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American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW
Washington, DC 20005

Statement

to the

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

RE: Assessing the Need to Enact Medical Liability Reform

Presented by: Donald J. Palmisano, MD, JD

February 27, 2003

Division of Legislative Counsel
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Statement

of the

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On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our gratitude to you, Mr. Chair, and Representatives Jim Greenwood (R-PA), Chris Cox (R-CA), Billy Tauzin (R-LA), and other cosponsors of H.R. 5 for providing a much needed focus for action at the national level.

I am Donald Palmisano, MD, JD, President-elect of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, nearly 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. AMA policy dictates support for national medical liability reform. In particular, the AMA supports H.R. 5, the HEALTH Act.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care. You know that our health care system is facing a crisis when pregnant women cannot find an OB/GYN to monitor their pregnancy and deliver their baby. You know that our health care system is facing a crisis when community health centers have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear, rather than a culture of safety. You know that our health care system is facing a crisis when efforts to improve patient safety and quality

We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

RECENT FEDERAL GOVERNMENT REPORTS

In a July 2002 report released by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. This federal government report states that insurance premiums are largely determined by the litigation system, and that the litigation system is inherently costly, unpredictable, and slow to resolve claims. **Just to defend a claim now costs on average over $24,000.** Further, **the fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being squandered on fruitless legal wrangling**—resources that could be used to reduce health costs so that more Americans could find health insurance.

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other "overhead" costs, can consume 40-50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse. The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002.

medical liability insurance rates. The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."

RECENT PRIVATE SECTOR REPORTS

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that "The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986," which is "equivalent to a 5% tax on wages." This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.

- As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.

- While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.

- **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.**

The study also adds that "These trends continued in 2002, with no sign of abatement in the near future." In a press release accompanying this study, a Tillinghast principal stated that, "Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond."

In a 2001 report by Jury Verdict Research, data show that in just a one year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that **the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.**

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. **Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.**

In addition to claiming that the current medical liability crisis is an insurance issue, there have been attempts to argue that medical liability insurance premium rates in California have remained stable because of Proposition 103, not because of the successful medical liability reforms (known as MICRA—discussed later) that have been in place in California since 1975. Such claims are misguided. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance, not just medical liability insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down its rate rollback provisions while maintaining the remainder of the law.

Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner." Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

According to Californians Allied for Patient Protection, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates." **None of these approved increases included medical liability insurance.** This illustrates that Proposition 103 is not responsible for keeping medical liability premiums down. Rather, as we discuss later, it is MICRA that has been the force behind California's success.

Such misdirected claims as discussed above are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, these claims are counterproductive to the debate on resolving the medical liability crisis.

FEDERAL SOLUTION

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their

provide quality care in recent years, and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) and hospital administrators (72%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

The Harris study found that a majority (59%) of physicians believe ("a lot") that the fear of liability discourages open discussion and thinking about ways to reduce health care errors. The AMA has long believed that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences. However, this "culture of fear" caused by our over-litigious society suppresses such information.

The AMA strongly supports the principle underlying the 1999 Institute of Medicine (IOM) report entitled, *To Err is Human: Building a Safer Health System*, that the health care system needs to transform the existing culture of blame and punishment, which suppresses information about errors, into a "culture of safety" that focuses on openness and information-sharing to improve health care and prevent adverse outcomes. The AMA also supports the IOM's focus on the need for a system-wide approach to eliminating adverse outcomes and improving safety and quality, instead of focusing on individual components of the health system in an isolated or punitive way.

Toward this end, the AMA supports H.R. 663, the "Patient Safety and Quality Improvement Act," which was favorably reported by the House Energy & Commerce Committee on February 12, 2003. H.R. 663 would provide a framework to create a "culture of safety" by establishing a confidential, non-punitive, and evidence-based system for reporting health care errors. There is a very broad and strong consensus of agreement on this legislative approach within the health care community. By implementing this approach, errors can be identified and analyzed to improve patient safety by preventing future errors.

In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the health care system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.

THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (i.e., amount of the claim) (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been extremely effective in reducing the severity of claims and medical liability premiums. Conversely, a 1996 American Academy of Actuaries study shows that medical liability costs rose sharply in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering. This Gallup poll is consistent with a 2002 survey conducted by Wirthlin Worldwide showing that three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. The Wirthlin survey shows that the vast majority of Americans agree we need common sense medical liability reform. In addition to the 78 percent discussed above who said that they are concerned about access to care, the survey found that:

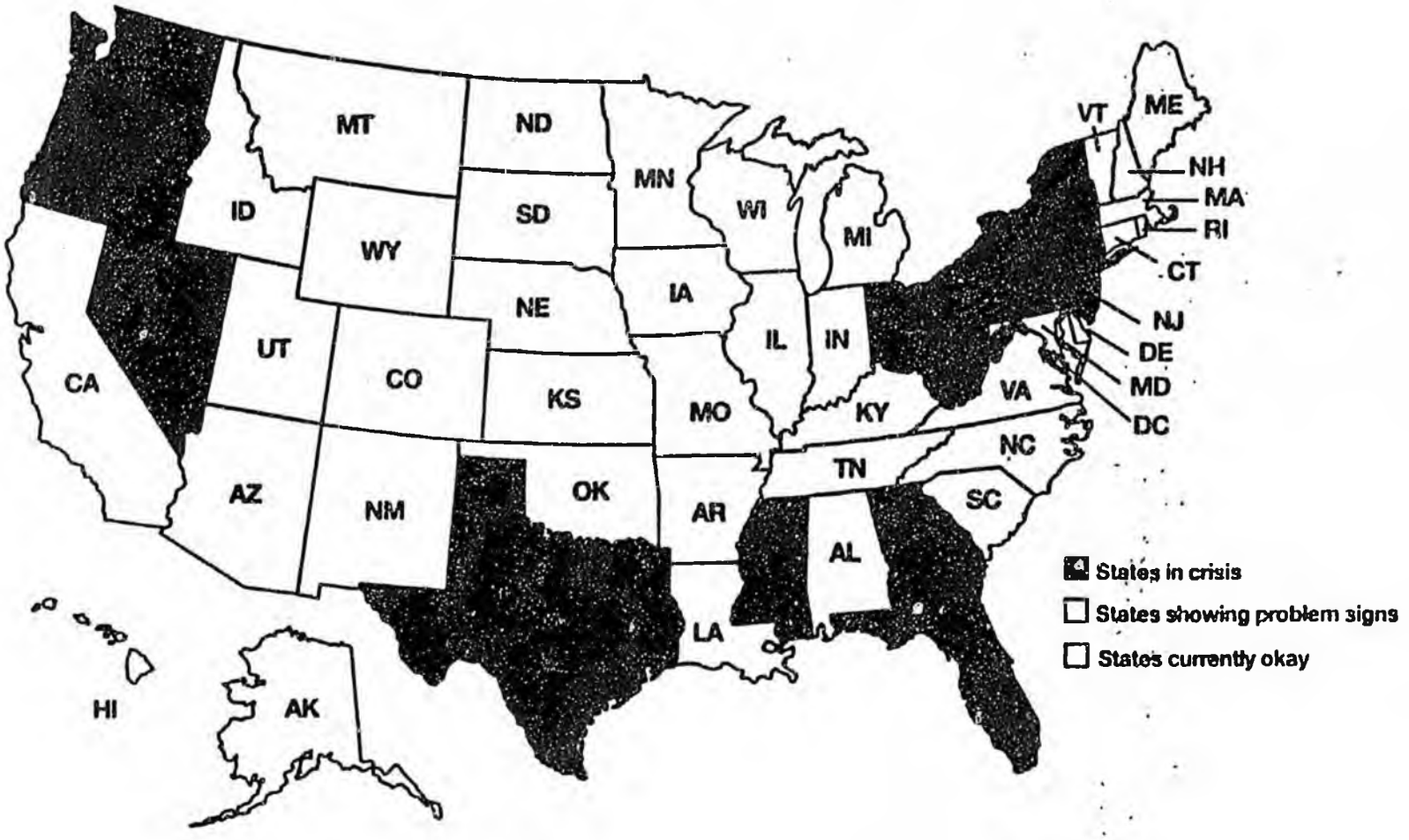
- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an

Appendix A

Medical Liability Crisis: A National View



APPENDIX B

Medical Liability Crisis Affects Access to Care

Crisis States

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Florida

- Women are facing waiting lists of four months before being able to get an appointment for a mammogram because at least six mammography centers in South Florida alone have stopped offering the procedure as a result of increasing medical liability insurance premiums. "This trend is troubling. There are a growing number of older people and less and less people to provide mammograms," said Jolean McPherson, a Florida spokeswoman for the American Cancer Society. *South Florida Sun Sentinel*, Nov. 4, 2002.

- Aventura Hospital in South Florida closed its maternity ward and cited $1,000 in insurance premiums for each delivery as the prime factor. Aventura is one of six maternity wards to close in recent months. Now, patients will be forced to drive to other counties and other facilities. "There may be waits getting into a labor-room floor," said OB/GYN Aaron Elkin, MD. *Miami Herald*, Oct. 19, 2002.

- "Without a doubt, access to health coverage is being affected. Some of our emergency rooms are losing their effectiveness," said Dr. Greg Zorman, neurosurgery chief at Memorial Regional Hospital in Hollywood. His unit gets several patients a week from smaller ERs that have lost neurosurgery coverage. *South Florida Sun Sentinel, February 5, 2003.*

- Port Charlotte cardiologist Leonardo Victores, MD, left for Kansas in the face of medical liability premiums that were going to increase 100 percent. "He's moving to Kansas because that state has caps on malpractice awards," said colleague Mark Asperilla, MD. *Sun Herald, Jan. 1, 2003.*

- Despite having no malpractice claims or disciplinary actions on his record, Lakeland OB/GYN John Kaelber, MD, was forced to close his practice and leave the state in the wake of insurance premiums that doubled. *Lakeland Ledger, Nov. 21, 2002.*

- More than 50 Bradenton patients had to postpone elective surgeries and more than 100 office visits were canceled because two physicians were unable to obtain liability insurance. The insurer may leave the state altogether. *Bradenton Herald, Jan. 24, 2003.*

- After recently receiving notice of a premium spike coming in July 2002, Vladimir Grnja, MD, decided that he would "go bare" and drop all medical liability insurance coverage. Rates for the Hollywood, FL radiologist were to rise to $112,000 from $35,000 a year (a 220% increase), mainly because of litigation over mammograms. "No doctor wants to go bare," said Dennis Agliano, MD, chairman of the Florida Medical Association's special task force on the Florida medical liability crisis. But with significant premium hikes in Florida for specialties like OB/GYN, neurosurgery, thoracic surgery, radiology and even primary care, "some doctors have no choice," he says. Some neurosurgeons in

- American Physicians Assurance announced on July 17, 2002 that it is leaving the state

- Farmer's Insurance has announced its intent to leave the state. Among other insurers. MAG is still writing policies, while Medical Protective and ProNational are being very selective. FPIC, the largest medical liability carrier in the state, endorsed by FMA. is only writing very selectively. Both Clarendon and St. Paul have pulled out entirely.

