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PROFESSIONAL ISSUES

Where does money go in malpractice cases?

Quick View. Nov. 3, 2003.

In a typical tort case, costs are broken down this way:

| | |
|-------------------------------|-----|
| Plaintiff attorneys | 19% |
| Recovery (economic losses) | 22% |
| Recovery (noneconomic losses) | 24% |
| Defense attorneys | 14% |
| Administrative costs | 21% |

Source: Tillinghast-Towers Perrin, as published in a study by the Center for Legal Policy at the Manhattan Institute, "Trial Lawyers Inc., a Report on the Lawsuit Industry in America 2003"

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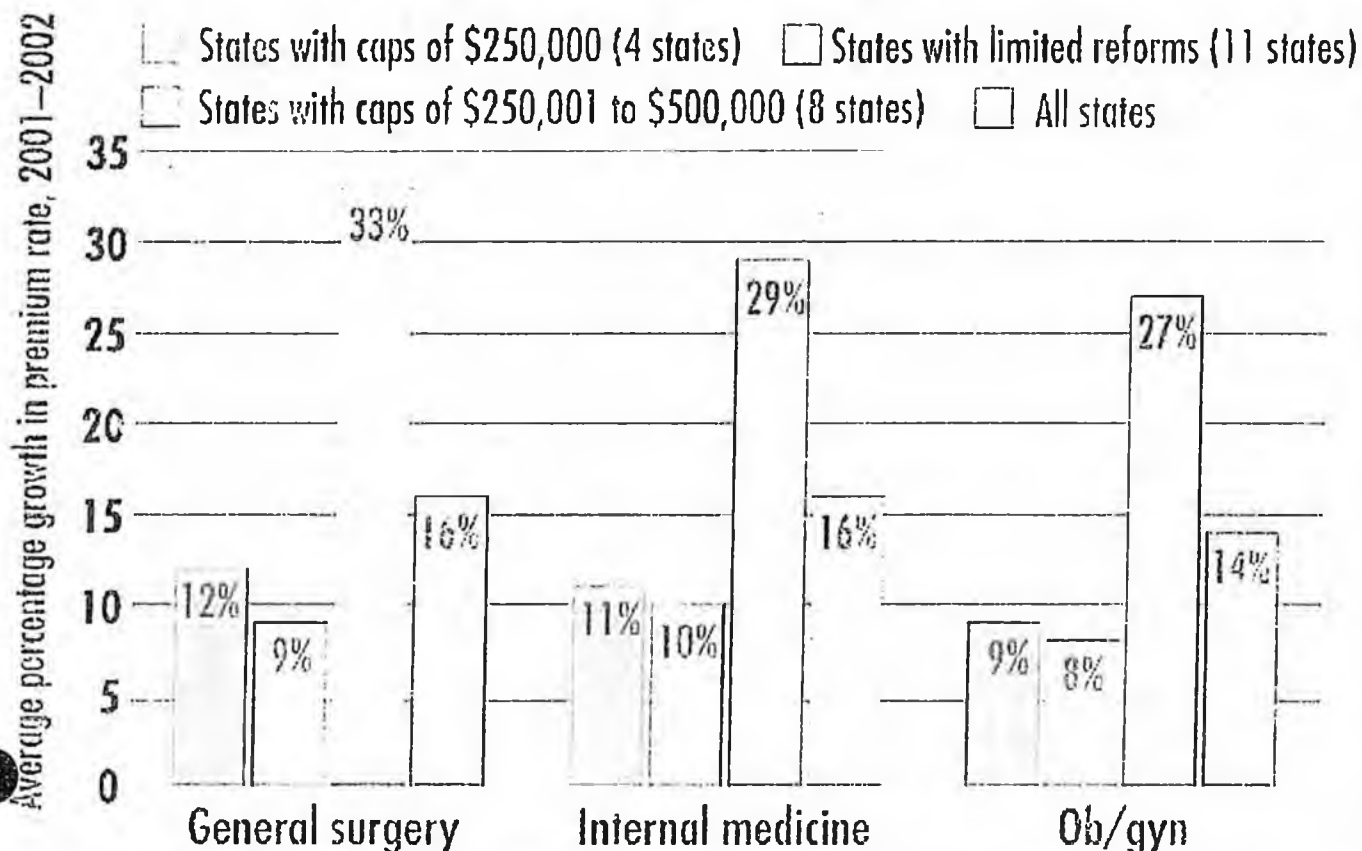
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AMA - Medical Malpractice Environment from a Practitioners Viewpoint
 AMA has ranked the states in terms of their members ability to obtain Professional
 Liability coverage at an affordable rate –

| States in Crisis – | States Showing Problem Signs | States OK |
|--------------------|------------------------------|------------|
| Arkansas | Alabama | California |
| Connecticut | Alaska | Delaware |
| Florida | Arizona | Indiana |
| Georgia | Delaware | Louisiana |
| Illinois | Hawaii | New Mexico |
| Kentucky | Idaho | Wisconsin |
| Mississippi | Iowa | |
| Missouri | Kansas | |
| Nevada | Maine | |
| New Jersey | Maryland | |
| New York | Massachusetts | |
| North Carolina | Michigan | |
| Ohio | Minnesota | |
| Oregon | Montana | |
| Pennsylvania | Nebraska | |
| Washington | New Hampshire | |
| West Virginia | North Dakota | |
| Wyoming | Oklahoma | |
| Wyoming | Rhode Island | |
| | South Carolina | |
| | South Dakota | |
| | Tennessee | |
| | Utah | |
| | Vermont | |
| | Virginia | |
| | | |

STATE TORT REFORMS SLOW PREMIUM GROWTH

Recent premium growth was lower for three physician specialties in states with noneconomic damage caps



Note: GAO analysis of Medical Liability Monitor base premium rates, excluding discounts, rebates and surcharges, reported for the specialties of general surgery, internal medicine and ob/gyn. Premiums are adjusted for inflation to 2002 drivers.

Source: General Accounting Office

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THE NEWSPAPER FOR AMERICA'S PHYSICIANS

PROFESSIONAL ISSUES

Tort crisis spreads, few signs of abating

But reforms enacted in some states did provide a few bright spots in 2003.

By Tanya Albert, AMNews staff. Dec. 8, 2003.

Rallies to express outrage over medical liability insurance rates. Marathon legislative sessions debating tort reform. Countless calls and letters to lawmakers explaining that high rates and fewer insurers to choose from are detrimental for physicians already seeing low payments from Medicare, Medicaid and managed care.



It's been a busy year for physicians battling the medical liability insurance crisis. And doctors in many states say they are in a worse position as 2003 draws to a close than they were when the year started.

| |
|--|
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| ■ Most states in or approaching a liability crisis |
| ■ Setting limits |
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| ■ Topic: Liability crisis |
| ■ Regional news: States |

Local newspapers in Missouri, Illinois, Wyoming and other states carry stories about physicians closing their doors. The AMA added seven states to its crisis list, bringing the total to 20.

And next year is shaping up to be worse of the same.

"Over this past year, the crisis has led to access to care for patients, has worsened the crisis," says AMA

President Donald J. Palmisano, MD, who has spent the year crisis-crossing the nation stumping for tort reform. "Without meaningful reforms, the crisis will get worse, and patient access will continue to decrease."

5 states in 2003 enacted reforms with caps on

After seeing initial signs of such problems this year, Maryland, Wyoming, Missouri, Illinois and Kentucky fear that they are on the verge of even bigger headaches in 2004.

"Joliet, Kankakee, you name it. It's all over the

noneconomic damages.

state," said Illinois State Medical Society President William E. Kobler, MD.

In November, two neurosurgeons in Rockford, Ill., announced that they were giving up practice. A number of physicians have given up obstetrics, and anesthesiologists and neurosurgeons have stopped practicing in parts of southern Illinois.

Obstetricians and neurosurgeons in Missouri have seen the impact as well. In early 2003, there were 98 neurosurgeons practicing, said David F. Jimenez, MD, president of the Missouri State Neurosurgical Society. As he gears up for another study of the situation, he expects to find at least 10% fewer practicing in the state now.

"It's definitely affecting care," Dr. Jimenez said.

In Maryland, several insurance companies have left, obstetricians in rural areas are leaving, and the shore area has lost some of its most experienced OBs, said T. Michael Preston, Maryland State Medical Society executive director. For the first time, none of the graduates from the University of Maryland School of Medicine went into obstetrics, he said. Neither that school nor Johns Hopkins School of Medicine filled their OB residency slots on the first round.

19 states are in a medical liability crisis.

"We're on the cusp of a real crisis here," Preston said.

In Wyoming, the state Legislature-created Wyoming Healthcare Commission found that there hasn't yet been a mass exodus of physicians, but physicians are slowly and steadily leaving the state.

And in Kentucky, obstetrical care is increasingly difficult to find. Family physician Steven Sartori, MD, is part of an eight-physician group that had to give up obstetrics. They were the only physicians delivering babies at Knox County Hospital in Barbourville, which boasts a new nursery and new labor and delivery rooms.

"The place is beautiful, and now it's sitting empty," Dr. Sartori said. "Patients are having to drive farther for care."

Caps pass in five states

Physicians in 2003 saw an increase in the public's and lawmakers' awareness of the problems created when liability insurance becomes unaffordable or unavailable. And they succeeded in getting reforms that included caps passed in five states.

"It's a gain over the previous year when only three states passed a cap," said Kathryn Moore, director of state legislation for the American

College of Obstetricians and Gynecologists.

Texas passed comprehensive reforms that included the \$250,000 cap on noneconomic damages that physicians say is essential to controlling costs. Voters then approved a constitutional amendment so that the law won't be subject to court challenges.

Legislatures in Idaho and West Virginia reduced existing noneconomic damage caps to the coveted \$250,000 mark. Florida adopted a \$500,000 cap for physicians in most cases, and Oklahoma established a \$300,000 cap for care involving pregnant women and for emergency care.

Although tort reform doesn't mean instant relief, Texas doctors say they believe an end is in sight.

"Every physician in Texas got six inches taller," said Texas orthopedic surgeon David Teuscher, MD, vice president of the Jefferson County Medical Society.

"Physicians are practicing with a little more relief now," added Juan Jimenez, MD, a general surgeon from McAllen, who was active in getting Texas' tort reform passed.

On the 2004 agenda

Doctors will continue pushing tort reform at state and federal levels.

Legislative battles are expected in Maryland, Missouri, Connecticut, Washington and Kentucky, to name a few. And many are hoping for relief on the federal level because state laws make it too difficult to put meaningful reform in place. Several states need a constitutional change to enact a cap on damages. Others, such as Illinois, have a Supreme Court that has struck down reforms in the past and is nearly guaranteed to strike it down again.

A federal bill with a \$250,000 cap passed the House in the spring, but a similar bill failed in the Senate. The AMA and others expect the bill to come back before the Senate in 2004.

"The pressure," Dr. Palmisano said, "is going to build to do something very quickly as states continue to melt down."

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ADDITIONAL INFORMATION:

Most states in or approaching a liability crisis

The American Medical Association this year added seven states -- Arkansas, Connecticut, Illinois, Kentucky, Missouri, North Carolina and Wyoming -- to its list of states that are in a medical liability insurance crisis, bringing the total to 19.

The Association in 2003 also elevated two states -- Hawaii and Rhode Island -- to the "showing problem signs" category. As the year draws to a close, that leaves six states that are considered to be "OK" because of tort reforms in place.

In crisis: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, Wyoming

Showing problem signs: Alabama, Alaska, Arizona, Delaware, Hawaii, Idaho, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia

Currently OK: California, Colorado, Indiana, Louisiana, New Mexico, Wisconsin

Source: American Medical Association

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Setting limits

The AMA considers a \$250,000 cap on noneconomic damages essential to tort reform. Here's how state legislatures that enacted tort reform in 2003 handled these "pain and suffering" damages caps.

Florida adopted a \$500,000 cap for individual physicians in most cases and a \$1 million cap that one or more plaintiffs can collect against multiple physicians.

Idaho rolled back an existing \$400,000 cap to \$250,000. Starting July 1, 2004, that cap will be adjusted annually based on the average annual wage.

Oklahoma established a \$300,000 cap for pregnancy, labor and delivery or immediate postpartum care cases; and emergency department care or follow-up medical services. It sunsets in five years.

Texas passed a \$250,000 cap per claimant, no matter how many defendant physicians. Voters later approved a constitutional change that

makes the cap constitutional.

West Virginia reduced an existing \$1 million cap to \$250,000 for most cases. The limit will be adjusted annually for inflation up to \$375,000 per occurrence.

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May 2003 - Volume XVI, Number 5

Worsening of Med Mal Market Expected to Continue in 2003 - Rate Increases Likely

by Medical PL Symposium Recap Article

Deterioration in operating profitability, weakened capitalization, inadequate loss reserves and greater retention levels continue to wreak havoc on the medical malpractice market, making it more challenging for those insurers willing to write new business, panelists told the PLUS Medical PL Symposium.

Victor T. Adamo, JD, president, ProAssurance Corporation, noted that premium increases and stricter underwriting decisions have added more pressure and more staff demands. "For the survivors in the business, there is the burden of constantly conveying bad news," he said. "Investments no longer provide a major advantage in long-tail lines. For reinsurers, it means more business and less relationship."

According to Adamo, rate adequacy is critical to companies avoiding price-driven markets and there are also regulatory barriers. "Unreasonable regulators are causing time-consuming approval and review processes."

Adamo explained that there is over \$1 billion of displaced premium in the market and that it is unclear whether small start-ups may be able to grow surplus enough to make a meaningful contribution to capacity. "A financial crunch restricts capital growth."

