately, Mr. Angoff was the only witness who discussed the surplus question. And, even more unfortunately it was demonstrated quite clearly that Mr. Angoff's work has not been embraced by regulators or actuaries. In fact, there are some well reasoned and articulate denunciations of the quality of his research, his use of flawed methodologies, his reliance on incomplete statistical data and a host of other substandard research protocols that have been published by very reputable entities including the NAIC. In short, Mr. Angoff suffers from a series of serious challenges to credibility and impartiality.

What was missing from the discussion was information relative to what Colorado requires in the way of capital, reserves and surplus. Without that factual information, it is an exercise in futility to speculate whether COPIC's surplus is excessive, just too high, just right, a tad low or dangerously low. When Commissioner Morrison testified in support of the bill in Senate Judiciary Committee, she offered no information or testimony about any regulatory standards used by the DOI, and no one inquired.

### **THE "QUALIFIED PERSON" GAMBIT**

When all of the arguments and hyperbole are dispatched, this bill came down to one issue. That issue was the creation of a new class of intervener in rate filings made by property and casualty insurers. The bill, as noted in a preceding section, created a designation of a "qualified person" who was empowered to request the Commissioner to conduct a public hearing of any proposed rate increase of a medical malpractice insurer that is greater in aggregate than 5%. While the bill

gave superficial authority to the Commissioner to set the qualifications of a person who is to be accepted as a "qualified person", the bill set forth certain threshold criteria that the Commissioner must include in his or her criteria.

Since those criteria were set forth in the preceding section, they will not be repeated here. It should be a red flag that this person does not have to have any affiliation with the insurer or the insureds. This person is no more than a self-anointed intervener. Nor does the individual need to have any tie to Colorado, and does not need to have ever set foot in Colorado. Nor is there any requirement that the Commissioner establish criteria to disqualify a person who may be in an adversarial relationship with the targeted insurer.

It is not clear under what Colorado Constitutional provision the General Assembly can extend such authority to a person with no nexus to Colorado, is not a party to the insurance contract and who does not have to disclose any conflicts of interest.

### **BILL WITHDRAWN**

After the bill passed the full Senate, it was sent to the House where the Speaker assigned it to the House Health and Human Services Committee. During the period while the bill was being scheduled for hearing, the Colorado Medical Society became assertively involved. The leadership of the CMS met with the leadership of the CTLA to discuss the bill. The legal counsel for the CMS had reviewed the insurance statutes and was able to provide the CMS leadership with very sound discussion points. The leadership of the trial lawyers proved to be extraordinarily uninformed and unprepared for the discussion.

Following a lengthy discussion, the CTLA agreed to withdraw the bill. The CTLA met with the bill sponsors and asked that the bill be withdrawn. The sponsors acceded to the request. The bill was given a perfunctory hearing in committee and was killed on a unanimous vote.