- . According to the FMA's General Counsel, Florida's existing caps simply do not work and are never used. The caps only apply in cases where the physician agrees to arbitration and in order for the case to go to arbitration the physician must admit liability. In addition, the original intent of this Florida provision was to have the cap apply to each incident, but it has been interpreted to apply to per claimant. which obviously also decreases its effectiveness. The lack of a straight cap is the primary reason for the current crisis in Florida. Unlike such States as Kansas, Florida. has not seen an increase in frequency of claims, but there has been an increase for severity in jury awards.

- In a presentation before FMA. the medical liability insurance carrier, EPIC. presented facts that demonstrate the medical liability crisis in Florida. During 1975, there were 380 health care lawsuits in Florida, resulting in $10.8 million in jury awards and costing $1.5 million to defend. In 2000 there were 880 lawsuits alleging malpractice, resulting in awards of $219 million and costing $36 million to defend.

- Dr. Oliver Bayouth says his medical-malpractice premiums are skyrocketing. The Orlando obstetrician is paying about $100.000 for insurance this year, up at least 25 percent from two years ago. Frustrated, Bayouth says he is thinking about moving his practice out of Florida. *Orlando Sentinel, January 20, 2002.*

- In South Florida, where insurers say litigation is the heaviest, ob/gyns pay as much as $202.949 a year--the highest rates in the country, according to Medical Liability Monitor, a Chicago-based newsletter. *Orlando Sentinel, January 20, 2002.*

- Dr. Alan Appley, an Orlando neurosurgeon. moved his practice to Lafayette, Louisiana, last year in part to escape Florida's soaring malpractice rates. *Orlando Sentinel, January 20, 2002.*

- Dr. Joseph Boyer, an Orlando cardiologist, says his rates rose 64.6 percent. to $99.000. in 2002. *Orlando Sentinel, January 20, 2002.*

- Central Florida Cardiothoracic Surgery in Orlando says it will pay about $140.000 to insure two surgeons in 2002, compared with about $54.000 last year. *Orlando Sentinel, January 20, 2002.*

- Dr. Alexander Jungreis, an Orlando neurosurgeon, said his liability insurance premiums tripled this year. *Orlando Sentinel, January 20, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Georgia

- According to a Georgia Board for Physician Workforce study released in January 2003, 2,800 physicians in Georgia are expected to stop providing high-risk procedures to limit medical liability.

- The study also indicated that 1,750 physicians reported that have stopped or plan to stop providing ER coverage and 630 physicians plan to quit practicing or leave the state. In addition, 1 in 5 family physicians and 1 in 3 OB-GYNs reported plans to stop providing high-risk procedures, including delivering babies.

- But numbers alone do not tell the whole story; there is a very human side to this crisis. For instance, although she is only in her first year of medical school at Medical College of Georgia, the liability crisis has already caused Thandeka Myeni, 26, to reconsider her preference for obstetrics, one of the specialties hardest hit by medical liability increases. "I definitely think it could be discouraging," she said. *The Augusta Chronicle, Nov. 13, 2002.*

- Evans Memorial, a rural hospital in Claxton, decided to "go bare"—have no coverage at all—instead of paying what it considered an exorbitant medical liability premium. Only one insurer offered a malpractice policy for the hospital and its nursing home, and the annual premium for $1 million in coverage would have been $581,000, up from $216,000 last year. "We just thought it was outrageous," said Eston Price, Evans Memorial administrator. *The Atlanta Journal-Constitution, Oct. 7, 2002.*

- The largest hospital in the state's health system has bought a new policy—with a deductible of $15 million—covering 953-bed Grady Memorial, a nursing home and clinics. On each paid claim below that mark, Grady is responsible for every dollar. The $15 million deductible starts again with each claim. "Grady faces open-ended liability," said Timothy Jefferson, Grady Health System executive vice president and chief counsel. *The Atlanta Journal-Constitution, Oct. 7, 2002.*

- Knowing that malpractice premiums were rising for everyone in the industry, Ty Cobb Health System CFO, Chuck Adams earmarked enough money for a 100 percent increase. The bill arrived by fax this summer, just 24 hours before a check was due. Not only was the insurance company increasing his deductible tenfold, but the premium jumped from $553,000 to $3.15 million – a 469 percent increase. "We were numb," said Adams, who eventually got an extension and another cheaper policy at $1.65 million. "There goes our expansions, like a renovation of the Hart County Emergency Room." *The Atlanta Journal-Constitution, Aug. 11, 2002.*

- "Dr. Edmund Wright, a Fitzgerald family practitioner who performed Caesarian sections, has given up that part of his practice. His premiums quadrupled to $80,000 in

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Mississippi

- Although Mississippi enacted some medical liability reforms late last year, it is still too early to see if this will stem the exodus of physicians from the State. The reason: the Mississippi cap on non-economic damages has broad exceptions and the trial bar is looking for ways to get around its limits. In short, Mississippi remains in crisis.

- The Mississippi State Medical Association still estimates that the state could lose as many as 10 percent of its 4,000-4,500 physicians.

- Obstetricians in Mississippi still worry about what is going to happen to their patients who face longer trips to the hospital while already in labor. Women who used to walk or make a short drive for both prenatal visits and delivery now face a 45-minute drive by car to the only physician in their area who can still treat OB patients.

- Pregnant women who are considered high-risk, such as someone with diabetes, cannot be treated at the Kosciusko Medical Clinic because it is too risky for physicians, where seven physicians formerly practiced obstetrics and gynecology. Only three were predicted to remain in January 2003. *The Clarion-Ledger, Aug. 26, 2002.*

- Only two neurosurgeons remain in practice in the Gulf Coast-area of Mississippi, and general surgeons are in short supply because of the state's medical liability crisis. "Everybody is reduced to the same low level of trauma care that we had 20 years ago," said Steve Delahousey, vice president of operations at American Medical Response ambulance service. *Jan. 29, 2003 Biloxi Sun Herald*

- Neurologist Terry Smith, MD said he had applied with 14 companies, and Medical Assurance was his last hope to find coverage before his current policy expired on Aug. 4, 2002. His premium went from $55,000 a year to potentially $150,000 with a $132,000 tail to his old insurer. "I'm looking at writing a check for $300,000," said Smith, who does brain surgery at three hospitals in Jackson and Harrison counties. *Associated Press, July 11, 2002.*

- Four rural hospitals in Ocean Springs faced closure, as their insurer, Medical Assurance Company of Alabama, was not renewing their coverage because the insurer was leaving Mississippi.

- Greenwood Hospital – the only trauma center in a 55-mile radius – was unable to keep its Level-II trauma center rating because area neurosurgeons have left, citing the high cost of liability insurance. Greenwood also has lost 2 of its 4 Ob-Gyns.

- At least 15 insurers, including St. Paul, have left Mississippi in the previous five years.

- In the northern half of the state last year there were nine practicing neurosurgeons: now there are just three on emergency call. *The Wall Street Journal, May 1, 2002*

- In 1998, 227 Mississippians filed malpractice suits. Based on the suits filed during the first quarter of 2002, the Medical Association Company of Mississippi predicts over 550 medical liability suits will be filed this year.

- Across the State, there is a veritable litigation explosion, in Jefferson County, for example, there are only about 9,740 residents - but the number of lawsuits filed in 1999 numbered 10,000. A year later, in 2000, the number of plaintiffs on the docket increased to 27,000, or nearly three times the number of residents. *The Washington Times, May 11, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Nevada

- In August, Nevada Governor Guinn called a special legislative session to address medical liability issues. In just four days, Nevada legislators enacted a meaningful liability reform bill.

- Unfortunately, while Nevada passed needed reforms, the crisis there has not yet been averted due to continued lack of availability and affordability of medical liability insurance. Insurers in Nevada have not yet reduced their premiums and physicians are still leaving the state, particularly in Southern Nevada.

- Why? Because the trial bar has threatened to institute legal challenges to this new law that could thwart and delay its implementation. Without the full force and effect of reforms right now, the scenario that has crippled access to medical care in Nevada will continue.

- 60 percent of Las Vegas-area Ob-gyns have said they would stop delivering babies in 2002 because of the out-of-control legal system and skyrocketing liability premiums.

- Las Vegas' only trauma center, which treated more than 11,000 patients in 2001, closed for 10 days in July 2002 because it did not have enough surgeons to staff the center.

- When a trauma center closes, "some patients are going to die that wouldn't die . . . the quicker you're at the trauma center, the better chance you have of survival," a Las Vegas surgeon told NPR. The next closest trauma center is at least 5 hours away.

- "There is an unavailability of [medical liability] insurance," said Nevada State Insurance Commissioner Alice Molasky-Arman, at a March 4, 2002 hearing where insurance officials testified they would no longer insure any new obstetricians, surgeons and other high-risk specialists.

- A Las Vegas Ob-gyn was forced to close her practice and leave 30 pregnant patients behind because her liability insurance increased from $37,000 to $150,000 in one year. She now practices in Los Angeles and pays only $17,000. Some Nevada women have had to call as many as 50 Ob-gyns just to find one who is accepting new patients.

- Nevada ranks 5th among states with the highest physician liability premiums (at $94,820 per year), but only 47th out of 50 states in the number of physicians for its population, according to the American College of Obstetricians and Gynecologists. An ACOG survey concludes that 6 out of 10 Nevada Ob-gyns will no longer practice obstetrics.

- "Approximately 100 Las Vegas physicians have already left Nevada to practice elsewhere, announced they will be closing their practices, or retire early because they

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

New Jersey

- A multi-physician practice in Teaneck, NJ, was forced to layoff employees and reduce the number of deliveries it performed because of medical liability insurance premium increases of more than 120 percent. "All of my colleagues are experiencing the same pressures," said George Ajjan, MD. *Bergen Record, May 22, 2002.*

- One out of every four hospitals—nearly 27 percent—has been forced to increase payments to find physicians to cover Emergency Departments. Physicians are increasingly reluctant to take on such assignments because of the greater liability exposure. Hospitals report that more and more physician specialties are being hit by the crisis. While a previous New Jersey Hospital Association survey in March 2002 found that OB/GYNs and surgeons were primarily affected, the new survey finds a deepening impact for neurologists/neurosurgeons, radiologists, orthopedists, general practitioners and emergency physicians. *New Jersey Hospital Association, Jan. 28, 2003 news release.*

- "We have as much to lose as they have," said Joan Hamilton, a patient who attended a recent rally in New Jersey in support of her physician. *Bergen Record, Oct. 6, 2002.*

- Physicians, nursing homes and hospitals are all in jeopardy. Liability premiums for hospitals increased more than 150% over the past 3 years. A N.J. American Hospital Association survey found that nearly 2/3 of hospitals had one or more instances where physicians were forced out of medicine because of high premiums.

- 64.8 percent of all New Jersey hospitals said they have had physicians stop practicing medicine or plan to stop because of the state's liability crisis.