Looking at hospital medical professional liability from the excess insurers' perspective, Judy Hart, executive vice president, Endurance Specialty Insurance, Ltd., said that volatility never seems to go away, but is increasing further. "Next to earthquake insurance, medical malpractice is the most dangerous line of insurance."

According to Hart, for 2003, there are further rating downgrades, additional retrenchment and withdrawal from the market and continued pricing and retention increases. "There is also new capacity and greater consideration of alternative options by clients with predictable loss exposure. Increased risk financing expenditures will cause greater clinical risk management and proactive claims defense."

Hart noted that the tort system is out of control. "Tort costs in the U.S. consumed two percent of GDP annually on average since 1990 and is expected to rise 2.4 percent of GDP by 2005," she said. "The tort system is extremely inefficient. Only 20 percent of the tort dollar compensates victims for economic losses and at least 58 percent of every tort dollar never reaches the victim."

Hart, who sees med mal as a market "correction" rather than a "crisis," said that the sophistication of the plaintiff's bar, a trial bar flush with cash and an erosion of tort reform to accept junk science have been factors driving severity. "There are some deep judicial 'pits' and a jury desensitization to 'deep pockets syndrome.' There are also some corporations that just do really dumb things."

In order to meet the challenges, Hart says first-rate underwriting and claims management knowledge are needed. "This is a great opportunity to learn from our mistakes. World class selling and negotiation skills are critical and health care specialists with technical expertise who can rise to the top will make a difference."

Matthew G. Fay, FCAS, MAAA, senior vice president, Converium, predicted that the medical malpractice market was going to get worse before it got better. "Loss ratios will continue to deteriorate," he said. "Reserve deficiency will wreak havoc on income statements and hurt companies. That's why it's so important to stay up to date."

Fay said that with the hardening of the market more reserve strengthening is on the way. "Increases on the primary side weren't enough and will continue to drive rates up higher," he said. "Without tort reform, there will be a more severe second round of rate increases. The industry has done a tremendous amount of work to get us back in place, but we have to pay more attention to rates."

Looking at the provider/captive market perspective, Anthony Mercurio, managing director, Marsh Healthcare Practice, said that there are differences in the hard market today than in the past that compound the problems. "In the past, most insurance buyers were imbedded in a cost-plus system. Today, it's not true. We're not going to be as elastic as we were in the past."

Mercurio said that there are alternatives in the market such as self-funding, group captives, PRUE captives and others. "While we're not immune from increased severity and lower investment returns on funded assets, ROI expectations are lower. In addition, many have engaged in a focused effort to reduce losses, most have lean budgets and have a camaraderie among their members that is very impressive."

Mercurio added that tort reform needs to be implemented at the grass roots level. "It has to start with doctors."

The panel was moderated by Paul A. Greve, Jr., RPLU, Senior Vice President at Willis Healthcare Practice.

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Medical Professional Liability - Not for the Faint of Heart

by Deborah Ropelewski

The A.M. Best 2003 Property/Casualty Review Preview(1) proclaimed that "Given the continued deterioration in operating profitability, weakened capitalization, uncertainty in the adequacy of loss reserves because of the heightened severity of claims and adverse trends, increased reinsurance costs and greater retention levels, A.M. Best views the outlook for the medical malpractice sector as negative." And if that's not enough to scare you, The Insurance Information Institute, based on A.M. Best's combined ratio data, estimates that Medical Professional Liability is one of the most dangerous lines of insurance, second only to earthquake (property) coverage.

The 2003 Conning Research and Consulting Study, "Medical Malpractice- Anatomy of a Crisis 2003,"(2) identified four key dimensions to the ongoing financial crisis being experienced by the Medical Professional Liability (MPL) industry:

1. A sustained escalation of underwriting losses,
2. A decline in investment income,
3. An epidemic of national proportions, and
4. There are emerging marketplace issues as carriers withdraw from the business and suffer rating downgrades.

It goes on to say, "Barring significant and rapid reform, we forecast no end to the industry's current financial problems. If, as expected, industry combined ratios remain at or near 2001 levels, the cumulative impact of a multiyear period of underwriting losses will be to deplete the industry's capital."

Perhaps it would help to take a closer look at the four issues that the Conning study(2) has identified, in order to glean a further understanding of what is happening in the MPL industry today.

A SUSTAINED ESCALATION OF UNDERWRITING LOSSES

The Conning study(2) makes the observation that "the root cause of today's crisis can be found in severity, i.e., a higher level of loss per paid claim." Whether you look at the data from the PIAA data-sharing project or individual company data, it will typically bear out the fact that frequency has either remained flat or even declined over the last few years. The Conning Study(2) indicates that the frequency, measured in terms of number of claims per 1000 doctors, declined from a high of 57 per 1000 doctors in 1996, to less than 50 per 1000 doctors in 2001. Severity, however, is quite another matter:

- A study done for the U.S. Department of Health & Human Services (HHS) dated July, 2002(3), indicates that the average award rose 76% in the period from 1996 to 1999. The median award increased 6.7% from 1998 to 1999, and another 43% in 1999-2000, or from roughly \$750,000 to \$1,140,000 in the two-year period from 1998-2000.

- The HHS study(3) notes that Jury Verdict Research data(3) reflects that the average jury award went from \$1,140,000 in 1994 to \$3,480,000 in 2000- a whopping 305% increase!

- The PIAA Data Sharing Project(4) illustrates that in 1985 less than 10% of all paid claims were

over \$250,000; by 2001 the number had jumped to over 40%. Likewise, less than 5% of all paid claims in 1985 were over \$500,000, but this had increased to over 25% by 2001.

A DECLINE IN INVESTMENT INCOME

Lower interest rates continue to depress the companies' investment income, and the days in which investment income could help to offset, at least partially, the underwriting losses are becoming a distant memory.

Not only are the returns so much lower than those enjoyed in years past, but the timeframe within which a company may invest the funds until the resolution of a claim is being compressed over time, further reducing the flow of investment income. Jury Verdict Research, as noted in the HHS study(3) reports that:

- The average number of months from the date an incident occurs until trial had dropped from 61 months in 1994 to 45 months by the year 2000.
- The average number of months from filing of a suit to date of trial had dropped from 36 months to 24 months in the same period. In many states this is the direct result of the "fast track" measures that have been enacted to bring cases to trial on a more timely basis.

AN EPIDEMIC OF NATIONAL PROPORTIONS

Data published by the American Medical Association in March 2003(5) depicting availability issues for MPL indicates that they consider Washington, Oregon, Nevada, Texas, Mississippi, Georgia, Florida, New York, Pennsylvania, Ohio, and West Virginia to be states "in crisis." Most other states, with nine possible exceptions, are considered to be "showing problem signs." "Problem signs" can be a euphemism for either affordability or availability.

The states "in crisis" share several key characteristics:

- These were states where the lead carriers exited the business – St. Paul, MIIX, PHICO, Frontier, Reciprocal of America/Doctors Insurance Reciprocal, etc.
- Many of these states have seen their claims severity magnified in the excess layers; a good example of this is Mississippi. The HHS Study indicates that before 1995, MS had no awards over \$9,000,000. Since 1995, MS has had 21 verdicts at or over \$9,000,000.
- These states have seen practice patterns changing as a result – the physicians are practicing more defensive medicine, MDs are abandoning high risk procedures, leaving the state, or even retiring from practice altogether.

EMERGING MARKETPLACE ISSUES

There have been several waves of companies leaving the MPL marketplace since the mid-to-late 1990s. The first round included PIE, PIC, and ICA, among others. PHICO and Frontier were taken over by regulators in August 2001, and in December 2001 St. Paul made the monumental announcement that they would no longer write MPL business. According to A.M. Best's August 5, 2002 Statistical Study(6), St. Paul was the second largest writer of MPL, with almost \$600 million in 2001 written premium. Their announcement was followed by the demise of Reliance and Reciprocal of America/Doctors Insurance Reciprocal, and Washington Casualty was placed in Receivership for purposes of rehabilitation. In all, over \$1 Billion of premium was displaced by these departures. Most recently, OHIC, MLMIC, and Princeton were downgraded by A.M. Best, with negative outlooks.

The companies that remain simply do not have the capacity to write all the business that is made available to them. Many that had enjoyed low Written Premium-to-Surplus ratios in the recent past now find their surplus stretched to an extent that they would have never thought possible, and much of that is just due to rating actions in the past few years that have significantly increased the written premiums on their existing books of business. This has been exacerbated by deteriorating results

due to development on prior years, and the companies have had difficulty in finding ways to increase surplus to finance additional premium growth. Primary insurers have returned to underwriting discipline and find themselves having to carefully and consciously allocate what surplus they do have available, if any.

At the PLUS MPL Symposium in March, 2003, Matthew Fay, FCAS, MAAA, Senior Vice President and Chief Underwriting Officer for Convergium, predicted that loss ratios and, therefore, the market would continue to deteriorate before things began to improve. Mr. Fay believes that the severity trends that many companies are utilizing for their projections are inadequate, in light of increasing medical costs and claim trends. Because of the negative effect of compounding, if the assumed trend is off by even a few percentage points, it can significantly understate the amount of reserve strengthening that is required. In addition, he believes that many companies are using overly optimistic interest rate assumptions, which further distort their projections.

SO WHAT IS THE REINSURERS' RESPONSE?

As with the primary companies that they reinsure, the reinsurers are also tightening their underwriting, claims, and financial scrutiny of the companies they choose to reinsure. For new clients, pre-quote underwriting, claims, and in some cases, financial audits have become a prerequisite to doing business. At the same time, even existing clients are experiencing a more aggressive audit timetable than they have seen in the past.

Virtually all working layer – usually defined as the first \$1 or \$2 million of coverage – MPL reinsurance is provided in the form of Excess of Loss reinsurance. Most of the contracts include a "per loss" cover that applies on an "each and every loss" basis, and a "Clash" provision for those instances in which more than one insured and/or policy may be involved in the same medical incident. Primary programs are seldom written on a quota share basis except in rare instances. Even then, it is most commonly utilized on fronted programs, which are in and of themselves few and far between in the current marketplace.

Some typical changes or restrictions in terms currently being seen include:

- One-year contracts only. After 9/11, multi-year contracts, even those with provisions for annual re-negotiation, quickly became unavailable.
- Increased "Per loss" and "Clash" retentions.
- Reduce (or even eliminate) coverage for ECO/XPL losses – i.e. if they were covered at 90% in previous contracts, that is reduced to 80% or even lower.
- Imposition of aggregate limits of liability or loss ratio caps.
- Flat rate contracts moved to loss-sensitive rating mechanisms, with a Provisional Premium expressed as a percentage of the underlying premium charged initially; subsequently premium is adjusted based on the actual experience in the reinsurance layer.

That being said, in 2003 we have seen some isolated cases of reinsurance terms easing slightly. If a reinsured company has remained relatively stable, in terms of exposures, AND their Written (and, therefore, Earned) Premium has significantly increased due to the underlying rate increases, reduced reliance on discounting, etc. For companies such as this, a few may actually have seen some relief in the Provisional and the Minimum Rates, which are expressed as a percentage of premium for these Excess of Loss Contracts. That is, given a stable exposure base, a lower percentage of a significantly higher Written Premium still yields higher Minimum, Provisional, and Maximum Premiums.

In conclusion, the key reinsurers that are dedicated to the Medical Professional Liability industry have made a renewed commitment to underwriting and pricing integrity and discipline over the past few years. One of their primary responsibilities going forward will be to monitor and evaluate the ongoing financial viability of their reinsureds, as reflected in responsive rate actions, their loss projections based on prior years' losses, and investment income assumptions, among other

measures. Given the current climate and experience in our industry it is unlikely that the MPL reinsurance market will become significantly less restrictive in the near future.

This article was first published in Vol. 10, Issue 4 of the Journal of Reinsurance and is reprinted with permission of the Intermediaries & Reinsurance Underwriters Association.

END NOTES:

1. "2003 Property/Casualty Review Preview," A.M. Best Company, Inc.
2. "Medical Malpractice- Anatomy of a Crisis in 2003," Conning Research & Consulting, Inc., 2003.
3. "Confronting the New Health Care Crisis: Improving Health Care Quality And Lowering Costs By Fixing Our Medical Liability System," U. S. Department of Health & Human Services, July 24, 2002.
4. "2002 PIAA Data Sharing Project," Physician Insurers Association of America.
5. "The New Medical Malpractice Crisis," Mello, Studdert, Brennan; New England Journal of Medicine, June 5, 2003.
6. "Med-Mal Premiums Barely Keeping Pace," A.M. Best Company, Inc., August 5, 2002.

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The Rising Cost of Medical Malpractice Claims – A Look behind the Numbers

by Dawn Dinkins

It has been well publicized that jury awards in medical malpractice suits have skyrocketed in recent years. The trend toward rising awards is supported by the 2000 Edition of Jury Verdict Research's Current Awards Trends in Personal Injury, which indicates that the median medical malpractice award increased from \$500,725 in 1997 to \$800,000 in 1999, an increase of 60%. 45% of awards are now over \$1,000,000. Settlements showed a similar trend, with median settlements climbing from \$400,000 in 1997 to \$650,000 in 1999 - a growth of over 60%. According to the study, median awards were highest in childbirth cases (\$2,000,000), medication error cases (\$636,844), and failure to diagnose cases (\$625,000). Even more alarming is the fact that the award mean almost doubled from \$1.9 million in 1997 to \$3.4 million in 1999. There is no question that loss severity in medical malpractice claims has increased significantly, even though frequency for the most part has remained flat. However, identifying the reasons why awards are so much higher is difficult. Experts point to several factors, such as managed care, the nursing home crisis and public attitudes as some of the reasons behind the escalating severity.

Managed Care: The conversion to managed care has profoundly affected the loss results in medical malpractice. According to a new study by Conning & Co., "Medical Malpractice Insurance, A Prescription for Chaos 2001," the short answer as to what is behind the increasing verdicts is managed care. The study indicates that the shift in health care delivery to cost-contained managed care has moved medical malpractice from "a world dominated by committed medical acts to one of omitted ones." Claims for alleged failure to diagnose are one of the leading causes of action today. Increased outpatient treatment under managed care has placed more responsibility on patients to ensure that they are taking the appropriate medication. This has shifted the burden away from healthcare professionals and has resulted in increased large losses for medication errors.

Another significant driver of adverse loss trends is the erosion of communication with patients within all sectors of the healthcare system. Primary care physicians are pushed to see more patients, negatively impacting the quality of care. The loss of intimate relationships between patients and their doctors due to the limited time being spent during visits has contributed to the increased number of suits for failure to diagnose and medication errors. Studies have shown that physicians who spend more time with their patients are less likely to be sued. However, since increasing the time spent with each patient decreases the number of patients that can be seen, it is unlikely that many physicians whose incomes are suffering as a result of managed care will change their ways.

Nursing Homes and Hospitals: According to the Conning & Co. study, nursing homes have experienced what may be the medical malpractice equivalent of the "perfect storm." Florida has been especially problematic, with loss costs per occupied bed rising to \$6,283 in 1999 - eight times the national average of \$809 (source: 2001 AON Worldwide Actuarial study of nursing homes.) The same study indicates that the average size of a nursing home claim in Florida in 2000 was \$455,000, three times higher than the rest of the country. Texas was a close second with an average value of \$399,000. (The average value for the rest of the country was \$112,000.) Verdicts have been stunning, with awards easily topping the eight to nine figure range. Legislative changes such as establishing minimum quality of care standards and strong patient's bill of rights, (Florida and Texas), difficulties in attracting and retaining qualified staff, and the easy availability of Internet access to information about nursing homes and physicians' medical malpractice histories have fueled the frequency and severity of losses. There is already evidence that the problems of Florida

and Texas are spreading to other states like California, Arkansas and Mississippi. With the aging population, the negative publicity surrounding nursing homes and aggressive trial lawyers, nursing home losses will continue to be a veritable "black hole" for medical malpractice insurers.

While nursing homes have experienced rapid increases in verdict/settlement values, hospitals are also experiencing similar difficulties. A study done by the Medical Underwriters of California in 1999 found that despite a cap of \$250,000 for non-economic damages, there was a record high thirty-eight awards or settlements of \$1 million or more. Thirty-one of those cases arose from incidents involving hospitals. The average indemnity loss was \$4,047,341, which was more than double the average of the prior year of \$1,227,536. Hospitals are targets by trial attorneys due to the higher limits they typically carry, making them a "deep pocket." Most physicians do not have coverage of more than \$1,000,000; thus trial attorneys will seek to involve the hospital in the hopes of tapping the larger policy. The Conning & Co. study also notes that hospitals face growing exposure due to the increased use of emergency rooms as replacements for primary care physicians for many patients. This has shifted the focus of medical malpractice claims from physicians to ERs.

Public Attitude: Jury attitude toward the medical community is perhaps the most obvious factor influencing the size of verdicts. This is due in part to the negative public perception of managed care and the publicity generated by large medical malpractice verdicts, which have made the public aware of the vulnerability of health-care professionals. Some juries appear to be replacing the applicable standard of care with an expectation of perfect care, feeling that physicians should be able to diagnose and treat all medical conditions regardless of a patient's prior history or lack of symptoms. However, on a more fundamental level it is clear that juries today have become desensitized as to the value of \$1 million. Multi-million dollar verdicts are more common today and are on the minds of jurors when deciding damages.

While verdicts are high and the factors driving severity costs are not easily solved, insurers can mitigate the cost of medical malpractice claims through aggressive use of alternative dispute resolutions. The use of mock juries and shadow juries can be a useful tool in the evaluation of damages and defense strategies. Strong communication with insureds during the life of the claim is crucial and will go a long way toward achieving good resolutions. However, adhering to strict underwriting guidelines will weed out many problematic risks and therefore prevent these claims from occurring – the best way for insurers to limit their exposure.

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Greater Risk Control Measures, Tort Reform Will Improve Hospital Professional Liability Market

by Medical PL Symposium Recap Article

Dramatically higher premium increases and risk retention requirements have added financial pressures to an industry segment that is already strained. Facilities are going bare, self-insuring or reducing limits of coverage. It is only through greater risk control measures, prudent underwriting and tort reform that hospital professional liability will recover, panelists told the PLUS Medical PL Symposium.

James D. Hinton, vice president, Risk & Insurance, HCA, Inc., noted that the physician malpractice crisis has had a tremendous impact on hospitals. "Hospitals are requested to lower or eliminate insurance requirements and more physicians are going bare in Texas and Florida," he said. "Physicians are relocating, retiring early or curtailing their practice," he added. "Hospital recruiting costs are up, service cutbacks are being made in some situations and employment of physicians is trending up again."

According to Hinton, the market has seen dramatically higher retentions, a formation of new captives and risk retention groups and insurance costs rising faster than hospital revenues. "For buyers, there is a tremendous amount of frustration," he said. "There is little evidence of underwriter judgment and little differentiation of risks. In addition, there are too many data requests, which are often irrelevant and there is diminished value of long term relationships."

Hinton noted that the crisis in the medical malpractice market is not an insurance problem. "They're not at fault. It is the legal system and astronomical jury awards that need to be addressed."

Going forward, the outlook for HPL underwriting should be positive, Hinton said. "Loss results will improve because of patient safety initiatives, a renewed focus on loss prevention and tort reform. Severity is impacting the market. That's where tort reform can make a huge difference for hospitals."

Using Ohio as a paradigm of what is happening in the med mal market throughout the country, D. Brent Mulgrew, J.D., executive director, Ohio State Medical Association, noted that malpractice insurance rates in Cleveland are among the highest in the nation. "Physicians are frustrated," he said. "They feel the system has been unresponsive and mismanaged. We all are potential patients. If we fail, the system will crash."

According to Mulgrew, the impact has resulted in increased expenses. "Revenue remains flat to declining. There has also been a decreased access to patient care. Ninety-six percent of doctors are discontinuing some procedures, 15 percent are leaving for less litigious areas and 51 percent are quitting the practice altogether."

Mulgrew noted that the passage of SB 281 may help. The bill, which limits non-economic damage awards in the vast majority of cases to \$350,000, also requires attorney contingency fees to be reviewed by a probate court if the fees exceed the non-economic damage awards. "SB 281 removes joint and several liability. In most cases, a physician who is named in a suit will only be held liable for the portion of the claim for which the doctor may be responsible."

Mulgrew said that SB 179 also provides a broader base of peer review protections and allows

health care entities outside the traditional hospital setting to establish peer review committees. "The activities are protected from discovery during litigation."

The impact of these bills, according to Mulgrew, will not mean a reduction in rates or trends. "There will be a selective underwriting of risks and specialties and a creation of new non-standard market options."

Looking at the long-term care liability impact, Michael R. Walton, president, AMWINS HealthCare, noted that liability insurance availability and affordability issues are severe. "There is a continued aggressiveness of plaintiffs' attorneys in soliciting cases and extraordinary jury awards."

According to Walton, the "broad brush" underwriting approach being used is inappropriate. "Many suffer for the sins of a few," he said, adding, "risk assessment tools and methodologies are inaccurate, faulty and subjective. Base rates are set according to geographical location, facility size, and percentage of more acute residents. Minimal or no consideration is given toward the level of quality care or the type of ownership."

Walton noted deficiencies in hospitals include failure to follow physicians' orders, failure to treat, physical or verbal abuse, medication error, failure to monitor adequately and failure to diagnose. He said there are also concerns with the analysis and accuracy of Online Survey, Certification and Reporting (OSCAR) data. "Simple counts of survey deficiencies can be misleading unless the scope, severity and type of each deficiency is considered," he said. "In a recent analysis of 16,698 OSCAR assessments, six percent of facilities report total census numbers not equal to the total number of residents calculated from other OSCAR items."

Walton said that there are better ways to measure quality and risk. "OSCAR analysis can be improved by using geographical adjustment, severity adjustment, focus on litigation risks and other methods," he said. "We need to utilize advanced methods of assessing, managing and defending the long-term care quality and associated risk and we need to eliminate the subjectivity in the data. We are making advancements with underwriters in this area."

The panel was moderated by Sarah Lawhorne, Esq., deputy insurance commissioner of Pennsylvania.

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Emerging Trends In Medical Professional Liability

by Edwin Scherlis

INTRODUCTION

As we enter the new millenium, we note that the traditional lawsuits against doctors for medical malpractice are not only increasing, but other healthcare providers and related entities are being drawn into the fray.

We note with considerable interest that managed healthcare has become so prevalent in most areas that the health maintenance organizations ("HMOs") are being named as defendants by injured claimants along with the doctors and the hospitals. The HMOs have attempted to limit the scope of their liability by pleading that ERISA, the federal statute relating to job-related benefits, should supersede state law as we know it. At this point, these attempts have been failing and the courts have ruled that claims relating to the quality of medical care do not fall within the scope of ERISA. The HMOs and other managed care entities have arguably invited the constant attack where medical malpractice has occurred because of their advertising ("We hire only the best and most competent physicians..."), their capitation agreements (doctors are forced to see too many patients...), and bonus agreements (save money on referrals and diagnostic tests and share in the savings at the end of the year...). Because the people, who are developing an animosity toward the HMOs, sit in our juries, we can anticipate verdicts directly against the managed care providers in the future.

Who among us has not seen the statistics reflecting the "aging of America." The growing number of geriatrics in our society will not only place a strain on our Social Security system, but will require an enormously expanded health system in the nature of nursing homes, hospices, assisted living facilities, convalescent homes, and the like. With the growth of these residential care units comes the need for qualified staffing, competent medical care, and active paramedical care. It, therefore, follows that accidents and mistakes will increase and this will expand the number and type of claims and lawsuits filed against these facilities. We are witnessing this trend already.

The law relating to the duties and obligations of nursing homes and similar facilities is now developing beyond the simple "duty of reasonable care." Medicare patients are entitled to certain protections as set forth in the federal statutes. Each state has statutes, rules, and regulations which must be followed by the personnel at each facility. Superimposed upon these obligations are the obvious facts that the residents of these facilities require significant care and monitoring but that staffing problems invite mistakes and malpractice.

The liability of hospitals has similarly been expanded by many courts. While at one time those physicians with staff privileges at hospitals were obliged to bear responsibility alone for acts and omissions committed on the hospital premises, hospitals now face corporate liability independent of that of the physician for negligent acts which take place within its four walls. In many instances, the hospital has become almost a guarantor of the quality of care to be provided by the physician.

The concept of liability rising out of "informed consent" cases is similarly on the rise. In situations where the best medicine was practiced, a physician may still face liability if the patient can prove that there was some risk or alternative which was not discussed prior to the procedure. In addition, the nature of activity that requires informed consent has been expanded. At one time it was limited to surgical procedures but has now been extended to blood transfusions, angiography, and other

procedures which are traditionally non-surgical.

While the basic legal requirements necessary for a successful plaintiff remain the same (duty-breach-damages), the manner in which the claimant can reach the jury has been eased by the court. At one time the plaintiff had the burden of proof of demonstrating that the patient would have refused the operative procedure had all risks been known. Now, the healthcare provider faces responsibility for all problems relating to the surgery, whether it was performed properly or not, even when the material risks were not discussed with the patient beforehand. The patient need not testify that he or she would have refused the treatment.

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Turmoil in the Medical Malpractice Insurance Market

by Paul Greve, Jr., JD, RPLU

The medical malpractice insurance industry has been in a state of turmoil in the last two years. Premiums have skyrocketed for institutional and individual providers thereby affecting the delivery of health care services in a number of states. Not since the 1970s have the national news media devoted so much coverage to the subject of medical malpractice. There have been featured reports on the network evening news, articles in the Wall Street Journal, USA Today, and other major newspapers, and periodical coverage in publications such as Forbes and U.S. News & World Report. Physicians have organized widely reported demonstrations in support of tort reform in Ohio, Florida, and Texas.(1)

Nationally, soaring verdicts and settlements have caused a significant deterioration of many carriers' results. Jury attitudes and the failure of tort reform in the majority of states have contributed to the poor results. The product was underpriced in the mid-to-late 1990s simultaneous with the rise in claim severity.(2) Investment income is down significantly since the mid-1990s, thereby exacerbating the pressure on carriers' bottom lines. Reserve redundancy has been virtually eliminated as a method to improve results, with a number of carriers needing to strengthen reserves. Medical malpractice insurance is the worst performing line of property/casualty insurance, according to A.M. Best.(3) The industry's combined ratio was 139% in 2001 and projected to go higher in 2002.(4)

The medmal insurance industry's struggles were highlighted when the largest writer of malpractice insurance by premium volume, St. Paul, announced its withdrawal in December 2001. PHICO, once a major player nationally, was placed in liquidation by Pennsylvania regulators in February. The elimination of these two carriers caused a marked reduction in capacity, especially at the primary insurance level. A number of other malpractice carriers have received significant ratings downgrades by A.M. Best since the beginning of this year, including SCPIE, MIIX, and ROA. Those carriers still able to write new business became swamped with potential new account volume and some have had to curtail their underwriting due to an imbalance of premium to surplus. Over the last few years there has also been more turnover in the executive suites of malpractice carriers than ever before.