- New Jersey's largest insurer, the MIIX company, declared May 9, 2002, it is getting out of the medical liability business. Previously, MIIX insured 7,000 physicians – nearly 40% of the state. MIIX previously left the medical liability insurance markets in Ohio, Pennsylvania and Texas, citing those states' out-of-control legal climates as an unacceptable business risk.

- After years of only a few large jury awards, New Jersey had 26 greater than $1 million in 2001, and is averaging one a week in 2002, MIIX President Patricia Costante told the *Philadelphia Inquirer* June 4. New Jersey has no limits on non-economic damages in medical liability cases.

- New Jersey physicians are also facing difficulty finding new insurance because PHICO, which insured 9%, and St. Paul, with 6% of the market, have pulled out.

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

New York

- New York physicians still pay, in most instances, the highest medical liability premiums in the country. Ob-gyns' average premium is $144,973, according to the American College of Obstetricians and Gynecologists.

- New York continues, by far, to lead the country in total medical liability payouts, with $633 million total in 2000. That is 80% more than the state with the second highest total, Pennsylvania (at $352 million), and 300% more than California (at $200 million). Average medical liability verdicts have skyrocketed recently, going from an average of $1.7 million in 1994 to $6 million in 1999.

- "The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002," wrote Donald Copley, MD, an officer of the Erie County Medical Society in *Business First of Buffalo*. "I've watched sadly as valued colleagues have left Erie County and even the profession. A competent young specialist recently quit doing high risk diagnostic procedures to become a business consultant. Several local obstetricians have stopped delivering babies to reduce their insurance expenses. A half dozen nationally-known doctors have quietly left Western New York. The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002." *Buffalo Business First, April 15, 2002.*

- The Medical Society of New York says the trend of physicians leaving New York State or retiring early is happening across the state.

- "The rising cost of malpractice coverage is becoming one of the most important factors driving inflation for physicians' services," said a managing director of the Carlyle Group, the investment group for *The New York Times*.

- After not replacing a retiring office manager and moving to a smaller office, a 55-year old Cleveland-area surgeon who was only sued once quit practicing medicine rather than accept an 80% liability premium insurance increase. Another surgeon, who has never been sued, no longer performs high-risk procedures and saw his insurance rates jump from $40,000 to $90,000 in one year.

- "If I were advising medical students now, I would tell them to take a real hard look at going into some of these high-risk specialties," John Bastulli, MD, told the *Plain Dealer*.

- Ohio ranked among the top five states for premium increases according to the *Medical Liability Monitor*.

- "My premium jumped this year from $14,000 to $35,000. I can't afford to continue obstetrics at that price. I'll have to give up delivering babies as of Jan. 1, 2003. I practice in a primarily rural area, and there isn't any other obstetrical care here, so expectant women will have to drive long distances to receive prenatal care. Some 75% of my patients don't have the financial resources to do so. Yet, studies have shown that proper prenatal care fosters healthier newborns and healthier newborns cost society less money. I find it difficult to accept that my liability insurance premiums will force me to give up a side of my practice that has meant a lot to me and to my patients, but I'll have no recourse." – A Mt. Gilead family practitioner.

- "We've done the math: If we're going to take care of this debt (our annual insurance payment will increase from $100,000 to more than $500,000), our service is going to go out the window. To recoup the loss, we'd have to add 400 patient visits a month. You can't turn ob-gyn into a factory." – A Columbus obstetrician-gynecologist.

- "I just sat down with paper and pencil, and it became not financially rewarding to stay." – An Athens obstetrician-gynecologist, in reference to why he retired from his practice early.

- "I practice in southern Ohio in a town of 7,000. We have a small community hospital with a family birth center. There are three of us who do obstetrics – two family practitioners and one OB/GYN. In order to break even, our unit needs 150 deliveries a year. That is 50 deliveries each. If we go over 30 deliveries now, our premiums are in the $40-60,000 range, which is impossible financially. We are struggling with limiting our ob to 30 each, but that will cause the OB unit to go under and close. We all love ob, and are well trained in providing high-risk OB care, but we're going to be forced to stop. If this occurs, there will be no OB care between Athens and Lancaster, Ohio. Tort reform needs to occur yesterday!" – A Logan family practitioner

- "I'm just postponing the inevitable. If the situation doesn't change, I could be insolvent in five years and have to close my practice. I'm only 49. Who will care for my patients? Discontinuing obstetrics is not an option. We need help!" – A Dayton obstetrician

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Oregon

- Rural families in John Day, Hermiston, and Roseburg counties, Oregon have either lost obstetric care or have seen services drastically reduced. *The Business Journal of Portland, Jan. 10, 2003.*

- Only by dropping obstetrics were two Hermiston physicians able to afford their liability insurance premiums. "It's something you don't like to tell patients," said Doug Flaiz, MD. *The Oregonian, Oct. 29, 2002.*

- "No one with $100,000 in debt from medical school wants to start a practice in a place where they could find themselves completely broke and having to pick up and go somewhere else to start all over again," said Rosemari Davis, CEO of Willamette Valley Medical Center, who has seen three of her center's family practitioners stop delivering babies. *The News Register, Jan. 28, 2003.*

- In 1999, the Oregon Supreme Court overturned the State's law capping non-economic damages. Since then, multi-million dollar claims have become commonplace, according to the Oregon Medical Association.

- Since the 1999 decision, Oregon physicians are experiencing rapidly rising premiums and insurers becoming more reluctant to offer policies to physicians, such as Ob-gyns and surgeons, who perform high-risk procedures.

- Recent jury verdicts include: $8 million, $8.5 million, $10 million and $17 million.

- Rural patients in Oregon are being particularly hard hit. A small town clinic, Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in May 2002 because its liability insurance was canceled after one large lawsuit. "We consider this a medical crisis for the community," Mercy Medical CEO Vic Fresolone told the Associated Press.

- The Roseburg clinic physicians paid $17,000 per physician per year in 2001 for medical liability insurance and are now receiving quotes for $80,000 - 100,000 per physician.

- Oregon's only academic health center – the Oregon Health & Science Center – reports fewer medical students are applying for its Ob-gyn residency positions. Ob-gyn residents elsewhere reportedly are increasingly concerned about setting up practice in Oregon due to the state's broken liability system.

- A major liability insurer, Northwest Physicians Mutual Insurance Company, announced in 2002 it would not write new policies to obstetricians. Remaining insurers are raising rates by 60% or more.

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Pennsylvania

- According to the Pennsylvania Medical Society Alliance, 919 doctors have decided to leave the Keystone State or have scaled back their practices as premiums spiraled upward over the past three years. *The Baltimore Sun, Feb. 5, 2003.*

- Dr. Anthony Clay never thought he would have to leave Philadelphia. He has spent his whole life there—growing up and attending college, medical school, and residency to become a cardiologist. He treats families he has known since boyhood. He likes knowing where his patients live, work, and shop. All nine of his siblings still live there. But, Dr. Clay is leaving his practice in Philadelphia this Spring because of surging malpractice insurance rates. He is starting over in Delaware, where his insurance costs will drop from roughly $70,000 a year to $8,000. "It's been terrible," said Dr. Clay, 40. "In this field, you've been with the patient, and also the family, in some of their most life-defining moments - in the throes of a heart attack with no blood pressure. Wrongly or rightly, the patient credits you with being there when they weren't doing so well. You realize you've created a bond. I take that very seriously." *Baltimore Sun, February 5, 2003.*

- Brian Holmes, MD, is one of an estimated 18 percent of Pennsylvania neurosurgeons to have left the state, retired, or limited his or her practices because of the medical liability crisis. "It saddened me to move, but I had no choice. It was either move or go out of business." *Philadelphia Business Journal, Sept. 25, 2002.*

- After 25 years of practice, OB/GYN Michael Horn, MD, stopped delivering babies in 2002 because of the fear of getting sued. "It's just the potential, the not knowing if someone will seek an outlandish reward. I don't want to expose myself or my family." *Burlington County Times, Oct. 2, 2002.*

- Medical students are less likely to seek residencies in Philadelphia, and residents are less likely to stay and practice in the area because of "prohibitively high" medical liability insurance rates, according to Jefferson Medical College professor Stephen L. Schwartz, MD. *Associated Press, Oct. 4, 2002.*

- OB/GYN Lawrence Glad, MD, used to deliver about 500 babies a year—40 percent of all the babies born in Fayette County annually. After his premiums skyrocketed from $57,000 to $135,000, however, he closed his practice in the fall of 2002. *Pittsburgh Business Times, Nov. 18, 2002.*

- Mercy Hospital chief of surgery Charles Bannon, MD, has watched numerous physicians leave Scranton and Lackawanna County—creating a shortage of surgeons, fewer medical school applications and residencies. "It will take generations to get back the quality of medicine in Philadelphia." *Scranton Times, Nov. 20, 2002.*

- 414 medical liability lawsuits were filed in Philadelphia County in February 2002 – five times the average number filed during the month over the previous decade, reported the *Philadelphia Inquirer*.

- One-quarter of respondents to an informal poll conducted by the American College of Obstetricians and Gynecologists say they have stopped or are planning to stop practicing obstetrics.

- Statistics compiled for the Pennsylvania Medical Association by Caso Consulting indicate it costs $96,199 to cover an orthopedic surgeon in Pennsylvania, compared with $37,783 in Delaware, and $36,291 in New Jersey. *Best's Insurance News, January 7, 2002.*

- Howard A. Richter, a neurosurgeon and president of the Pennsylvania Medical Society, said a 2001 survey by the medical society showed that 72% of doctors have either deferred the purchase of new medical equipment or have not hired needed staff because of "sudden and sharp increases" in insurance rates. *Best's Insurance News, January 21, 2002.*

- "To lower their risk and insurance premiums, doctors who normally would take on high-risk medical procedures are opting not to do so. For example, we've seen obstetrician/gynecologists give up delivering babies. Virtually every medical liability insurance carrier increased their rates in recent years. From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates between 80.7 percent and 147.8 percent." *York Daily Record, January 20, 2002.*

- Driving premiums through the roof are excessive sums awarded in malpractice suits. Medical liability payments for physicians in 2000 totaled $3,908,113,303. *York Daily Record, January 20, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Texas

- In the "Lone Star State" medical liability insurance premiums for physicians have skyrocketed as much as 300 percent in some regions and for some specialties, acccording to the Texas Medical Association. As a result, there is only one neurosurgeon serving 600,000 people in the McAllen area.

- In the past two years, four South Texas patients with head injuries died before they could be flown out of the area for medical attention. As reported in a July 10, 2002, article in *The Courier*, a community family practice clinic in Conroe (just north of Houston) was recently forced to turn away half of its normal patient load because its liability insurance provider would not provide coverage while "highly lawsuit-risky obstetrics training was conducted."

- Even though the Texas legislature has passed medical liability reforms, the Texas Supreme Court has regularly overturned them.

- Medical liability premiums were expected to increase by at least 20 percent and perhaps as much as 75 percent in 2002, according to the Texas Department of Insurance. *San Antonio Express-News*, April 8, 2002.

- In 1999, 17 companies offered malpractice coverage to doctors in Texas. Today, the field has dwindled to only four, and Texas is considered the least profitable state for liability carriers. *The Dallas Morning News*, September 1, 2002.