Hospitals and physicians have found coverage difficult to find and very expensive in certain states, particularly: Nevada, West Virginia, Pennsylvania, Florida, and Texas, among others. Certain physician specialties have been more severely impacted by adverse national loss trends, such as emergency medicine, obstetrics, and radiology. Primary care physicians have seen many claims alleging failure to diagnose. There have been bona fide reports of curtailed services, especially deliveries in rural areas, due to the cost of malpractice insurance.(5) The AMA has published a list of twelve states where physicians are leaving the practice of medicine, taking early retirement, or discontinuing high-risk services: Washington, Oregon, Nevada, Texas, Mississippi, Georgia, Florida, West Virginia, Ohio, Pennsylvania, New York, and New Jersey.(6) Institutional insureds have been dramatically affected, especially nursing homes. Coverage for nursing homes is very difficult to find and more expensive than other segments of medical malpractice insurance.(7)

Malpractice insurance carriers have responded in a number of ways in an attempt to restore profitability. These include withdrawal from this line of insurance, double to triple digit rate increases, restrictive underwriting of certain classes of business and in certain territories, raising

attachment points/mandating deductibles, and offering lower limits of liability.

In the 1970s and 1980s, malpractice insurance industry results improved with tort reform initiatives and rate increases. Many industry experts are not as hopeful for tort reform in 2002, due to the political power of the trial bar and a judiciary that has often ruled unfavorably on the constitutionality of such legislation. Without tort reform, it will be very difficult for carriers to know that the premiums charged in 2002 will be adequate to pay claims over the typical 3-5 year time frame for malpractice claims resolution. There currently is a federal tort reform bill that was introduced in Congress in April. It is modeled on California's MICRA legislation, especially a \$250,000 cap on pain and suffering.⁽⁸⁾ The bill faces the significant hurdle of passage by a Democratic-controlled U.S. Senate.

If we try to use a crystal ball and project future industry trends, what are some of the negative and positive factors medical malpractice carriers must face?

Negative Factors

Rate Adequacy. Only time will tell whether the substantial rate increases being taken will restore profitability in the long term. There is at least some concern that they are being offset by the dramatic rise in the number of large awards and settlements.

Jury Attitudes. Juries appear to be far less reluctant to give large awards due to such societal influences as lottery winnings and sports salaries. There has also been the negative influence of publicity about medical errors. Thus, the industry faces the recent and unprecedented problem of "frequency of severity": The rapidly escalating number of large awards.

The Failure of Tort Reform. Very few states have a favorable tort climate due to the absence of legislation or case law overturning tort reform. The prospects for federal tort reform are not promising in the near term.

Inadequate Medicare/Medicaid Reimbursement. Nursing homes and hospitals struggle with providing adequate staffing while physicians may try to increase patient volume. Both scenarios can potentially reduce patient safety. Inadequate reimbursement squeezes insureds at the same time that their expenses soar from increased malpractice premiums. Less money is also available for needed patient safety initiatives.

Rapidly Rising Health Care Costs. These are again rising much faster than inflation, and affect indemnity payments to injured patients.

Migration to the Plaintiff's Bar. Many rising stars in defense firms have left to go to the plaintiff's side where they need not keep track of their billable time nor seek permission for travel to depositions, etc. The potential for large awards with 40-50% in fees to the plaintiff's lawyer is a huge incentive to switch sides. The scarcity of capable defense lawyers could become a serious issue in the future.

Positive Factors

The Cyclical Nature of Medical Malpractice. Certainly there have been peaks and valleys since the mid-1970s, and the industry results were actually substantially worse in the mid-1980s than today. Medical malpractice then became the most profitable line of property-casualty insurance. History would seem to indicate that profitability could be restored in time.

Renewed Emphasis on Pricing, Terms, and Conditions. Many carriers lost this discipline in the 1990s in an effort to obtain market share. It is hoped that mandatory deductibles and higher attachment points will require providers to increase their efforts to reduce patient injuries. More providers will consider some degree of self-insurance than ever before, voluntarily or involuntarily.

The Influx of New Capital. The number of new companies entering this line is encouraging. Most are providing additional reinsurance and excess lines capacity, although they are being selective as to new business and attachment points. Ease of entry is a factor here since primary insurance

requires far more of a commitment in the way of resources and regulatory compliance. Some of these markets have stated an intention to enter the primary insurance market in time.

Frequency is Flat. Loss costs are being driven by severity. Jury Verdict Research reported a 43% rise in the median medical malpractice award between 1999 and 2000, hitting the highest median ever of \$1 million.⁽⁹⁾ There does not appear to be any significant national increase in claims volume.

Renewed Efforts at Tort Reform. Carriers are increasing their efforts and are being joined at the state and national level by health care industry organizations with significant clout, such as state medical societies and hospital associations, the American Medical Association and the American Hospital Association. The argument that must successfully be made to federal and state legislators is that the lack of tort reform in many states will adversely impact the availability and affordability of health care services such as obstetrics and trauma.

Increased Focus on Patient Safety. The future has never been more promising for proven risk management initiatives. Evidence-based patient safety standards and emerging technologies, such as the use of bar coding for medication administration or computerized physician order entry, hold the promise of reducing the incidence of patient injuries.

Many in the malpractice insurance industry think that a return to stability is at least two years away. While the two most critical factors in restoring stability may be adequate pricing and tort reform, all carriers will be influenced in some way by these negative and positive factors over the next two years.

FOOTNOTES:

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GOVERNMENT & MEDICINE

Texas tort reform vote signals lower liability rates

Physicians believe a constitutional amendment will ease the state's medical liability crisis.

By Damon Adams, *AMNews* staff. Oct. 6, 2003.

Passage of a Texas medical malpractice ballot initiative appears likely to produce the impact physicians desired -- a decrease in liability premiums. And doctor groups hope that the measure's success will spur similar action in other states.

"It's going to send a message all over the nation that it can be done. This will give greater impetus to other states," said AMA President Donald J. Palmisano, MD. The AMA contributed \$100,000 to support the initiative, called Proposition 12.

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The measure amends the Texas Constitution to allow caps on noneconomic damages in medical malpractice lawsuits. Within days of the vote, some insurers announced plans to reduce liability insurance rates.

For example, Texas Medical Liability Trust, the state's largest medical liability insurer, said it would cut premiums 12% beginning Jan. 1, 2004.

"We believe the 12% [reduction] is really just the start," said W. Thomas Cotten, president and CEO of physician-owned TMLT, which has about 10,800 policyholders. "Hopefully, the number of carriers will increase so there will be more sources of competition. With that competition, carriers will need to reduce their rates."

The Doctor's Company, a medical liability insurer based in Napa, Calif., plans at least a 12% reduction on \$1 million policies in Texas, said Richard E. Anderson, MD, company chair. With 2,000 physician policies in the state, the insurer is looking at other potential savings to doctors and hopes to write more policies, he said.

"I guarantee the rates will be lower than they otherwise would have been," Dr. Anderson said.

State Rep. Joe Nixon said insurers' premium cuts would save doctors about \$100 million a year.

Now that the amendment has passed, state leaders said, some doctors will feel secure enough to go back to practicing high-risk procedures. Medical students and practicing doctors will be less likely to leave Texas, said Charles W. Bailey Jr., MD, president of the Texas Medical Assn. and a Houston plastic surgeon.

"The real winners of this election are the people of Texas, who can be more certain that their doctor will be there for them when they're sick or injured," he added.

But opponents of the measure said it strips juries of their power and gives it to special interests. They are watching to see if insurers follow through on promises to lower rates.

"There is no guarantee that's going to happen," said Abby Sandlin, deputy director of Texas Watch, a group that is part of Texans Against Proposition 12. "We've had empty promise after empty promise from insurers over the decades. Now is the time they are going to have to put up."

The Medical Protective Co. in Fort Wayne, Ind., is still exploring whether to change its rates.

"We are assessing the impact this will have on our rates," said John Novaria, spokesman for the company, which has 7,000 physician policyholders in Texas.

Heading off a legal challenge

Earlier this year, the Texas Legislature passed a law placing a \$750,000 cap on noneconomic damages in medical malpractice lawsuits. It limited an individual physician's liability to \$250,000.

Knowing the law would face a legal challenge, legislators called for a ballot measure, Proposition 12, to ratify the Legislature's cap on noneconomic damages in civil lawsuits. A similar cap was passed in 1977, but after a legal challenge, the Texas Supreme Court found it unconstitutional.

Some liability insurers already plan to

Supporters and opponents of Proposition 12 waged media campaigns to woo voters. The two camps spent more than \$13 million on television commercials and mailings. About 12% of Texas' 12 million registered voters cast

cut rates 12%. ballots Sept. 13. The measure passed narrowly, with 51% supporting it and 49% opposing it.

Supporters said the amendment means the cap would survive any legal challenge.

"I'm extremely relieved we came out on the positive side of it. It was a very intense media campaign," Dr. Bailey said. "The key thing is it will at least hold premiums at their current level so we can stop this escalation."

The passage of Proposition 12 will benefit Texas' liability insurance market in other ways, proponents said. "The stability in the state will allow other medical insurers an opportunity to come sell their policies in Texas," said Nixon, who sponsored the legislation on damage caps.

Since the vote, the Texas Dept. of Insurance said no insurers had contacted the agency about coming back to a state that once had 17 medical liability insurers and now has only a handful left. That likely will change.

"We fully expect that companies will return to Texas," said department spokesman Jim Hurley.

But for some doctors, it's too late.

"The doctors that already left or have gone out of practice will not go back into practice," said David Schneider, MD, president of the Texas Academy of Family Physicians. "Once you've made that decision to change your life, you won't come back."

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ADDITIONAL INFORMATION:

Voters have spoken

The ballot question for Proposition 12: "The constitutional amendment concerning civil lawsuits against doctors and health care providers, and other actions, authorizing the Legislature to determine limitations on noneconomic damages." The results:

In favor: 51%

Against: 49%

Statewide voter turnout: 12.2%

Source: Texas Secretary of State

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Texas Medical Assn. information on Proposition 12
(www.texmed.org/prop12/yes.asp)

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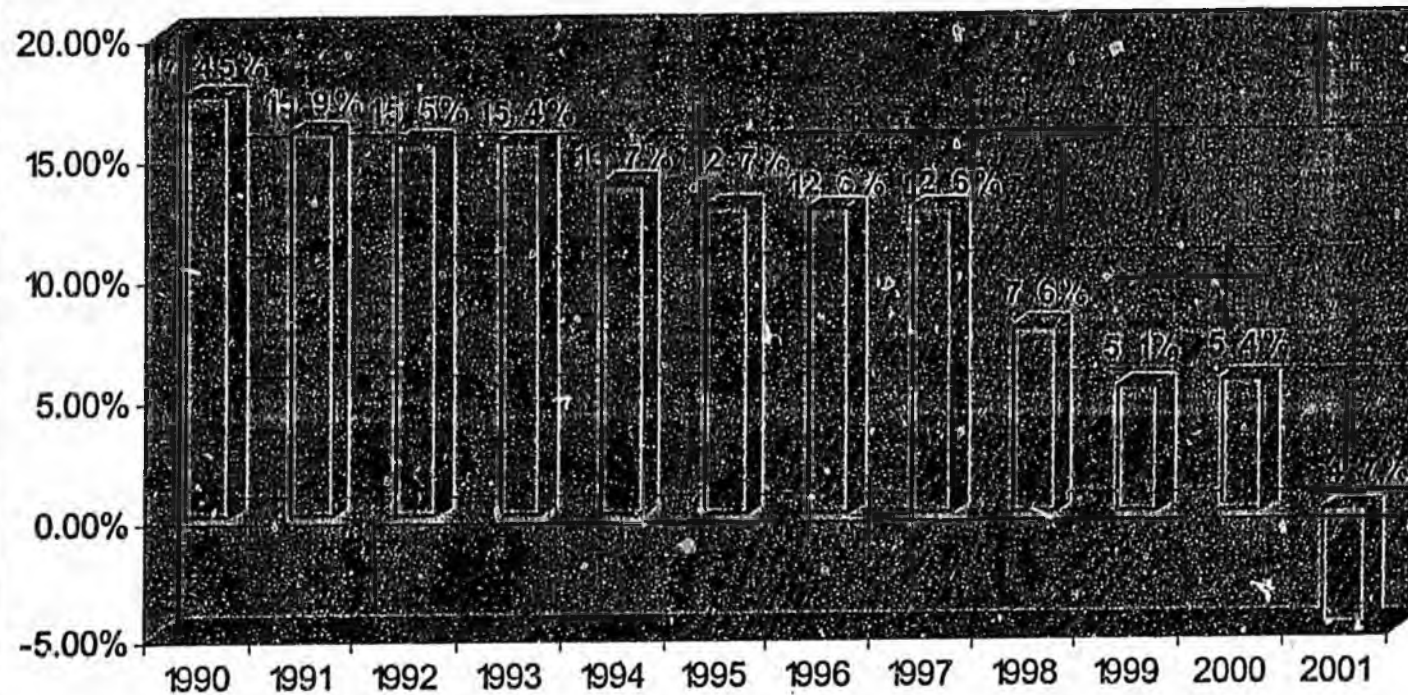
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Physicians win award cap as Texas passes tort reform June 23