- Moreover, premiums this year have climbed at triple-digit rates for many of Texas' 36,000 physicians. That's on top of double-digit increases in prior years. Now it's not uncommon for doctors in high-risk specialties such as trauma surgery, emergency medicine, and orthopedic surgeries and obstetrics to pay more than $ 100,000 annually for coverage. This means that some 6,100 Texas physicians are scrambling to find liability insurance.

- The Doctor's Company, a national insurer, told the *Dallas Morning News* the company is selective about which types of physicians it will cover. "Texas is a very dangerous venue, and we don't really encourage . . . [growth] from there – not without tort reform," said senior vice president Jack Myer.

- In South Texas, one jury awarded $43 million to a woman who claimed a diabetes drug damaged her liver, while another gave $15 million to three women who received faulty hip implants. *The Wall Street Journal*, May 1, 2002.

- 6 of every 7 medical liability claims in Texas are closed with no fault found on the doctor's part. Nonetheless, tens of millions of dollars are spent fighting these cases.

- In Texas, about 85 percent of cases are closed without payment to plaintiff, yet they still cost money to resolve, said Texas Medical Liability Trust president W. Thomas Cotton. *The Dallas Morning News, January 20, 2002.*

- Insurance carriers in Texas paid more than $381 million in claims in 2000, according to the Texas Department of Insurance--costs passed on to policyholders. That's an 87 percent increase since 1995. Nationally, the median malpractice award more than doubled from 1994 to 1999, to $800,000. *The Dallas Morning News, January 20, 2002.*

- Texans filed 4,501 claims in 2000, up 51 percent from 1990, according to the Texas Medical Examiners Board. More troublesome is the rise in expenses involved in resolving a case. Each claim cost an average of $68,681 to litigate in 2000, compared with $46,079 in 1995. The figure does not include the amount of settlement or award. *The Dallas Morning News, January 20, 2002.*

- Meanwhile, physicians in the Rio Grande Valley are in crisis, said Texas Medical Liability Trust president W. Thomas Cotton. An OB-GYN in North Texas pays $47,500 annually for $500,000 in coverage, while his Rio Grande Valley counterparts pay $82,300. Neurosurgeons pay even higher premiums. *The Dallas Morning News, January 20, 2002.*

- Seven in 10 Rio Grande Valley doctors have had medical liability claims filed against them. A February 2001 survey by the Texas Medical Association found that 1 in 3 Valley doctors say their insurance providers have stopped writing liability insurance. *The Dallas Morning News, January 20, 2002.*

- In Rio Grande Valley, half of the physicians admitted to being inclined to leave the area or to retire, according to a survey conducted in February 2001 by the Texas Medical Association. Many doctors in the Valley said they profile patients and refuse to treat some, because they fear the patients are prone to sue. They said they deny care for people who pay with cash, because the patients are most likely poor and may look at a lawsuit like a lottery opportunity. Some physicians are even hesitant to respond to a "code blue," which indicates a medical crisis, in a hospital. Dr. Carlos Cardinez, a gastroenterologist in McAllen, said he doesn't want to respond anymore because of the legal uncertainty. *The Dallas Morning News, January 20, 2002.*

- Increases in medical practice costs have outstripped revenue increases over the last 10 years, according to the Medical Group Management Association's 2000 cost survey. Operating costs for multispecialty groups went up an average of 35 percent over the past 10 years, while revenue increased 21 percent over that same period. *The Dallas Morning News, January 20, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Washington

- "There is a growing crisis in medical malpractice in Washington state and nationally," state insurance commissioner Mike Kriedler said in an April 2002 news release.

- "Patients in many communities are finding that their physicians have either started limiting their services or have closed their doors completely due to rising malpractice premiums," said Dr. Maureen Callaghan, president of the Washington State Medical Association. *PR Newswire, Feb. 3, 2003.*

- "I went through my mourning and my grieving, and now I have to find a place for my [380] patients," said a South Send internist who has not been sued but can no longer afford liability insurance coverage.

- The cost of medical malpractice insurance has soared so high that Mount Vernon obstetrician Robert Pringle, MD, has stopped delivering babies, according to the *Puget Sound Business Journal.*

- So have his two colleagues at the North Cascade Women's Clinic, and so have others. "Of the nine obstetricians in our community, six have stopped delivering babies or left the area," Pringle said.

- When he began his practice 20 years ago, Pringle paid a premium of $1,000 for medical malpractice insurance, which covers physicians against claims of injury resulting from negligent medical care. "Now it's in the neighborhood of $60,000," he said. "From an economic standpoint, you would have to be a lunatic to continue private practice of obstetrics." *Puget Sound Business Journal.*

- The severe premium hikes besetting many doctors "could not come at a worse time," said Dr. Sam Cullison, president of the Washington State Medical Association. Cullison said the high cost of malpractice insurance has combined with low reimbursement rates from Medicaid, Medicare and private insurers to clamp many doctors in a financial squeeze. As a result more physicians are retiring early, or leaving the State, he said. Also, it's increasingly difficult to recruit doctors from other states." *Puget Sound Business Journal.*

- "Everyone is in the same situation in terms of increasing premiums, increasing overhead and decreasing reimbursement." said Olympia neurologist Maureen Callaghan, MD. "The final end point," she added. "is that people are not to be able to get in to see a doctor." *Puget Sound Business Journal.*

- During the past five years, medical liability premiums paid by orthopedic surgeons increased 30 percent, to nearly $40,000, and premiums paid by family physicians who

- *The World* cites the example of a Tulsa pediatrician whose malpractice insurance doubled this year. *The Oklahoman*, July 17, 2002

- Oklahoma pediatricians have far less to worry about than the State's obstetricians and surgeons, whose rates in Oklahoma in 2003are expected to rise by 25 percent to 30 percent, says the Oklahoma State Medical Association.

South Carolina

- The medical liability crisis is rapidly spreading to the Palmetto State.

- A 10-physician OB/GYN group in Columbia had to take out a $400,000 loan this year to continue to provide OB services *and* pay malpractice premiums.

- In rural Oconee County, just four physicians deliver babies now, down from 11 physicians one year ago.

- A family practice group in Seneca was forced to drop OB coverage for four of their six physicians because of skyrocketing premiums. There are currently a total of four physicians in Seneca treating pregnant women.

- A solo practitioner practicing geriatrics in Charleston has had to quit treating patients in nursing homes because of high premiums.

Tennessee

- Professional liability premiums for physicians in Tennessee have been steadily rising in recent years.

- According to State Volunteer Mutual Insurance Company, which covers most practitioners in Tennessee, premiums have increased by 45% over the past three years, in order to keep up with rapidly escalating losses in medical liability lawsuits.

- Only approximately 4% of this 45% increase was related to lower investment yield, with the remainder being due to increasing medical malpractice losses. (State Volunteer Mutual Insurance Company is a policyholder owned mutual company with no outside investors).

- In recent years both juries and judges in Tennessee have made multi-million dollar awards for non-economic damages, over and above a patient's actual economic losses.

THE MEDICAL LIABILITY CRISIS – A NATIONWIDE PROBLEM

West Virginia

- The "Mountaineer State" was one of the first states to experience wide-spread medical liability insurance problems.

- According to the West Virginia State Medical Association, some 100 doctors have already retired early or moved out of the state within the previous two years.

- That has helped drive 1 out of every 20 doctors out of West Virginia or into early retirement in the past two years. *CNN, Jan. 2, 2003.*

- General surgeon Gregory Saracco, MD, only 49 years old, was forced to borrow money twice in 2002 to pay $73,000 for his liability insurance. His premiums for 2003 are expected to rise to $100,000. He is considering leaving West Virginia and while he has taken time away from his practice this year to decide what his options are, he said "my job is to help people—I couldn't drive past an accident on the road and not stop. I don't know any doctor that could." *Associated Press, Jan. 2, 2003.*

- Although orthopedic surgeon George Zakaib, MD, was raised and went to school in Charleston, WV, he and his family left because of the state's medical liability crisis. Dr. Zakaib's premiums had increased to $80,000 plus $94,000 in "tail" coverage. *Charleston Daily Mail, July 27, 2002.*

- Fourth-year medical school student Jennifer Knight isn't sure she'll stay in West Virginia. The Charleston Area Medical Center says fewer medical students are applying to its residency programs, and fewer students are applying to Marshall University's medical school. "I think the problem is, we have too many frivolous lawsuits," said Ms. Knight. *Sunday Gazette-Mail, Nov. 24, 2002.*

- The state legislature has been trying for more than a year to come up with a solution that will prevent more physicians from curtailing services or leaving the state. A state medical association poll found that 40% of the State's doctors are considering similar action to stop practicing or leave the State.

- "It's a 'code blue' emergency" threatening the state's trauma centers and other health care services in the state, WVSMA President Ahmed D. Faheen, MD, told *The New York Times.*

- Wheeling, West Virginia, has no remaining neurosurgeons, forcing closure of its only trauma center. Trauma patients must be flown by helicopter for care elsewhere.

- Across the State, the pattern is the same, trauma centers are closing or headed in that direction, and there is incredible difficulty in recruiting high-risk specialty residents.

APPENDIX C

Medical Liability Crisis Affects Access to Care

Selected States Showing Problem Signs

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Alabama

- The severe liability crisis in the neighboring States of Mississippi. Georgia and Florida has not left Alabama untouched.

- Atmore Community Hospital has had to close its maternity ward because of soaring medical liability premiums, forcing pregnant mothers to travel 15 miles to the nearest hospital with an obstetrics department.

Arizona

- Arizona has not been immune to the medical liability crisis. Serious access problems are already developing.

- The Copper Queen Community Hospital, was forced to stop delivering babies in January after a group of family physicians said they could no longer afford medical liability insurance.

- Pregnant mothers in this part of Arizona must now travel over 35 miles to the nearest hospital – the only hospital left in that County that is still delivering babies.

Connecticut

- The crisis may be spreading to Connecticut as evidenced by the recent decisions of 28 OB/GYNs to stop delivering babies.

- Some OB/GYNs in Connecticut are now paying between $120.000-$160.000 per year in insurance premiums, according to state medical society executive Tim Norbeck.

- Connecticut already is on a "watch" list issued by the American College of Obstetricians and Gynecologists. *Hartford Courant, Jan. 3, 2003.*

- The average payment made by one of Connecticut's major insurers to resolve a claim rose from $271,000 in 1995 to $536,000 in 2001.

- OB/GYN Jose Pacheco, MD's, insurer stopped offering medical liability insurance, and he had to seek another carrier. However, because of the high cost of new insurance—estimated around $60,000—combined with "tail" coverage of $80,000, Dr. Pacheco retired after a 27-year career. *Hartford Courant, Nov. 17, 2002.*

- A recent survey completed by the Missouri State Medical Association found that 31.4 percent of the responding physicians were considering leaving their practice, and 28.6 percent said they would consider limiting their practice because of rising liability insurance premiums.

- This same survey showed an average premium increase for medical liability insurance of 61.2 percent for 2002, on top of a 22.4 percent average increase last year.