Carrier Results – Percent Of Profit On NWP



Source: U.S. General Accounting Office analysis of National Association of Insurance Commissioners Data

Malpractice Premium Comparison by State

| 1970 | California | Florida | Nevada | United States |
|----------------------------|----------------|----------------|---------------|-----------------|
| Total premium | \$228,451,000 | \$18,357,000 | \$1,978,000 | \$1,182,000,000 |
| 1970 Pop. | 19,971,069 | 6,791,418 | 488,738 | 203,302,031 |
| % US Pop. (1) | 9.8% | 3.3% | 0.2% | 100.0% |
| % US Premium | 19.3% | 1.6% | 0.2% | 100.0% |
| Premium /Person | \$11.44 | \$2.70 | \$4.05 | \$5.81 |
| 1980 | California | Florida | Nevada | United States |
| Total premium | \$629,448,000 | \$173,522,000 | \$3,311,000 | \$3,435,000,000 |
| 1980 Pop. (2) | 23,667,764 | 9,746,961 | 800,508 | 226,542,199 |
| % US Pop. | 10.4% | 4.3% | 0.4% | 100.0% |
| % US Premium | 18.3% | 5.1% | 0.1% | 100.0% |
| Prem. Dollars (3) | \$327,312,960 | \$90,231,440 | \$1,721,720 | \$1,786,200,000 |
| % Change Prem. Dollars (3) | 43.3% | 391.5% | -13.0% | 51.1% |
| Premium /Person | \$26.60 | \$17.80 | \$4.14 | \$15.16 |
| Premium /Person (3) | \$13.83 | \$9.26 | \$2.15 | \$7.88 |

Source: NAIC Insurance Company Profitability Reports 1976 to 2000; US Census; CPI Calculator

(1) 1970 Census

(3) Adjusted for Inflation per CPI

(2) 1980 Census

(4) 2000 Census

Malpractice Premium Comparison by State

| | California | Florida | Nevada | United States |
|--|----------------|----------------|-----------------|-----------------|
| Total Premium | \$609,712,000 | \$505,535,000 | \$508,000,000 | \$5,549,552,000 |
| Population | 33,871,648 | 15,982,378 | 1,998,259 | 281,421,906 |
| % US Pop. (4) | 12.0% | 5.7% | 0.7% | 100.0% |
| % US Premium | 11.0% | 9.1% | 9.2% | 100.0% |
| Prem. Dollars (3) | \$201,204,960 | \$166,826,550 | \$167,640,000 | \$1,831,352,160 |
| % Change since 1976 in Premium Dollars (3) | -11.9% | 808.8% | 8375.2% | 54.9% |
| % Change since 1986 in Premium Dollars (3) | -38.5% | 84.9% | 9636.8% | 2.5% |
| Premium/Person | \$18.00 | \$31.63 | \$254.22 | \$19.72 |
| Premium/Person (3) | \$5.94 | \$10.44 | \$83.89 | \$6.51 |
| % Change in Premium/Person | -51.9% | 386.2% | 2072.9 | 111.9% |

Source: NAIC Insurance Company Profitability Reports 1976 to 2000; US Census; CPI Calculator

(1) 1970 Census

(2) 1980 Census

(3) Adjusted for Inflation per CPI

(4) 2000 Census

PROFESSIONAL ISSUES

Physicians feel double-digit pain as liability rates continue to rise

Some doctors are seeing bigger bills than reflected in the raw numbers as companies continue to eliminate discounts and tighten underwriting.

By Tanya Albert, *AMNews* staff. Nov. 10, 2003.

Internists, general surgeons and obstetrician-gynecologists in the Miami area are paying the highest professional liability insurance rates for those specialties in the nation, according to a new report.

The next highest rates for those specialties are found in Michigan, Illinois, Texas and Pennsylvania.

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Nationwide, rates are on the rise. More than half of the internists, general surgeons and ob-gyns out there -- 58.2% to be exact -- saw double-digit insurance rate increases of 10% to 49% between 2002 and 2003.

Slightly more than 1% of those specialists saw increases of 100% or more.

But there is some good news: 22.6% of physicians in those three specialties saw no increase, and some saw a decrease in rates over the past year.

The lowest rates in the nation for internists, general surgeons and ob-gyns are in Idaho, Minnesota, Nebraska, South Dakota and Richmond, Va.

Liability insurance payout rates are increasing

This is according to the latest state of the union for medical liability insurance rates from "2003 Rate Survey" by the *Medical Liability Monitor*. The data, which the monthly newsletter has collected annually since 1991, are based on 641 rates insurance companies

7% a year. reported that can be compared with 2002 data. Companies report their mature claims-made manual rates in effect July 1 with \$1 million/\$3 million limits.

The information collected from 40 insurance companies provides the most comprehensive look at the amount physicians are paying for their insurance. The report also offers a glimpse at what doctors can expect in the coming year. And 2004 doesn't look to be much better than its most recent predecessors. About 83% of the companies surveyed believe they will need additional large increases next year, according to the report. Many of those companies believe those increases will be in the double digits although they hope they won't be as high as they have been in recent years.

"The rate survey shows what we expected," said Larry Smarr, president of the Physician Insurers Assn. of America. "And I agree with the headline [on the report] 'No end in sight.' "

Rates will continue to rise because they are based on losses that companies pay out, and right now that number is rising 7% annually, he said. On top of that, low interest rates force insurers to collect more money through premiums.

But raw numbers don't tell the whole story, *Medical Liability Monitor* editor Barbara Dillard said.

More expensive, harder to get

In addition to increases in rates, physicians are seeing fewer discounts than they once did.

"Discounts for risk management have gone away," Smarr said. So too have dividends that physician-owned companies historically have offered doctors to help offset premiums.

58% of internists, ob-gyns and general surgeons saw liability insurance hikes of 10% to 49% from 2002 to 2003.

The *Medical Liability Monitor* survey also notes that companies are increasingly requiring physicians to buy tail coverage that may once have been included in premiums and that some companies are limiting corporate coverage.

"All of these things mean that a bill that an individual doctor is getting this year may be an even bigger increase for him than it looks on the rate survey," Dillard said.

In addition, physicians are finding it more difficult to find insurance.

In all, 14 companies who responded to the survey said they withdrew or severely restricted new writings in some states. And companies that are staying in the market are continuing to restrict who they will cover.

According to the *Monitor's* survey of 40 companies:

- 73.5% said they are tightening their underwriting.
- 48.6% said they are not renewing more physicians than they did last year.
- 20% said they are restricting coverage in one form or another, such as no longer covering punitive damages.

As rates keep rising and insurance becomes harder to find, physicians and insurers continue to push their state legislatures and Congress to enact tort reform that includes a \$250,000 noneconomic damages cap. This, they believe, will help stabilize insurance rates.

Insurers have stopped offering discounts for risk management.

The survey showed states without noneconomic damages caps generally saw larger rate increases than states with caps. For example, ob-gyns, internists and general surgeons in Pennsylvania saw a 25.8% to 73% increase in rates; those specialists in Illinois saw a 25% to 50% increase and New York physicians saw a 7.3% to 12.7% hike.

In states with caps, Indiana and Louisiana physicians saw a 3.9% to 21.8% increase and Colorado physicians saw a 12.7% to 38% increase, the survey showed. Some Wisconsin physicians saw as much as a 12.7% increase, but some saw a 14.2% decrease. Wisconsin adopted reforms, including a patient compensation fund, in 1975. It added a \$350,000 adjustable noneconomic damages cap in 1995 that now stands at \$410,000.

"We had the foresight to do something for the people and they look after us," said Ft. Atkinson, Wis., orthopedic surgeon Walter Moritz, MD, who helped craft the original Wisconsin legislation and is vice chair of the state's patient compensation fund. "It's fantastic to be in Wisconsin and practicing medicine."

The medical community looks toward California tort reform as the gold standard when trying to get laws passed elsewhere. Some California doctors in the three specialties on which the survey focused saw no increase in rates between 2002 and 2003, but some saw as much as a 54% hike in one year.

Even so, California physicians still pay significantly less than counterparts in other states. For example, internists in Dade County, Fla., paid 133.7% more for their insurance than internists in Los Angeles, according to the survey. General surgeons in Dade County paid 285.1%

more than their counterparts in Los Angeles and ob-gyns in Dade County paid 220.2% more than ob-gyns in Los Angeles.

At the state and federal levels, "we need tort reform," Smarr said.

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ADDITIONAL INFORMATION:

Pain scale

A comparison of liability rates for internists, general surgeons and obstetrician-gynecologists for 2002 and 2003 shows that some actually fell 16%, while others soared 144.2%. Of the 641 rates that were compared, most showed increases.

- 1.2% of insurers increased rates 100% or more.
- 1.1% increased 70% to 99%.
- 3.7% increased 50% to 69%.
- 26.8% increased 25% to 49%.
- 31.4% increased 10% to 24%.
- 13.1% increased 1% to 9%.
- 20.3% kept rates the same.
- 2.3% decreased rates.

Note: Percentages have been rounded.

Source: Medical Liability Monitor, 2003 Rate Survey

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Taking the hit

Of the states with the highest liability insurance rates for select specialties, Florida, Illinois and Pennsylvania are on the AMA's list of crisis states. Michigan is listed as a state showing problems.

| | 2002 | 2003 | Increase |
|-------------------------|----------|----------|----------|
| Internists | | | |
| Florida (Dade County) | \$56,153 | \$65,697 | 17% |
| Michigan (Wayne County) | \$45,761 | \$50,063 | 9.4% |
| Illinois (Cook County) | \$31,722 | \$41,238 | 30% |

General surgeons

| | | | |
|--------------------------------|-----------|-----------|-------|
| Florida (Dade County) | \$174,268 | \$226,542 | 30% |
| Michigan (Wayne County) | \$107,139 | \$154,165 | 43.9% |
| Pennsylvania (Philadelphia) | \$104,388 | \$131,348 | 25.8% |

Obstetrician-gynecologists

| | | | |
|--------------------------------|-----------|-----------|-------|
| Florida (Dade County) | \$201,376 | \$249,196 | 24% |
| Michigan (Wayne County) | \$140,917 | \$154,165 | 9.4% |
| Pennsylvania (Philadelphia) | \$116,388 | \$152,730 | 31.2% |

Source: *Medical Liability Monitor*, 2003 Rate Survey

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How low did they go

States with the lowest medical liability rates for specific specialties.

| | 2002 | 2003 | Increase |
|-----------------------------------|----------|----------|----------|
| Internists | | | |
| Nebraska | \$2,786 | \$2,786 | 0% |
| Virginia (Richmond) | \$2,920 | \$2,920 | 0% |
| Minnesota | \$2,700 | \$3,375 | 25.0% |
| General surgeons | | | |
| Minnesota | \$8,717 | \$8,717 | 0% |
| Virginia (Richmond) | \$9,384 | \$9,384 | 0% |
| Nebraska | \$9,474 | \$9,474 | 0% |
| Obstetrician-gynecologists | | | |
| South Dakota | \$13,325 | \$14,662 | 10.0% |
| Virginia (Richmond) | \$14,907 | \$14,907 | 0% |
| Nebraska | \$12,674 | \$16,194 | 27.8% |

Source: *Medical Liability Monitor*, 2003 Rate Survey

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Medical Professional Liability Insurance

The Crisis Continues

Over the past four years, physicians in many parts of the country and in many specialties have faced large and repeated increases in their medical professional liability insurance (PLI) premiums. The impact of these rate increases on patients' access to care, though difficult to quantify, is ultimately predictable. With a significant proportion of payments constrained according to the fee schedules of public and private payors, physicians who cannot pass these cost increases through to payors instead look for ways to limit their legal liability exposure in ways that may tend to reduce patients' access to medical care.

Although anecdotes and survey data document many instances in which physicians have shut down their medical practices temporarily, stopped performing high risk procedures, or permanently relocated their practices (or intend to do so) in response to the PLI crisis, national data sets tend to be of limited value in quantifying those effects and the degree to which they impair patients' access to critical medical services. However, the best available evidence indicates the continuation of adverse liability trends and their adverse impact on patients' access to care. Specifically, those conditions that contribute to the current crisis, including escalation in jury awards, indemnity payments, and PLI premiums, have persisted or in some

cases, further deteriorated. At the same time, new evidence links changes in the geographical distribution of physicians to variation in local tort environments, hinting at the nature of the relationship between the way our legal system apportions liability for adverse medical outcomes, on the one hand, and patients' access to care, on the other.

Escalating PLI Manual Rates and Increasing Geographical Rate Variation

Physicians experienced a fourth consecutive year of large rate increases that disproportionately affected specific specialties and markets. Markets in states lacking effective tort reforms tended to experience both the highest rates (Exhibit 1) and the largest rate increases. Though many carriers raised rates across all specialties, the largest rate increases in absolute terms were experienced by specialists, such as obstetricians/gynecologists, who perform high-risk procedures or serve high risk populations. PLI rates in California, which has capped malpractice awards for non-economic damages at \$250,000 since 1976, have remained far below those of otherwise comparable markets in states that do not have caps on non-economic damages (Exhibit 1).