- Neurosurgeons in Kansas City are facing an increase in premiums of $12,000 to $42,000 this year, with further increases expected next year.

- The 2002 premiums for Ob-gyns have increased by as much as $50,000 from 2001. Again, further increases are expected next year.

- According to a separate survey by the Metropolitan Medical Society of Greater Kansas City, 40% of practices are looking for new coverage because their insurer has stopped writing medical liability coverage.

- Predictably, an access crisis to needed health care is developing. The St. Joseph Health Center in Kansas City recently lost another trauma doctor. It is now down to three. The situation is even worse because a local nearby trauma center has been virtually shut down, meaning St.Joseph's must treat double the number of patients, and it is having trouble finding other surgeons willing to cover trauma.

- According to the *St. Louis Business Journal*, access issues are spreading. Dr. John Anstey, an obstetrician/gynecologist, recently faced a difficult choice. He knew he had to cut expenses after learning his medical malpractice insurance premium, which cost about $26,000 this year, would jump to $50,000 next year. Consequently, he closed his office in St. Ann effective July 30th. Previously, Anstey and his partner, Dr. Fred Monterubio, Jr., deliver about 400 babies a year through their practice, St. Ann OB/GYN. As a stopgap measure, Drs. Anstey and Monterubio were forced to move their practice to a hospital-based setting where they await news of their 2003 premium by October.

- The current medical liability insurance market in Missouri is extremely tight, with at least three insurers having pulled out of the market over the past year.

- Intermed Insurance Company, based in Springfield, is the largest provider of medical liability insurance coverage in Missouri. The Missouri Department of Insurance said the company had a 34 percent market share in 2001. The company imposed an 18 percent hike, effective July 1, and also put a moratorium on writing new business in Missouri.

- Andy Bennett, president and chief executive of Intermed, said rates went up because the severity, or average amount paid per settlement or verdict, has continued to go up fairly dramatically in Missouri. *St. Louis Business Journal.*

- A case in point is Manuel Belandres, MD, a general surgeon who was is in the twilight of his career but still practicing until recently when he was unable to obtain tail coverage. He subsequently closed his practice rather than expose himself to open-ended future liability.

- In Virginia's western border, many physicians are no longer treating West Virginia patients who cross the State-line due to aggressive personal injury attorneys attempting to bring suit against Virginia physician in West Virginia courts. This has further aggravated the access problem for pregnant West Virginia Medicaid patients, in particular, and their access to needed care.

American Medical Association
Physicians dedicated to the health of America

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Washington, DC 20005

Statement

to the

Committee on the Judiciary
U.S. House of Representatives

RE: Legislative Hearing on H.R. 5, to Improve Patient Access to Health Care Services and Provide Improved Medical Care by Reducing the Excessive Burden the Liability System Places on the Health Care Delivery System

Presented by Donald J. Palmisano, MD, JD

February 28, 2003

Division of Legislative Counsel
202 789-7426

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Presented by: Donald J. Palmisano, MD, JD

February 28, 2003

On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our gratitude to you, Mr. Chair, and other Members of the Committee who are cosponsors of H.R. 5, for providing a much needed focus for action at the national level.

I am Donald Palmisano, MD, JD, President-elect of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, nearly 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. AMA policy dictates support for national medical liability reform. In particular, the AMA supports H.R. 5, the HEALTH Act.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care. You know that our health care system is facing a crisis when pregnant women cannot find an OB/GYN to monitor their pregnancy and deliver their baby. You know that our health care system is facing a crisis when community health centers have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear, rather than a culture of safety. You know

We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.

THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

RECENT FEDERAL GOVERNMENT REPORTS

In a July 2002 report released by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. This federal government report states that insurance premiums are largely determined by the litigation system, and that the litigation system is inherently costly, unpredictable, and slow to resolve claims. **Just to defend a claim now costs on average over $24,000.** Further, **the fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being squandered on fruitless legal wrangling**—resources that could be used to reduce health costs so that more Americans could find health insurance.

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other "overhead" costs, can consume 40-50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse. The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002.

medical liability insurance rates. The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."

RECENT PRIVATE SECTOR REPORTS

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that "The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986," which is "equivalent to a 5% tax on wages." This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.

- As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.

- While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.

- **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.**

The study also adds that "These trends continued in 2002, with no sign of abatement in the near future." In a press release accompanying this study, a Tillinghast principal stated that, "Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond."

In a 2001 report by Jury Verdict Research, data show that in just a one year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that **the proportion of jury awards topping $1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top $1 million, and the average jury award has increased to about $3.5 million.**

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. **Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.**

In addition to claiming that the current medical liability crisis is an insurance issue, there have been attempts to argue that medical liability insurance premium rates in California have remained stable because of Proposition 103, not because of the successful medical liability reforms (known as MICRA—discussed later) that have been in place in California since 1975. Such claims are misguided. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance, not just medical liability insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down its rate rollback provisions while maintaining the remainder of the law.

Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner." Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

According to Californians Allied for Patient Protection, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates." **None of these approved increases included medical liability insurance.** This illustrates that Proposition 103 is not responsible for keeping medical liability premiums down. Rather, as we discuss later, it is MICRA that has been the force behind California's success.

Such misdirected claims as discussed above are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, these claims are counterproductive to the debate on resolving the medical liability crisis.

FEDERAL SOLUTION

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their

provide quality care in recent years, and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) and hospital administrators (72%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

The Harris study found that a majority (59%) of physicians believe ("a lot") that the fear of liability discourages open discussion and thinking about ways to reduce health care errors. The AMA has long believed that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences. However, this "culture of fear" caused by our over-litigious society suppresses such information.

The AMA strongly supports the principle underlying the 1999 Institute of Medicine (IOM) report entitled, *To Err is Human: Building a Safer Health System*, that the health care system needs to transform the existing culture of blame and punishment, which suppresses information about errors, into a "culture of safety" that focuses on openness and information-sharing to improve health care and prevent adverse outcomes. The AMA also supports the IOM's focus on the need for a system-wide approach to eliminating adverse outcomes and improving safety and quality, instead of focusing on individual components of the health system in an isolated or punitive way.

Toward this end, the AMA supports H.R. 663, the "Patient Safety and Quality Improvement Act," which was favorably reported by the House Energy & Commerce Committee on February 12, 2003. H.R. 663 would provide a framework to create a "culture of safety" by establishing a confidential, non-punitive, and evidence-based system for reporting health care errors. There is a very broad and strong consensus of agreement on this legislative approach within the health care community. By implementing this approach, errors can be identified and analyzed to improve patient safety by preventing future errors.

In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the health care system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.

THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out of pocket "economic" losses. The AMA also believes that patients should receive reasonable

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (i.e., amount of the claim) (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a $50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been extremely effective in reducing the severity of claims and medical liability premiums. Conversely, a 1996 American Academy of Actuaries study shows that medical liability costs rose sharply in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering. This Gallup poll is consistent with a 2002 survey conducted by Wirthlin Worldwide showing that three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. The Wirthlin survey shows that the vast majority of Americans agree we need common sense medical liability reform. In addition to the 78 percent discussed above who said that they are concerned about access to care, the survey found that:

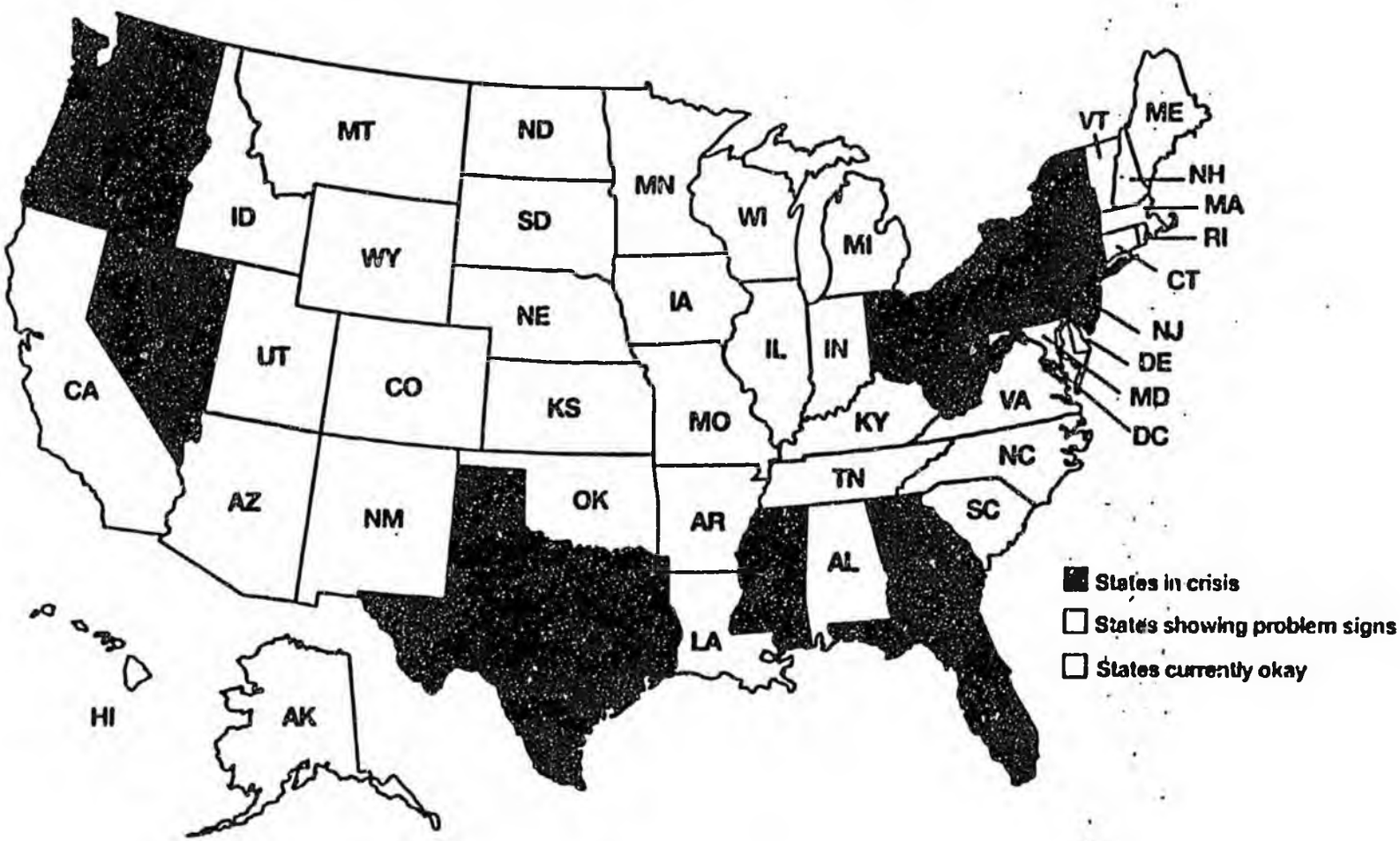
- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 73 percent support reasonable limits on awards for "pain and suffering" in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an

Appendix A

Medical Liability Crisis: A National View



APPENDIX B

Medical Liability Crisis Affects Access to Care

Crisis States

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Florida

- Women are facing waiting lists of four months before being able to get an appointment for a mammogram because at least six mammography centers in South Florida alone have stopped offering the procedure as a result of increasing medical liability insurance premiums. "This trend is troubling. There are a growing number of older people and less and less people to provide mammograms," said Jolean McPherson, a Florida spokeswoman for the American Cancer Society. *South Florida Sun Sentinel*, Nov. 4, 2002.

- Aventura Hospital in South Florida closed its maternity ward and cited $1,000 in insurance premiums for each delivery as the prime factor. Aventura is one of six maternity wards to close in recent months. Now, patients will be forced to drive to other counties and other facilities. "There may be waits getting into a labor-room floor," said OB/GYN Aaron Elkin, MD. *Miami Herald*. Oct. 19, 2002.

- "Without a doubt, access to health coverage is being affected. Some of our emergency rooms are losing their effectiveness," said Dr. Greg Zorman, neurosurgery chief at Memorial Regional Hospital in Hollywood. His unit gets several patients a week from smaller ERs that have lost neurosurgery coverage. *South Florida Sun Sentinel, February 5, 2003.*

- Port Charlotte cardiologist Leonardo Victores, MD, left for Kansas in the face of medical liability premiums that were going to increase 100 percent. "He's moving to Kansas because that state has caps on malpractice awards," said colleague Mark Asperilla, MD. *Sun Herald, Jan. 1, 2003.*

- Despite having no malpractice claims or disciplinary actions on his record, Lakeland OB/GYN John Kaelber, MD, was forced to close his practice and leave the state in the wake of insurance premiums that doubled. *Lakeland Ledger, Nov. 21, 2002.*

- More than 50 Bradenton patients had to postpone elective surgeries and more than 100 office visits were canceled because two physicians were unable to obtain liability insurance. The insurer may leave the state altogether. *Bradenton Herald, Jan. 24, 2003.*

- After recently receiving notice of a premium spike coming in July 2002, Vladimir Grnja, MD, decided that he would "go bare" and drop all medical liability insurance coverage. Rates for the Hollywood, FL radiologist were to rise to $112,000 from $35,000 a year (a 220% increase), mainly because of litigation over mammograms. "No doctor wants to go bare," said Dennis Agliano, MD, chairman of the Florida Medical Association's special task force on the Florida medical liability crisis. But with significant premium hikes in Florida for specialties like OB/GYN, neurosurgery, thoracic surgery, radiology and even primary care, "some doctors have no choice," he says. Some neurosurgeons in

- American Physicians Assurance announced on July 17, 2002 that it is leaving the state

- Farmer's Insurance has announced its intent to leave the state. Among other insurers. MAG is still writing policies, while Medical Protective and ProNational are being very selective. FPIC, the largest medical liability carrier in the state, endorsed by FMA, is only writing very selectively. Both Clarendon and St. Paul have pulled out entirely.

- According to the FMA's General Counsel, Florida's existing caps simply do not work and are never used. The caps only apply in cases where the physician agrees to arbitration and in order for the case to go to arbitration the physician must admit liability. In addition, the original intent of this Florida provision was to have the cap apply to each incident, but it has been interpreted to apply to per claimant, which obviously also decreases its effectiveness. The lack of a straight cap is the primary reason for the current crisis in Florida. Unlike such States as Kansas, Florida, has not seen an increase in frequency of claims, but there has been an increase for severity in jury awards.

- In a presentation before FMA, the medical liability insurance carrier, EPIC, presented facts that demonstrate the medical liability crisis in Florida. During 1975, there were 380 health care lawsuits in Florida, resulting in $10.8 million in jury awards and costing $1.5 million to defend. In 2000 there were 880 lawsuits alleging malpractice, resulting in awards of $219 million and costing $36 million to defend.

- Dr. Oliver Bayouth says his medical-malpractice premiums are skyrocketing. The Orlando obstetrician is paying about $100,000 for insurance this year, up at least 25 percent from two years ago. Frustrated, Bayouth says he is thinking about moving his practice out of Florida. *Orlando Sentinel, January 20, 2002.*

- In South Florida, where insurers say litigation is the heaviest, ob/gyns pay as much as $202,949 a year--the highest rates in the country, according to Medical Liability Monitor, a Chicago-based newsletter. *Orlando Sentinel, January 20, 2002.*

- Dr. Alan Appley, an Orlando neurosurgeon, moved his practice to Lafayette, Louisiana, last year in part to escape Florida's soaring malpractice rates. *Orlando Sentinel, January 20, 2002.*

- Dr. Joseph Boyer, an Orlando cardiologist, says his rates rose 64.6 percent, to $99,000, in 2002. *Orlando Sentinel, January 20, 2002.*

- Central Florida Cardiothoracic Surgery in Orlando says it will pay about $140,000 to insure two surgeons in 2002, compared with about $54,000 last year. *Orlando Sentinel, January 20, 2002.*

- Dr. Alexander Jungreis, an Orlando neurosurgeon, said his liability insurance premiums tripled this year. *Orlando Sentinel, January 20, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Georgia

- According to a Georgia Board for Physician Workforce study released in January 2003, 2,800 physicians in Georgia are expected to stop providing high-risk procedures to limit medical liability.

- The study also indicated that 1,750 physicians reported that have stopped or plan to stop providing ER coverage and 630 physicians plan to quit practicing or leave the state. In addition, 1 in 5 family physicians and 1 in 3 OB-GYNs reported plans to stop providing high-risk procedures, including delivering babies.

- But numbers alone do not tell the whole story; there is a very human side to this crisis. For instance, although she is only in her first year of medical school at Medical College of Georgia, the liability crisis has already caused Thandeka Myeni, 26, to reconsider her preference for obstetrics, one of the specialties hardest hit by medical liability increases. "I definitely think it could be discouraging," she said. *The Augusta Chronicle, Nov. 13, 2002.*

- Evans Memorial, a rural hospital in Claxton, decided to "go bare"—have no coverage at all—instead of paying what it considered an exorbitant medical liability premium. Only one insurer offered a malpractice policy for the hospital and its nursing home, and the annual premium for $1 million in coverage would have been $581,000, up from $216,000 last year. "We just thought it was outrageous," said Eston Price, Evans Memorial administrator. *The Atlanta Journal-Constitution, Oct. 7, 2002.*

- The largest hospital in the state's health system has bought a new policy—with a deductible of $15 million—covering 953-bed Grady Memorial, a nursing home and clinics. On each paid claim below that mark, Grady is responsible for every dollar. The $15 million deductible starts again with each claim. "Grady faces open-ended liability," said Timothy Jefferson, Grady Health System executive vice president and chief counsel. *The Atlanta Journal-Constitution, Oct. 7, 2002.*

- Knowing that malpractice premiums were rising for everyone in the industry, Ty Cobb Health System CEO, Chuck Adams earmarked enough money for a 100 percent increase. The bill arrived by fax this summer, just 24 hours before a check was due. Not only was the insurance company increasing his deductible tenfold, but the premium jumped from $553,000 to $3.15 million – a 469 percent increase. "We were numb," said Adams, who eventually got an extension and another cheaper policy at $1.65 million. "There goes our expansions, like a renovation of the Hart County Emergency Room." *The Atlanta Journal-Constitution, Aug. 11, 2002.*

- "Dr. Edmund Wright, a Fitzgerald family practitioner who performed Caesarian sections, has given up that part of his practice. His premiums quadrupled to $80,000 in

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Mississippi

- Although Mississippi enacted some medical liability reforms late last year, it is still too early to see if this will stem the exodus of physicians from the State. The reason: the Mississippi cap on non-economic damages has broad exceptions and the trial bar is looking for ways to get around its limits. In short, Mississippi remains in crisis.

- The Mississippi State Medical Association still estimates that the state could lose as many as 10 percent of its 4,000-4,500 physicians.

- Obstetricians in Mississippi still worry about what is going to happen to their patients who face longer trips to the hospital while already in labor. Women who used to walk or make a short drive for both prenatal visits and delivery now face a 45-minute drive by car to the only physician in their area who can still treat OB patients.

- Pregnant women who are considered high-risk, such as someone with diabetes, cannot be treated at the Kosciusko Medical Clinic because it is too risky for physicians, where seven physicians formerly practiced obstetrics and gynecology. Only three were predicted to remain in January 2003. *The Clarion-Ledger, Aug. 26, 2002.*

- Only two neurosurgeons remain in practice in the Gulf Coast-area of Mississippi, and general surgeons are in short supply because of the state's medical liability crisis. "Everybody is reduced to the same low level of trauma care that we had 20 years ago," said Steve Delahousey, vice president of operations at American Medical Response ambulance service. *Jan. 29, 2003 Biloxi Sun Herald*

- Neurologist Terry Smith, MD said he had applied with 14 companies, and Medical Assurance was his last hope to find coverage before his current policy expired on Aug. 4, 2002. His premium went from $55,000 a year to potentially $150,000 with a $132,000 tail to his old insurer. "I'm looking at writing a check for $300,000," said Smith, who does brain surgery at three hospitals in Jackson and Harrison counties. *Associated Press, July 11, 2002.*

- Four rural hospitals in Ocean Springs faced closure, as their insurer, Medical Assurance Company of Alabama, was not renewing their coverage because the insurer was leaving Mississippi.

- Greenwood Hospital – the only trauma center in a 55-mile radius – was unable to keep its Level-II trauma center rating because area neurosurgeons have left, citing the high cost of liability insurance. Greenwood also has lost 2 of its 4 Ob-Gyns.

- At least 15 insurers, including St. Paul, have left Mississippi in the previous five years.

- In the northern half of the state last year there were nine practicing neurosurgeons: now there are just three on emergency call. *The Wall Street Journal, May 1, 2002*

- In 1998, 227 Mississippians filed malpractice suits. Based on the suits filed during the first quarter of 2002, the Medical Association Company of Mississippi predicts over 550 medical liability suits will be filed this year.

- Across the State, there is a veritable litigation explosion, in Jefferson County, for example, there are only about 9,740 residents - but the number of lawsuits filed in 1999 numbered 10,000. A year later, in 2000, the number of plaintiffs on the docket increased to 27,000, or nearly three times the number of residents., *The Washington Times, May 11, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Nevada

- In August, Nevada Governor Guinn called a special legislative session to address medical liability issues. In just four days, Nevada legislators enacted a meaningful liability reform bill.

- Unfortunately, while Nevada passed needed reforms, the crisis there has not yet been averted due to continued lack of availability and affordability of medical liability insurance. Insurers in Nevada have not yet reduced their premiums and physicians are still leaving the state, particularly in Southern Nevada.

- Why? Because the trial bar has threatened to institute legal challenges to this new law that could thwart and delay its implementation. Without the full force and effect of reforms right now, the scenario that has crippled access to medical care in Nevada will continue.

- 60 percent of Las Vegas-area Ob-gyns have said they would stop delivering babies in 2002 because of the out-of-control legal system and skyrocketing liability premiums.