Exhibit 1: Manual Malpractice Liability Rate Ranges by Specialty by Geography as of July, 2003

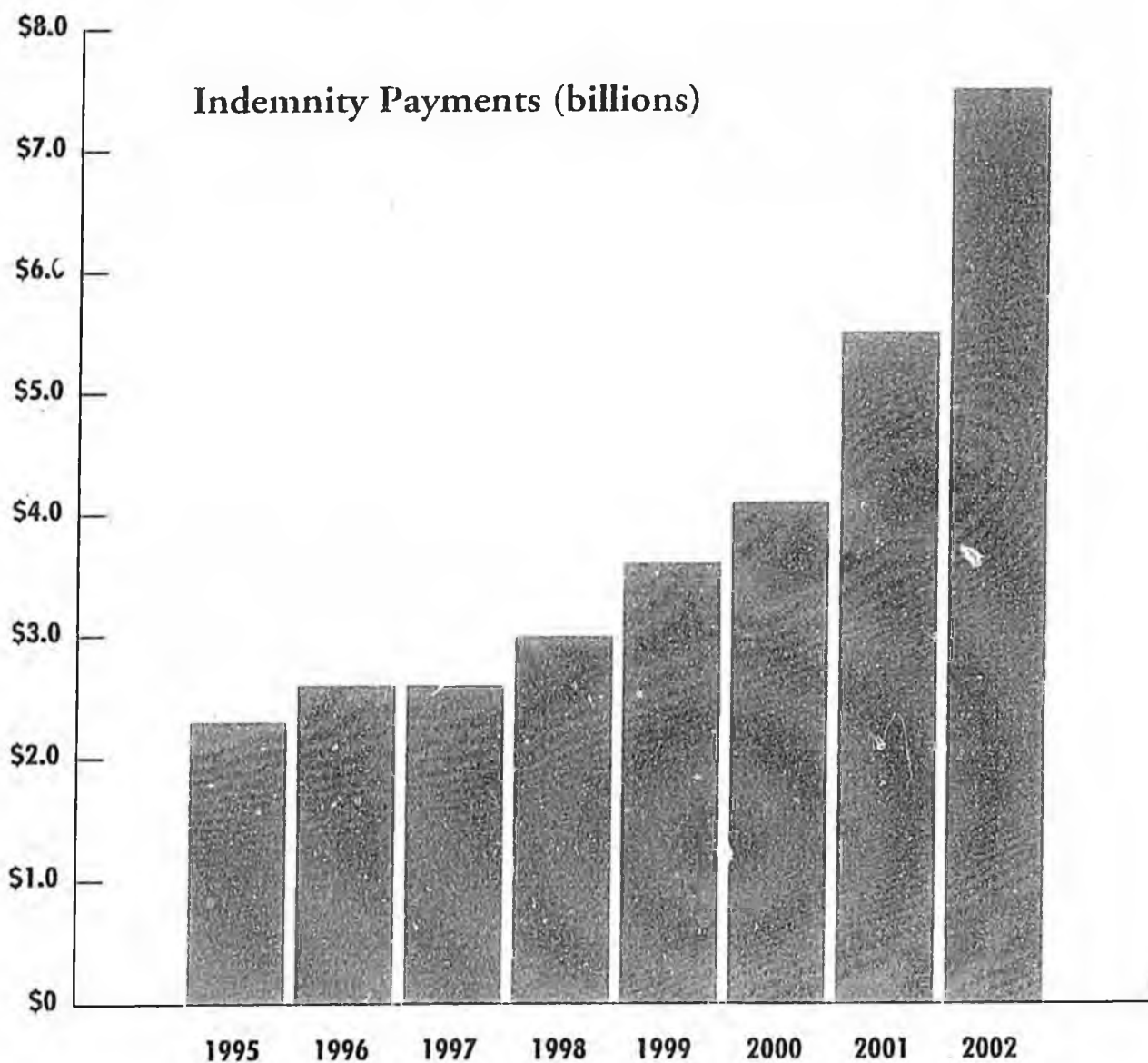
| | Low | High |
|--|----------|----------|
| Internists | | |
| Florida (Miami and Ft. Lauderdale areas) | \$30,557 | \$65,697 |
| Michigan (Detroit area) | 33,514 | 50,063 |
| Illinois (Chicago area) | 27,836 | 41,238 |
| Texas (Dallas and Houston areas) | 15,122 | 34,346 |
| Pennsylvania (Philadelphia area) | 24,546 | 29,667 |
| Ohio (Cleveland and Cincinnati areas) | 11,445 | 25,013 |
| Nevada (Las Vegas area) | 19,273 | 23,620 |
| New York (New York City and Long Island areas) | 17,974 | 23,228 |
| California (Los Angeles) | 9,510 | 12,668 |
| General Surgeons | | |
| Florida (Miami and Ft. Lauderdale areas) | 108,473 | 226,542 |
| Michigan (Detroit area) | 106,889 | 154,165 |
| Pennsylvania (Philadelphia area) | 100,119 | 131,348 |
| Texas (Dallas and Houston areas) | 50,428 | 109,668 |
| Illinois (Chicago area) | 85,197 | 98,319 |
| Ohio (Cleveland and Cincinnati areas) | 44,256 | 93,064 |
| Nevada (Las Vegas area) | 69,949 | 85,024 |
| New York (New York City and Long Island areas) | 57,423 | 74,211 |
| California (Los Angeles) | 26,600 | 58,830 |
| Obstetricians/Gynecologists | | |
| Florida (Miami and Ft. Lauderdale areas) | 154,670 | 249,196 |
| Michigan (Detroit area) | 133,913 | 154,165 |
| Pennsylvania (Philadelphia area) | 128,114 | 152,730 |
| Illinois (Chicago area) | 130,035 | 147,023 |
| Nevada (Las Vegas area) | 88,586 | 141,704 |
| Texas (Dallas and Houston areas) | 71,611 | 131,601 |
| New York (New York City and Long Island areas) | 95,837 | 123,853 |
| Ohio (Cleveland and Cincinnati areas) | 60,138 | 120,275 |
| California (Los Angeles) | 45,530 | 77,814 |

Increases in Indemnity Payments

PLI carriers base the premiums they charge physicians principally on their expected loss experience. Exhibit 2 shows that U.S. claims losses (indemnity payments) have

escalated dramatically, from less than \$2.3 billion in 1995 to over \$7.5 billion in 2001, reflecting a cumulative increase of 232% and an annual growth rate of 18.7%. The rate of growth in indemnity payments accelerated since the onset of the current crisis to an annual rate of 26.3% over the period 1998-2002.

**Exhibit 2:
Payouts For Malpractice Liability Claims Have Increased Dramatically Since 1995**



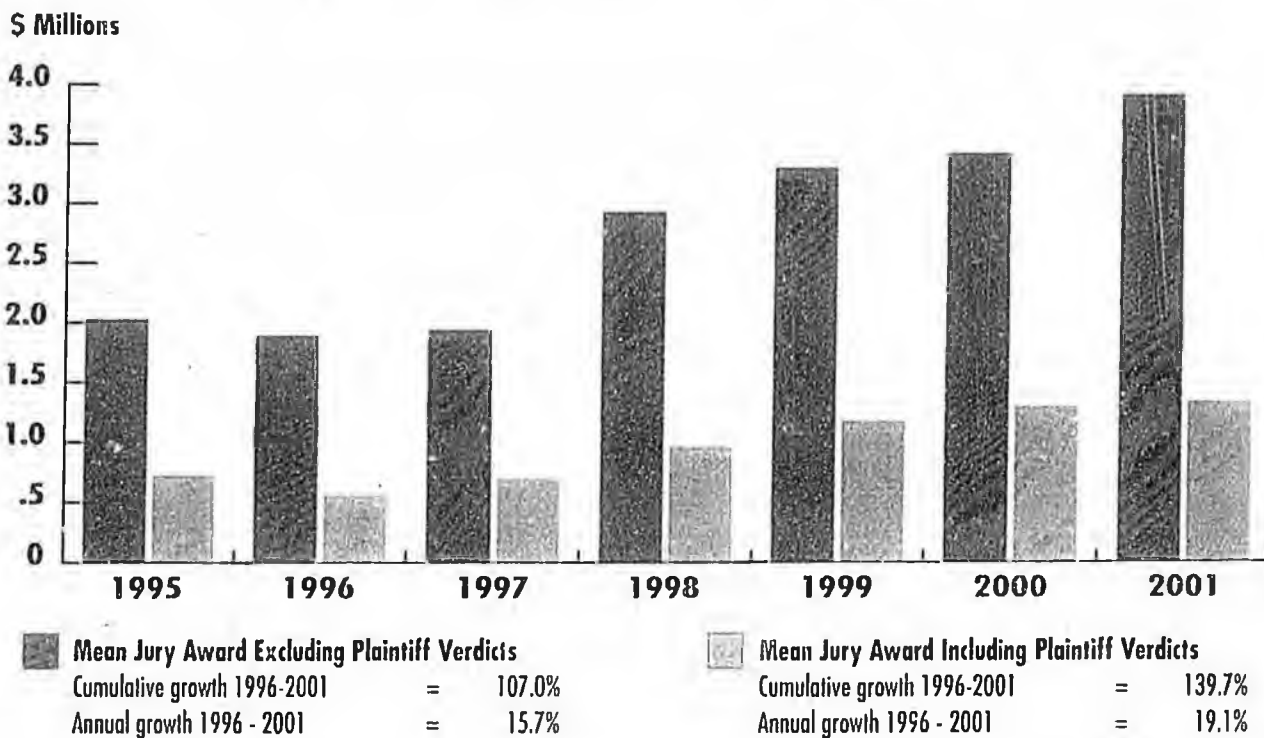
Source: Best's Aggregates & Averages, Property & Casualty, U.S., 2003 Edition, page 364.

Increases in Compensatory Awards

Coinciding with the growth in carriers' indemnity payments and the growth in the premiums they charge physicians has been growth in average medical liability compensatory jury verdict awards (Exhibit 3). Though most claims payments result from settlement negotiations rather than jury awards, jury awards are a key predictor of settlement payments because claimants and defendants use jury award information to estimate liability exposure. As jury verdicts rise, so then do settlement payments rise. Exhibit 3 illustrates the steep recent increase in average jury awards. According to Jury Verdict Research®, as reported in its most recent (2002) release of "Current Award Trends in Personal Injury," average jury awards, excluding the cases won by defendants (i.e., the \$0 award cases), grew at an annual rate of 15.7% from 1996-2001, more than doubling over the period.

Some have suggested that increases in the average award yield an exaggerated picture of the legal system's contribution to growth in PLI rates. They believe that the growth is overstated when the calculation omits the cases won by defendants. However, when one chooses to look at the average in consideration of all cases, including those won by defendants, one sees comparable growth rates. This is consistent with data from the Physician Insurers Association of America, which show that the rate at which physicians win those malpractice suits that go to verdict has been stable, at about 80%, over the past 15 years. So while the argument may be effective at diverting attention from the role of the judicial system in driving up claims costs, it has no bearing on the only two factors that are relevant to that issue: the large increases in indemnity payments (Exhibit 2) and the large rate of growth in average jury awards, no matter how that growth rate is calculated (Exhibit 3).

Exhibit 3:
Mean Medical Liability Compensatory Jury Verdict Awards, 1995-2001



Source: Reprinted with permission from 2002 Current Award Trends in Personal Injury by Jury Verdict Research®. Copyright 2003 by LRP Publications, 747 Dresher Rd, P.O. Box 980, Horsham, PA 19044-0980. All rights reserved. For more information on this or other products published by LRP Publications, please call 1-800-341-7874, ext. 307.

Insurers Continue to Lose Money on PLI

With claims payments rising rapidly, even large increases in premiums are not enough to restore the medical malpractice insurance business to profitability over the short run.

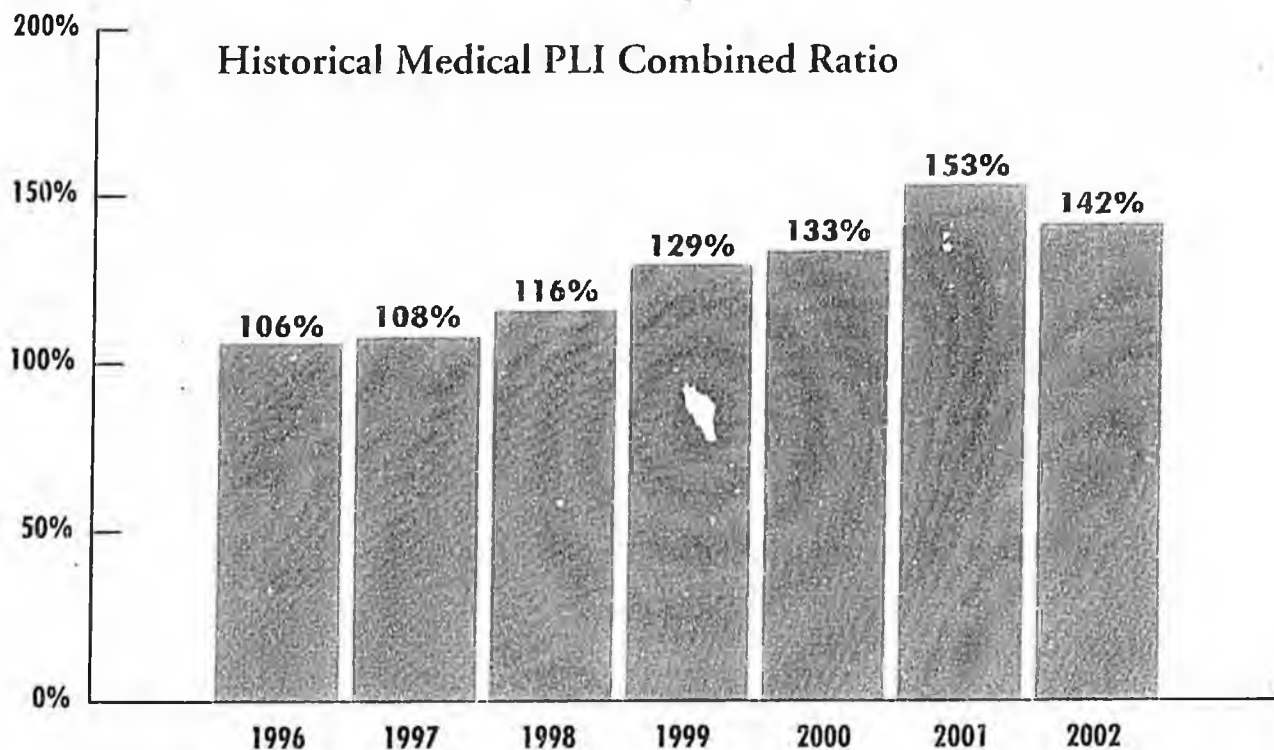
Although the recent rate increases have led to a decline in the industry's rate of unprofitability, Exhibit 4 shows that the combined ratio remains near its historically highest (worst) level, with carriers collectively having paid out \$1.42 for every dollar of premium revenue they collected in 2002.