- Las Vegas' only trauma center, which treated more than 11,000 patients in 2001, closed for 10 days in July 2002 because it did not have enough surgeons to staff the center.

- When a trauma center closes, "some patients are going to die that wouldn't die . . . the quicker you're at the trauma center, the better chance you have of survival," a Las Vegas surgeon told NPR. The next closest trauma center is at least 5 hours away.

- "There is an unavailability of [medical liability] insurance," said Nevada State Insurance Commissioner Alice Molasky-Arman, at a March 4, 2002 hearing where insurance officials testified they would no longer insure any new obstetricians, surgeons and other high-risk specialists.

- A Las Vegas Ob-gyn was forced to close her practice and leave 30 pregnant patients behind because her liability insurance increased from $37,000 to $150,000 in one year. She now practices in Los Angeles and pays only $17,000. Some Nevada women have had to call as many as 50 Ob-gyns just to find one who is accepting new patients.

- Nevada ranks 5th among states with the highest physician liability premiums (at $94,820 per year), but only 47th out of 50 states in the number of physicians for its population, according to the American College of Obstetricians and Gynecologists. An ACOG survey concludes that 6 out of 10 Nevada Ob-gyns will no longer practice obstetrics.

- "Approximately 100 Las Vegas physicians have already left Nevada to practice elsewhere, announced they will be closing their practices, or retire early because they

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

New Jersey

- A multi-physician practice in Teaneck, NJ, was forced to layoff employees and reduce the number of deliveries it performed because of medical liability insurance premium increases of more than 120 percent. "All of my colleagues are experiencing the same pressures," said George Ajjan, MD. *Bergen Record, May 22, 2002.*

- One out of every four hospitals—nearly 27 percent—has been forced to increase payments to find physicians to cover Emergency Departments. Physicians are increasingly reluctant to take on such assignments because of the greater liability exposure. Hospitals report that more and more physician specialties are being hit by the crisis. While a previous New Jersey Hospital Association survey in March 2002 found that OB/GYNs and surgeons were primarily affected, the new survey finds a deepening impact for neurologists/neurosurgeons, radiologists, orthopedists, general practitioners and emergency physicians. *New Jersey Hospital Association, Jan. 28, 2003 news release.*

- "We have as much to lose as they have," said Joan Hamilton, a patient who attended a recent rally in New Jersey in support of her physician. *Bergen Record, Oct. 6, 2002.*

- Physicians, nursing homes and hospitals are all in jeopardy. Liability premiums for hospitals increased more than 150% over the past 3 years. A N.J. American Hospital Association survey found that nearly 2/3 of hospitals had one or more instances where physicians were forced out of medicine because of high premiums.

- 64.8 percent of all New Jersey hospitals said they have had physicians stop practicing medicine or plan to stop because of the state's liability crisis.

- New Jersey's largest insurer, the MIIX company, declared May 9, 2002, it is getting out of the medical liability business. Previously, MIIX insured 7,000 physicians – nearly 40% of the state. MIIX previously left the medical liability insurance markets in Ohio, Pennsylvania and Texas, citing those states' out-of-control legal climates as an unacceptable business risk.

- After years of only a few large jury awards, New Jersey had 26 greater than $1 million in 2001, and is averaging one a week in 2002, MIIX President Patricia Costante told the *Philadelphia Inquirer* June 4. New Jersey has no limits on non-economic damages in medical liability cases.

- New Jersey physicians are also facing difficulty finding new insurance because PHICO, which insured 9%, and St. Paul, with 6% of the market, have pulled out.

New York

- New York physicians still pay, in most instances, the highest medical liability premiums in the country. Ob-gyns' average premium is $144,973, according to the American College of Obstetricians and Gynecologists.

- New York continues, by far, to lead the country in total medical liability payouts, with $633 million total in 2000. That is 80% more than the state with the second highest total, Pennsylvania (at $352 million), and 300% more than California (at $200 million). Average medical liability verdicts have skyrocketed recently, going from an average of $1.7 million in 1994 to $6 million in 1999.

- "The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002," wrote Donald Copley, MD, an officer of the Erie County Medical Society in *Business First of Buffalo*. "I've watched sadly as valued colleagues have left Erie County and even the profession. A competent young specialist recently quit doing high risk diagnostic procedures to become a business consultant. Several local obstetricians have stopped delivering babies to reduce their insurance expenses. A half dozen nationally-known doctors have quietly left Western New York. The number of doctors leaving Erie County last year doubled from the previous year, a trend that continues in 2002." *Buffalo Business First, April 15, 2002.*

- The Medical Society of New York says the trend of physicians leaving New York State or retiring early is happening across the state.

- "The rising cost of malpractice coverage is becoming one of the most important factors driving inflation for physicians' services," said a managing director of the Carlyle Group, the investment group for *The New York Times.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Ohio

- The Ohio Supreme Court has overturned three tort reform measures in the past 15 years. Following the state Supreme Court's 1995 overturning of the state's tort reforms, premium increases and jury verdicts began rising. Family physicians in rural areas are increasingly no longer performing obstetrical services. Recently, Ohio again enacted medical liability reforms, but it is too soon to tell if the courts there will let these reforms take root.

- Meanwhile, according to a recent Ohio State Medical Association survey, 79% of Ohio physicians reported an increase in their medical lawsuit insurance costs over the last two years, with an average increase of 41%. And 51% of Ohio physicians are contemplating early retirement, while 15% are considering or have relocated their practices, as a result of rising costs.

- Physician groups in Cincinnati are seeing increases between 20 and 100%. "I expect this to get worse," Ken Folz, CEO of Patient First, told the *Cincinnati Business Courier.*

- According to Daniel J. McLaughlin, a vascular surgeon in Cleveland, some specialists in the region have seen their malpractice premiums increase 600 percent this year, and typical premiums for surgeons with just three or four years of experience have doubled or tripled, to from $50,000 a year to as much as $100,000 or more. *Health Leaders Magazine, Sept. 2002.*

- In July, Westlake oncologist Dr. Romeo Diaz was faced with an insurance premium of $80,000 – double what he paid last year. He would have gone out of business had it not been for his patients, who raised the needed $40,000 to help Diaz stay insured. "At first I thought he was playing," said Kathy Fritsch, a patient of Diaz for 10 years. "But when he looked up at me, he was crying. He said his insurance rose from $40,000 last year to $80,000 this year. It used to be $20,000." *Morning Journal, July 31, 2002.*

- Dr. William Hurd, chairman of the department of obstetrics and gynecology at the Wright State University School of Medicine, said the liability insurance issue already is driving young doctors out of the Dayton area. "In the last two years, not a single one of our (OB/GYN) residents has set up a practice in Dayton, or even Ohio," Hurd said. *Dayton Daily News, Aug. 28, 2002.*

- The average jury verdict in Ohio was $11.7 million in 2001. In 2000, it was $8.6 million.

- Physicians in Cleveland are being forced to lay-off staff and discontinue high-risk procedures, reported the Cleveland *Plain Dealer* February 18, 2002.

- "In the past two years, my medical liability premiums have increased more than 50%. I have no claims, graduated first in my medical school class, and was chief resident at OSU. I had been treating some of my chronic pain patients with acupuncture (medical research documents decreased pain and decreased inflammation with acupuncture). Due to the skyrocketing medical liability premiums, I will have to stop offering this treatment for these patients to try to decrease my costs of insurance." – A Columbus physical medicine and rehabilitation physician.

- "My premiums increased significantly, but my reimbursement level is down because of the Medicare cuts. In order to stay in practice, I had to float a loan from my pension fund. I am actively looking to leave this state. I know of one colleague who gave up his private practice and went to work at the local VA hospital, so they would cover his liability premium. – A Warren cardiologist.

- "This five physician practice recently had to give up obstetrics due to our rates. We have been committed to delivering full-range family practice...true womb to tomb medicine. We had to send our patients to local OBs. We and our patients are devastated by this turn of events." – A Medina family practitioner

- "After a mad scramble to obtain insurance, it came down to 5:45 p.m. on the day before my insurance expired to obtain insurance. I was literally 15 minutes from having to close a practice that cares for over 4,000 people in this town." – A Coldwater family practitioner

- "We have an obstetrician-gynecologist retiring because his insurance company pulled out of Ohio. To buy a tail and the new policy would cost this man $140,000, which he couldn't afford to do." – A Rossford obstetrician-gynecologist.

- "I was told two months ago that I will have no insurance after the 11th of September. I have had no claims filed against me." – An Akron general surgeon

- "My carrier has refused to cover me for bariatric procedures. I have had to turn patients away who need this service." – A Massilon general surgeon

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Oregon

- Rural families in John Day, Hermiston, and Roseburg counties, Oregon have either lost obstetric care or have seen services drastically reduced. *The Business Journal of Portland, Jan. 10, 2003.*

- Only by dropping obstetrics were two Hermiston physicians able to afford their liability insurance premiums. "It's something you don't like to tell patients," said Doug Flaiz, MD. *The Oregonian, Oct. 29, 2002.*

- "No one with $100,000 in debt from medical school wants to start a practice in a place where they could find themselves completely broke and having to pick up and go somewhere else to start all over again," said Rosemari Davis, CEO of Willamette Valley Medical Center, who has seen three of her center's family practitioners stop delivering babies. *The News Register, Jan. 28, 2003.*

- In 1999, the Oregon Supreme Court overturned the State's law capping non-economic damages. Since then, multi-million dollar claims have become commonplace, according to the Oregon Medical Association.

- Since the 1999 decision, Oregon physicians are experiencing rapidly rising premiums and insurers becoming more reluctant to offer policies to physicians, such as Ob-gyns and surgeons, who perform high-risk procedures.

- Recent jury verdicts include: $8 million, $8.5 million, $10 million and $17 million.

- Rural patients in Oregon are being particularly hard hit. A small town clinic, Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in May 2002 because its liability insurance was canceled after one large lawsuit. "We consider this a medical crisis for the community," Mercy Medical CEO Vic Fresolone told the Associated Press.

- The Roseburg clinic physicians paid $17,000 per physician per year in 2001 for medical liability insurance and are now receiving quotes for $80,000 -100,000 per physician.

- Oregon's only academic health center – the Oregon Health & Science Center – reports fewer medical students are applying for its Ob-gyn residency positions. Ob-gyn residents elsewhere reportedly are increasingly concerned about setting up practice in Oregon due to the state's broken liability system.

- A major liability insurer, Northwest Physicians Mutual Insurance Company, announced in 2002 it would not write new policies to obstetricians. Remaining insurers are raising rates by 60% or more.