The loss ratios in Exhibit 4 exclude carriers' performance on investments in the capital markets (primarily in the bond market). Though some have indicated that investment losses explain the carriers' large rate increases and unprofitability, the fact is that their returns on those investments have been

positive in every year and stable, ranging from 4.5% to 5.4% in each of the past five years (AM Best Aggregates & Averages, Property and Casualty, 2003 Edition, p. 335). This is confirmed by the U.S. General Accounting Office, which found in its recent report on the drivers of PLI premium increases that "none of the (insurance) companies experienced a net loss on investments" (GAO 03-702, p. 25) and "insurers are not charging and profiting from excessively high premium rates" (GAO 03-702, p. 32).

Because PLI insurers must set their rates in consideration of their investment income, the impact of these investments is to lower PLI premiums, not raise them. Even with this additional stream of revenue, however, the failure of recent rate increases to catch up with escalation in claims payments ultimately portends future rate increases, as carriers attempt to restore their PLI lines to profitability.

**Exhibit 4:
PLI Carriers Continue to Lose Money on their PLI Business**



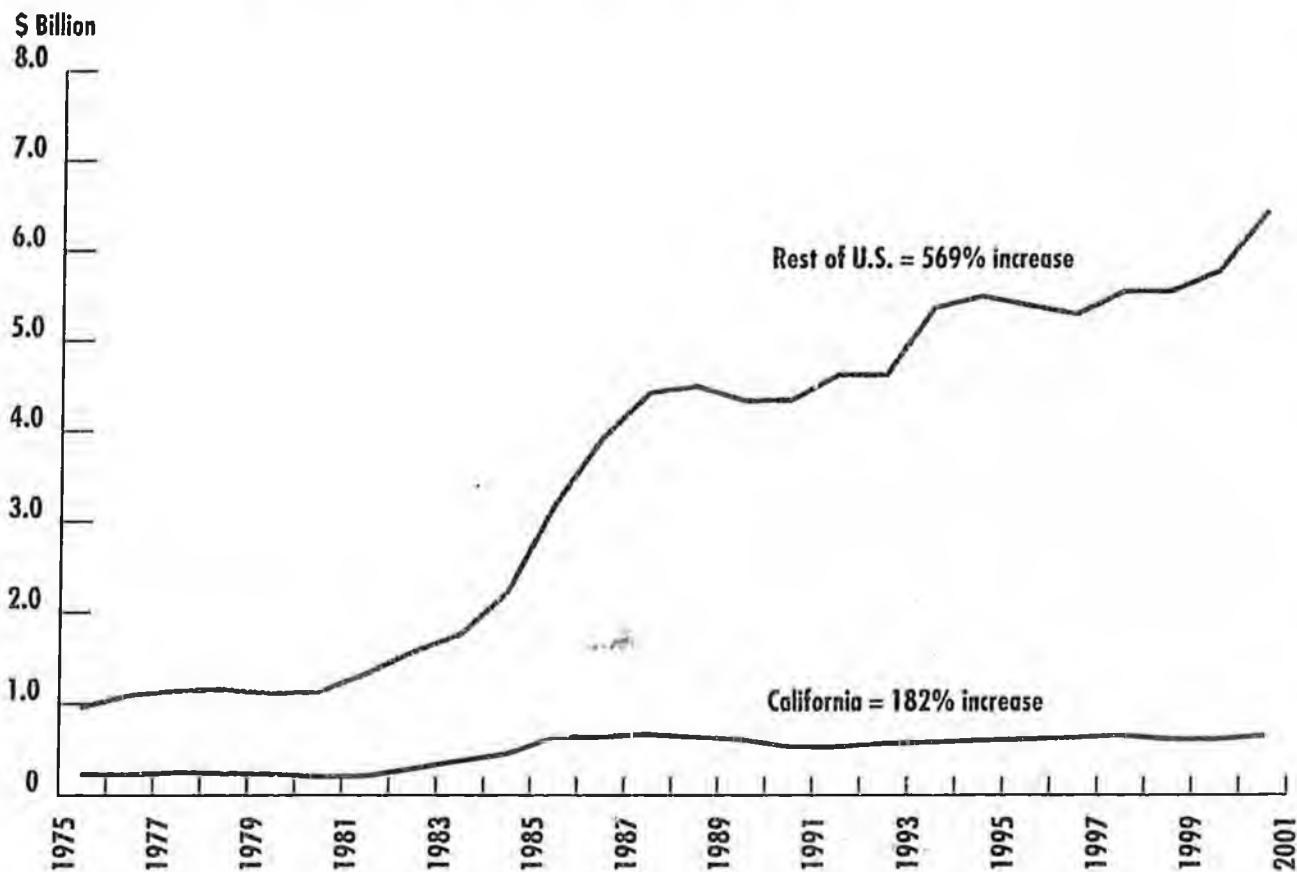
Source: Best's Aggregate and Averages: Property-Casualty, U.S., 2003 Edition, p. 364.

The Influence of Tort Reform

In the interest of preserving patients' access to physicians, some state governments have tried to keep a lid on growth in PLI premiums through a variety of tort reforms. California's Medical Injury Compensation Reform Act (MICRA) provides the model that is most frequently heralded by advocates of medical liability reform. Including a \$250,000 hard cap (no exceptions; not indexed for inflation) on non-economic damage awards, a sliding scale for the contingency fees of plaintiffs' attorneys, a collateral source offset rule, and other reform measures, MICRA has been in place long enough to provide a basis for general inferences about the potential long-range impact of certain tort reforms.

Exhibit 5 shows a dramatic level of variation in the rates of growth in total premiums for California versus the rest of the U.S. Since MICRA was enacted in 1976, total medical liability premiums collected by licensed carriers throughout the U.S., as reported by the National Association of Insurance Commissioners, grew at over three times the rate they did in California. This comparatively low level of growth for California's medical liability insurance premiums has culminated in the wide disparity between the manual PLI rates of California and the PLI rates of those states that lack effective tort reform, as illustrated by the table of rates presented in Exhibit 1.

Exhibit 5:
MICRA Has Kept the Lid on Premium Growth in California



Source: National Association of Insurance Commissioners Reports on Profitability by Line by State, 1976-2001.

Long-Term Impacts of Liability and Loss Trends

While escalating jury awards, indemnity payments, and PLI premiums all represent links in a causal chain, the ultimate outcomes of concern are the quality of care patients receive and their access to that care. Numerous peer-reviewed academic studies document the adverse impact of our medical liability system both on medical cost (defensive medicine costs) and on patient safety (risks associated with defensive medicine practices; provider incentives to avoid disclosure of dangerous errors and system failures). However, there has been little hard evidence of a more direct nature regarding the impact of liability and loss trends on patients' access to care, until recently.

Access to Care: Beyond the Anecdotes

The relationship between increases in PLI rates and patients' access to care is extremely difficult to quantify for two reasons. First, existing data sets do not capture relatively current information that can be used to discern how physicians respond to increases in their PLI premiums. Second, conventional measures of patients' access to care are not sensitive enough to detect important changes occurring at the specific levels of individual specialties within individual markets. Unfortunately, the absence of statistical evidence of impaired access to care has been construed by some as an indicator that impairment of access has not yet occurred. However, the absence of evidence need not be mistaken for the evidence of absence, and a recent study by the Agency for Healthcare Research and Quality helps to make the connection between tort reform and its impact on patients' access to care more explicit.

The 2003 AHRQ study took advantage of circumstances that lend themselves to a natural experiment. In 1970, before any states had enacted damage caps for medical liability awards, there was an approximately even distribution of physicians per capita between the group of states that would eventually adopt damage caps and the group of states that still had not adopted caps by the year 2000. AHRQ examined how that distribution varied over time between the two groups of states. Controlling for other variables found to influence the supply of physicians, the study demonstrated that by the year 2000, states with damage caps had 12% more physicians per capita than the group of states that did not enact damage caps.

Update: Health Insurance Coverage and Costs

Growth in the Uninsured Population

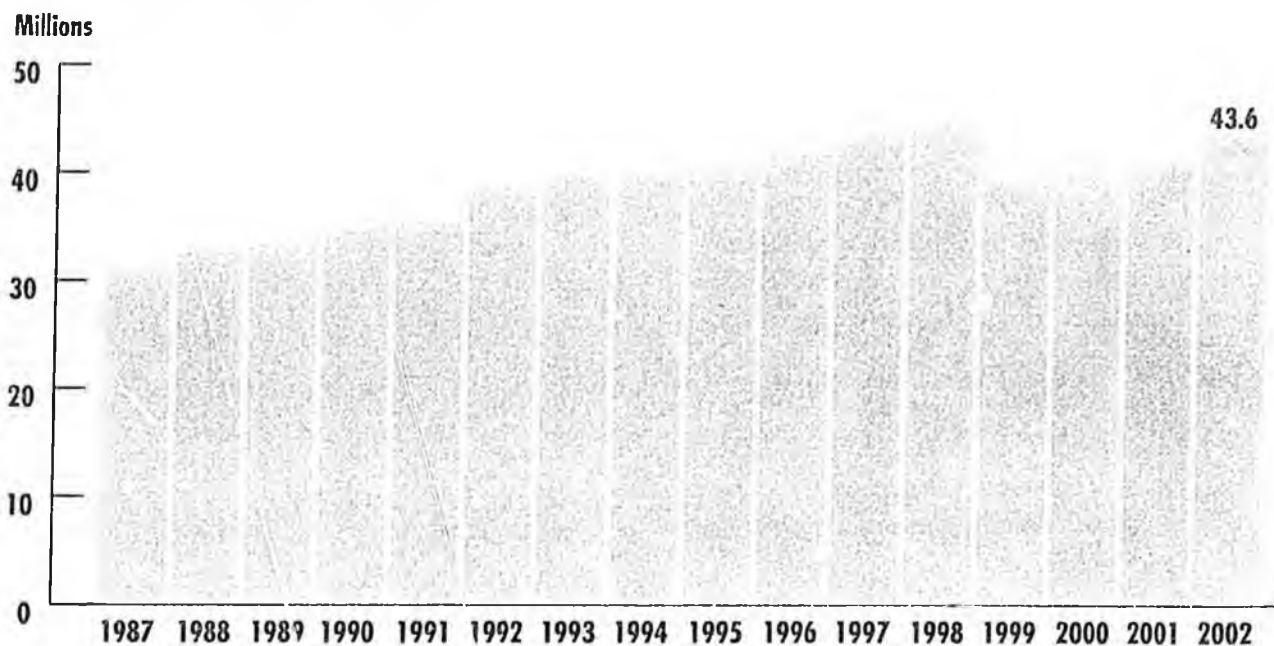
Data recently released by the U.S. Census Bureau from its Current Population Survey, and illustrated in Exhibit 6, show that the uninsured population increased from 41.2 million to 43.6 million from 2001 to 2002. The 2.4 million increase represents the largest year-to-year rise in the number of uninsured people over the past ten years. The count of 43.6 million uninsured people is intended to reflect the number of people who lacked health insurance throughout all of 2002. The total also represents the second highest annual count in history, and represents 15.2% of the

time over the period 1987-2002. However, 62% of that 5 million person decline was attributable to a change in the Census Bureau's data collection methodology. The big picture take-away, however, is that the robust, high-employment economy of the U.S. throughout the 1990s failed to stem the general trend of growth in the uninsured population.

The Cost of Health Insurance

Of all the factors that drive growth in the size of the uninsured population, the most familiar to employers are the increases in the costs of coverage. The cost of health insurance continued to grow at double-digit annual rates for the third consecutive year. In the most recent release of their annual

**Exhibit 6:
U.S. Uninsured Population, 1987-2002**



Source: U.S. Census Bureau Current Population Survey.

Note: The count for each year is intended to represent the number of individuals who were uninsured over the entire term of each year's one-year reference period.

general population of the U.S. The most noteworthy characteristic of the upward trend in the uninsured population is that, through economic times both good and bad, it was almost unrelenting. The lone exception occurred in 1999, when the uninsured population decreased for the one and only

Employer Health Benefits Survey, the Kaiser Family Foundation and the Health Research and Educational Trust reported that the average premium for employer-sponsored, family health insurance coverage increased 13.9% from 2002 to 2003, to \$9,068.

Changes in the Characteristics of the Uninsured

Of perhaps even greater concern to policymakers are the changing characteristics of the uninsured population. Exhibit 7 shows that, since 1993, the fastest growing segments of the uninsured population are comprised of those who reside in middle- and upper-income households. Although the majority of the uninsured are still members of low-income households, the number of the uninsured who are members of households with annual incomes of less than \$25,000 actually decreased by 17% over the past 10 years. According to the National Center for Policy Analysis, "about three-quarters of the rise in the number of uninsured over the past four years has been among households earning more than \$50,000 per year, and almost half of that has occurred among households earning more than \$75,000 per year. In fact, almost one third of the uninsured now live in households with annual incomes above \$50,000 and one in five live in households earning more than \$75,000." These findings appear to imply that employment, which is directly related to household income, has come to confer less and less protection over recent years against being uninsured.

This supposition is consistent with a recent study, "The Growing Share of Uninsured Workers Employed by Large Firms," released by the Commonwealth Fund in October 2003. The main finding of the study was that in 2001, 26% (almost 10 million) of the uninsured population worked for large firms (i.e., firms with 500 or more employees) or were

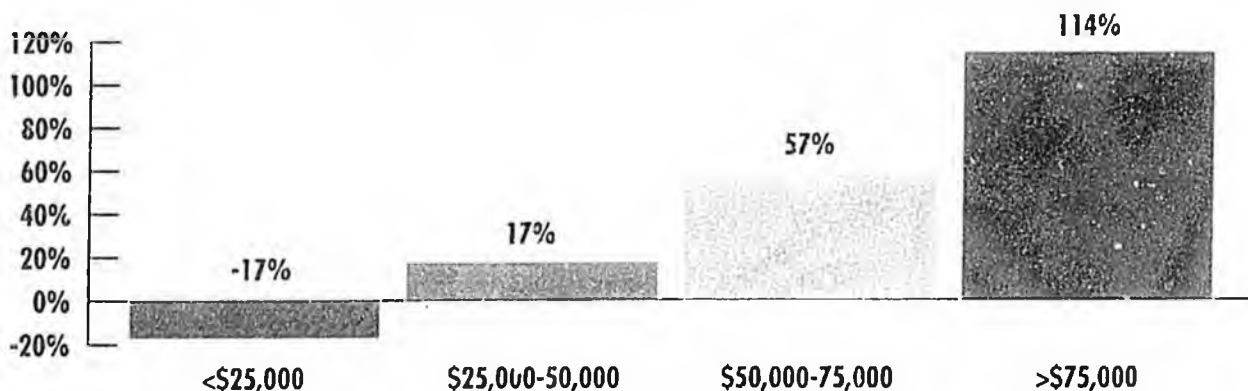
dependents of workers employed by large firms. The study also found that coverage rates for employees of large firms fell from 75% to 68% between 1987 and 2001. It would appear that, over time, employment by a large firm also has become less and less of a guarantee of having health insurance, particularly for those employed in low-wage jobs.

Policy Implications

One important hypothesis is consistent with the preceding findings about the economic context of the growth trend in the uninsured population and the characteristics of the uninsured population: the link between employment and sponsorship of coverage may impose a significant hindrance to any policy initiative intended to reduce the uninsured population. Furthermore, that barrier may be in the form of a progressively declining upper bound to the proportion of the population that is able to obtain health insurance.

Proposals that aim to substantially reduce the size of the uninsured population may have little prospect for success unless they incorporate mechanisms for moving away from the link between health insurance and employment. The AMA proposal for health insurance reform recognizes this important principle and thus its strategy focuses on empowering patients with the resources, authority, and opportunity to choose between individual and employer-sponsored options for health insurance coverage.

**Exhibit 7:
Change in the Uninsured Population by Household Income, 1993-2002**



Source: U.S. Census Bureau Current Population Survey, as presented in National Center for Policy Analysis Brief Analysis No. 460, Oct. 7, 2003.

Note: The current distribution of the uninsured population by household income segments, from lowest to highest, is 34%, 34%, 16%, and 17%, respectively.

Data Sources and Descriptions

Professional Liability Insurance

AMA Survey Data — The AMA, with the assistance of 33 state/specialty medical societies, recently conducted a National Physician Survey on PLI, in which a national random sample of physicians reported their intentions for adapting their practices in response to increases in their PLI premiums (p.1). Detailed findings from the survey are posted on the Health Policy page of the AMA's website (<http://www.ama-assn.org/ama1/x-ama/upload/mm/363/plisurvey2003.pdf>) on a for-members-only basis.

Medical Liability Monitor (MLM) — MLM publishes annually updated manual rates for three specialties — internal medicine; general surgery; obstetrics/gynecology — reflecting the middle and extremes of the rate class risk spectrum (Exhibit 1). Rates are further stratified by state or substate district and carrier. The manual rates, reflecting mature claims-made policies with \$1MM/\$3MM coverage limits, are a proxy for premiums. MLM data do not reflect variation in premiums that is due to surcharges for adverse claims experience, and they do not reflect discounts due to qualifications, affiliations, or exclusions from scope of covered practice.

AM Best Aggregates & Averages, Property and Casualty — AM Best tracks the financial performance of individual insurance carriers by line based on the information licensed carriers provide in the financial statements they file with the National Association of Insurance Commissioners. Best publishes its findings, including aggregate losses (Exhibit 2) and combined ratios (Exhibit 4), at the product line level, in its annually compiled Aggregates & Averages.

Jury Verdict Research (JVR) Reports — JVR tracks professional liability indemnity payments through annual reports of mean and median settlements and awards (Exhibit 3) based on the sample of jury verdict reports contained in its proprietary database. JVR data warrant careful interpretation. They are based on a sample of verdict reports that, according to JVR, adequately reflect jurisdictional variation in award and settlement amounts. They are not specific to specialties and they do not separately account for award and settlement amounts attributable to physicians, institutions, and nonphysician practitioners. Reductions of awards on appeal or negotiation are not reflected in the data. Although time lags between alleged occurrences and payouts (e.g., 1999 median for all malpractice claims was 45 months) are significant, the effect of these lags on current conditions is unknown.

Physician Insurers Association of America (PIAA) — This organization is a trade association of more than 60 medical PLI companies owned and operated by physicians and dentists. Collectively, these companies cover about 60% of U.S. private practice physicians. PIAA data are specific to the physician component of PLI indemnity payments. The costs are actual, not based on proxies, estimates, or preliminary judgments. The historical defendant win rate of 80% was calculated on the basis of data from exhibits 6A-2 and 6A-4 of the PIAA Claim Trend Analysis, 2002 Edition. PIAA claims trend data are based on a survey of about 20 of its member carriers.

U.S. General Accounting Office (GAO) — The GAO is an agency of the federal government that examines the use of public funds, evaluates federal programs and activities, and provides analyses, options, recommendations, and other assistance to help the U.S. Congress make effective oversight, policy, and funding decisions.

National Association of Insurance Commissioners (NAIC) — NAIC reports profitability measures by insurance line for licensed carriers, aggregated to the state and national levels (Exhibit 5), in its annual Reports on Profitability by Line by State. These voluntarily reported data are estimated to reflect 95% of all premiums written in the United States. They exclude financial data of self-insured health plans, estimated by one private source to account for more than half the total market. Although they are specific to the medical PLI product line, these measures of profitability are based on losses that include payouts on behalf of physicians and institutions. Caution is advised when drawing inferences about the physician-specific segment of the PLI industry.

Agency for Healthcare Research and Quality (AHRQ) – AHRQ is the health services research arm of the U.S. Department of Health and Human Services. AHRQ specializes in major areas of health care research including quality improvement and patient safety; outcomes and effectiveness of care; health care organization and delivery systems; and health care costs and sources of payment. AHRQ's July 2003 study titled "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians," used multivariate regression techniques to isolate the impact of tort reform on physicians' choice of practice location.

Health Insurance Costs and Coverage

Current Population Survey (CPS) – The annual March Supplement of the U.S. Census Bureau's CPS, the source of official U.S. statistics on health insurance coverage (Exhibits 6 and 7), is a survey of 60,000 households. Respondents are asked if they had any of various types of private or public health insurance in the previous calendar year. Since 2000, if they answer "no" for every type of coverage, they are then also asked to verify that they had no coverage at any time during the previous calendar year. The effect of adding this verification question to the survey was to decrease the 1999 count of the uninsured from 42.1 million to 39.0 million. The CPS is relatively timely, statistically reliable, and can be highly stratified due to the extremely large sample size. The Congressional Budget Office (CBO) speculates that CPS overestimates the number of people who are uninsured all year, indicating that the CPS estimate more closely tracks other surveys' estimates of the number of uninsured at a given point in time, rather than their estimates of the number of people who lacked coverage for the entire year.

Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Employer Health Benefits Annual Survey – This survey yields time-series data regarding employer-sponsored health insurance access, take-up and coverage rates, premiums, and plan choice. Statistics are typically stratified by such variables as employer share, firm size and geography. Estimated average cost of employer-sponsored health insurance coverage is based on coverage for a family of four and reflects premiums across all plan types (i.e., conventional, HMO, PPO, and POS).

National Center for Policy Analysis (NCPA) – The NCPA is a nonprofit, nonpartisan public policy research organization, established in 1983. The NCPA's goal is to develop and promote private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

The Commonwealth Fund – The Fund is a private foundation that supports independent research on health and social issues and makes grants to improve health care practice and policy. The Fund is dedicated to helping people become more informed about their health care, and improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. The Fund's national program areas are improving health insurance coverage and access to care and improving the quality of health care services.

How do escalating PLI rates affect patients' access to care?

Look inside for answers to your questions about PLI markets and for up-to-date findings about the growing number of patients without health insurance.

To learn more about how PLI premium growth and other socioeconomic factors impact medical practice, visit the AMA's Health Policy Web site at: <http://www.ama-assn.org/go/healthpolicy>

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515 North State Street
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Horst Loeblich, Editor
Robert D. Otten, Director

www.ama-assn.org/go/healthpolicy



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Medical Malpractice Myths vs. Truths

[The Governor](#)

Myth #1: The only thing that Governor Bush and reform proponents want are caps.

[First Lady Bush](#)

Reality: Governor Bush's reform package is based on the 60 recommendations of the Governor's Task Force. It offers a comprehensive approach to improve patient safety, enhance physician discipline, stabilize the insurance market, and create more fairness in lawsuits.

[Schedule](#)

Myth #2: People hurt in medical mishaps would be limited to \$250,000 in compensation.

[Help Desk](#)

Reality: Governor Bush's proposal only has a cap on non-economic damages, which are arbitrary, subjective and currently without guidelines. Economic damages (the injured person's medical costs, lost wages and earning potential) will remain unlimited and should be distributed quicker, because they won't be tied up in court battles over non-economic damages.

[Site and Library](#)

[The Governor's Initiatives and Programs](#)

Myth #3: Trial lawyers oppose caps because caps take money from injured parties.

[Executive Orders Initiative](#)

Reality: Non-economic damage awards are a significant source of income for trial lawyers. Today, injured parties receive less than 50% of the premium dollars paid from insurance coverage, with attorneys receiving most of the rest. Injured parties will receive fair compensation more quickly under the Governor's proposal.

[The Governor's Bush Team](#)

Myth #4: Caps on non-economic damages don't lower rates or protect healthcare.

[Contact Links and Information](#)

Reality: Caps make losses more predictable, bringing risk stability for insurance rates. The nationally recognized actuarial firm Milliman USA said payments for non-economic damage are "one of the primary drivers" of Florida's crisis. A task force of independent university leaders cited the cap as an important factor in lowering rates and protecting healthcare availability.

[Additional Facts in](#)

Myth #5: The Governor's reform package will not lead to insurance rate rollbacks.

[Press Releases and Statements](#)

Reality: Governor Bush proposes a 20% rate rollback if lawmakers pass the reform package intact. The state's largest medical liability insurer has already committed to comply with the rollback.

[The Governor's Office](#)

Myth #6: Mandatory Insurance Rate Rollbacks, not Caps, stabilized the market in California.

Reality: \$250,000 caps on non-economic damages passed in California in 1975 and were upheld by the CA courts in 1985. A year later, the amount of losses dropped and premiums stabilized. The mandatory rate rollback didn't take effect until 1989. By then, losses were already lower, premiums were more stable and insurers were returning savings to doctors.

Despite the fact that California has more than twice as many practicing physicians, it has approximately the same number of medical malpractice cases and pays less in total claims than Florida currently does. From 1991 to 2001, California had an increase in payouts of 47%, while Florida had an increase of a whopping 141%. During the same period, the number of paid claims in California dropped by 2.5%, while Florida had an increase of 82%.

Myth #7: This crisis is caused by bad or incompetent doctors.

Reality: Each year in Florida, one out of 18 doctors is sued. In high-risk specialties like neurosurgery or Ob/Gyn, nearly every doctor is sued. The legal climate is to blame - frequency of claims and "per premium" losses per Florida doctors are 36% and 50% higher than national average, respectively.

Myth #8: Bad stock market investments by insurers are the cause of this crisis.

Reality: In Florida, insurance companies can invest a maximum of 15% of their assets in the stock market. Florida's largest medical liability insurer has not had more than 9/10 of one percent invested in the stock market since 1995.

Myth #9: Proposed rollback will only decrease rates for physicians in low risk specialties.

Reality: The Governor's proposal is intended to give savings to all specialties. The state's largest insurer has already committed to give savings equally in each specialty, and the Governor will continue to challenge all insurers to do the same.

Myth #10: Florida citizens don't support reasonable caps on medical liability awards.

Reality: Sixty-eight percent of Floridians support capping non-economic damages at \$250,000, according to a statewide poll conducted in May by *The St. Petersburg Times*, *The Miami Herald* and *The Palm Beach Post*.