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Pennsylvania

- According to the Pennsylvania Medical Society Alliance, 919 doctors have decided to leave the Keystone State or have scaled back their practices as premiums spiraled upward over the past three years. *The Baltimore Sun, Feb. 5, 2003.*

- Dr. Anthony Clay never thought he would have to leave Philadelphia. He has spent his whole life there—growing up and attending college, medical school, and residency to become a cardiologist. He treats families he has known since boyhood. He likes knowing where his patients live, work, and shop. All nine of his siblings still live there. But, Dr. Clay is leaving his practice in Philadelphia this Spring because of surging malpractice insurance rates. He is starting over in Delaware, where his insurance costs will drop from roughly $70,000 a year to $8,000. "It's been terrible," said Dr. Clay, 40. "In this field, you've been with the patient, and also the family, in some of their most life-defining moments - in the throes of a heart attack with no blood pressure. Wrongly or rightly, the patient credits you with being there when they weren't doing so well. You realize you've created a bond. I take that very seriously." *Baltimore Sun, February 5, 2003.*

- Brian Holmes, MD, is one of an estimated 18 percent of Pennsylvania neurosurgeons to have left the state, retired, or limited his or her practices because of the medical liability crisis. "It saddened me to move, but I had no choice. It was either move or go out of business." *Philadelphia Business Journal, Sept. 25, 2002.*

- After 25 years of practice, OB/GYN Michael Horn, MD, stopped delivering babies in 2002 because of the fear of getting sued. "It's just the potential, the not knowing if someone will seek an outlandish reward. I don't want to expose myself or my family." *Burlington County Times, Oct. 2, 2002.*

- Medical students are less likely to seek residencies in Philadelphia, and residents are less likely to stay and practice in the area because of "prohibitively high" medical liability insurance rates, according to Jefferson Medical College professor Stephen L. Schwartz, MD. *Associated Press, Oct. 4, 2002.*

- OB/GYN Lawrence Glad, MD, used to deliver about 500 babies a year—40 percent of all the babies born in Fayette County annually. After his premiums skyrocketed from $57,000 to $135,000, however, he closed his practice in the fall of 2002. *Pittsburgh Business Times, Nov. 18, 2002.*

- Mercy Hospital chief of surgery Charles Bannon, MD, has watched numerous physicians leave Scranton and Lackawanna County—creating a shortage of surgeons, fewer medical school applications and residencies. "It will take generations to get back the quality of medicine in Philadelphia." *Scranton Times, Nov. 20, 2002.*

- 414 medical liability lawsuits were filed in Philadelphia County in February 2002 – five times the average number filed during the month over the previous decade, reported the *Philadelphia Inquirer*.

- One-quarter of respondents to an informal poll conducted by the American College of Obstetricians and Gynecologists say they have stopped or are planning to stop practicing obstetrics.

- Statistics compiled for the Pennsylvania Medical Association by Caso Consulting indicate it costs $96,199 to cover an orthopedic surgeon in Pennsylvania, compared with $37,783 in Delaware, and $36,291 in New Jersey. *Best's Insurance News, January 7, 2002.*

- Howard A. Richter, a neurosurgeon and president of the Pennsylvania Medical Society, said a 2001 survey by the medical society showed that 72% of doctors have either deferred the purchase of new medical equipment or have not hired needed staff because of "sudden and sharp increases" in insurance rates. *Best's Insurance News, January 21, 2002.*

- "To lower their risk and insurance premiums, doctors who normally would take on high-risk medical procedures are opting not to do so. For example, we've seen obstetrician/gynecologists give up delivering babies. Virtually every medical liability insurance carrier increased their rates in recent years. From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates between 80.7 percent and 147.8 percent." *York Daily Record, January 20, 2002.*

- Driving premiums through the roof are excessive sums awarded in malpractice suits. Medical liability payments for physicians in 2000 totaled $3,908,113,303. *York Daily Record, January 20, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Texas

- In the "Lone Star State" medical liability insurance premiums for physicians have skyrocketed as much as 300 percent in some regions and for some specialties, according to the Texas Medical Association. As a result, there is only one neurosurgeon serving 600,000 people in the McAllen area.

- In the past two years, four South Texas patients with head injuries died before they could be flown out of the area for medical attention. As reported in a July 10, 2002, article in *The Courier*, a community family practice clinic in Conroe (just north of Houston) was recently forced to turn away half of its normal patient load because its liability insurance provider would not provide coverage while "highly lawsuit-risky obstetrics training was conducted."

- Even though the Texas legislature has passed medical liability reforms, the Texas Supreme Court has regularly overturned them.

- Medical liability premiums were expected to increase by at least 20 percent and perhaps as much as 75 percent in 2002, according to the Texas Department of Insurance. *San Antonio Express-News*, April 8, 2002.

- In 1999, 17 companies offered malpractice coverage to doctors in Texas. Today, the field has dwindled to only four, and Texas is considered the least profitable state for liability carriers. *The Dallas Morning News*, September 1, 2002.

- Moreover, premiums this year have climbed at triple-digit rates for many of Texas' 36,000 physicians. That's on top of double-digit increases in prior years. Now it's not uncommon for doctors in high-risk specialties such as trauma surgery, emergency medicine, and orthopedic surgeries and obstetrics to pay more than $ 100,000 annually for coverage. This means that some 6,100 Texas physicians are scrambling to find liability insurance.

- The Doctor's Company, a national insurer, told the *Dallas Morning News* the company is selective about which types of physicians it will cover. "Texas is a very dangerous venue, and we don't really encourage . . . [growth] from there – not without tort reform," said senior vice president Jack Myer.

- In South Texas, one jury awarded $43 million to a woman who claimed a diabetes drug damaged her liver, while another gave $15 million to three women who received faulty hip implants. *The Wall Street Journal*, May 1, 2002.

- 6 of every 7 medical liability claims in Texas are closed with no fault found on the doctor's part. Nonetheless, tens of millions of dollars are spent fighting these cases.

- In Texas, about 85 percent of cases are closed without payment to plaintiff, yet they still cost money to resolve, said Texas Medical Liability Trust president W. Thomas Cotton. *The Dallas Morning News, January 20, 2002.*

- Insurance carriers in Texas paid more than $381 million in claims in 2000, according to the Texas Department of Insurance--costs passed on to policyholders. That's an 87 percent increase since 1995. Nationally, the median malpractice award more than doubled from 1994 to 1999, to $800,000. *The Dallas Morning News, January 20, 2002.*

- Texans filed 4,501 claims in 2000, up 51 percent from 1990, according to the Texas Medical Examiners Board. More troublesome is the rise in expenses involved in resolving a case. Each claim cost an average of $68,681 to litigate in 2000, compared with $46,079 in 1995. The figure does not include the amount of settlement or award. *The Dallas Morning News, January 20, 2002.*

- Meanwhile, physicians in the Rio Grande Valley are in crisis, said Texas Medical Liability Trust president W. Thomas Cotton. An OB-GYN in North Texas pays $47,500 annually for $500,000 in coverage, while his Rio Grande Valley counterparts pay $82,300. Neurosurgeons pay even higher premiums. *The Dallas Morning News, January 20, 2002.*

- Seven in 10 Rio Grande Valley doctors have had medical liability claims filed against them. A February 2001 survey by the Texas Medical Association found that 1 in 3 Valley doctors say their insurance providers have stopped writing liability insurance. *The Dallas Morning News, January 20, 2002.*

- In Rio Grande Valley, half of the physicians admitted to being inclined to leave the area or to retire, according to a survey conducted in February 2001 by the Texas Medical Association. Many doctors in the Valley said they profile patients and refuse to treat some, because they fear the patients are prone to sue. They said they deny care for people who pay with cash, because the patients are most likely poor and may look at a lawsuit like a lottery opportunity. Some physicians are even hesitant to respond to a "code blue," which indicates a medical crisis, in a hospital. Dr. Carlos Cardinez, a gastroenterologist in McAllen, said he doesn't want to respond anymore because of the legal uncertainty. *The Dallas Morning News, January 20, 2002.*

- Increases in medical practice costs have outstripped revenue increases over the last 10 years, according to the Medical Group Management Association's 2000 cost survey. Operating costs for multispecialty groups went up an average of 35 percent over the past 10 years, while revenue increased 21 percent over that same period. *The Dallas Morning News, January 20, 2002.*

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Washington

- "There is a growing crisis in medical malpractice in Washington state and nationally," state insurance commissioner Mike Kriedler said in an April 2002 news release.

- "Patients in many communities are finding that their physicians have either started limiting their services or have closed their doors completely due to rising malpractice premiums," said Dr. Maureen Callaghan, president of the Washington State Medical Association. *PR Newswire, Feb. 3, 2003.*

- "I went through my mourning and my grieving, and now I have to find a place for my [380] patients," said a South Send internist who has not been sued but can no longer afford liability insurance coverage.

- The cost of medical malpractice insurance has soared so high that Mount Vernon obstetrician Robert Pringle, MD, has stopped delivering babies, according to the *Puget Sound Business Journal.*

- So have his two colleagues at the North Cascade Women's Clinic, and so have others. "Of the nine obstetricians in our community, six have stopped delivering babies or left the area," Pringle said.

- When he began his practice 20 years ago, Pringle paid a premium of $1,000 for medical malpractice insurance, which covers physicians against claims of injury resulting from negligent medical care. "Now it's in the neighborhood of $60,000," he said. "From an economic standpoint, you would have to be a lunatic to continue private practice of obstetrics." *Puget Sound Business Journal.*

- The severe premium hikes besetting many doctors "could not come at a worse time," said Dr. Sam Cullison, president of the Washington State Medical Association. Cullison said the high cost of malpractice insurance has combined with low reimbursement rates from Medicaid, Medicare and private insurers to clamp many doctors in a financial squeeze. As a result more physicians are retiring early, or leaving the State, he said. Also, it's increasingly difficult to recruit doctors from other states." *Puget Sound Business Journal.*

- "Everyone is in the same situation in terms of increasing premiums, increasing overhead and decreasing reimbursement," said Olympia neurologist Maureen Callaghan, MD. "The final end point," she added, "is that people are not to be able to get in to see a doctor." *Puget Sound Business Journal.*

- During the past five years, medical liability premiums paid by orthopedic surgeons increased 30 percent, to nearly $40,000, and premiums paid by family physicians who

THE MEDICAL LIABILITY CRISIS – A NATIONWIDE PROBLEM

West Virginia

- The "Mountaineer State" was one of the first states to experience wide-spread medical liability insurance problems.

- According to the West Virginia State Medical Association, some 100 doctors have already retired early or moved out of the state within the previous two years.

- That has helped drive 1 out of every 20 doctors out of West Virginia or into early retirement in the past two years. *CNN, Jan. 2, 2003.*

- General surgeon Gregory Saracco, MD, only 49 years old, was forced to borrow money twice in 2002 to pay $73,000 for his liability insurance. His premiums for 2003 are expected to rise to $100,000. He is considering leaving West Virginia and while he has taken time away from his practice this year to decide what his options are, he said "my job is to help people—I couldn't drive past an accident on the road and not stop. I don't know any doctor that could." *Associated Press, Jan. 2, 2003.*

- Although orthopedic surgeon George Zakaib, MD, was raised and went to school in Charleston, WV, he and his family left because of the state's medical liability crisis. Dr. Zakaib's premiums had increased to $80,000 plus $94,000 in "tail" coverage. *Charleston Daily Mail, July 27, 2002.*

- Fourth-year medical school student Jennifer Knight isn't sure she'll stay in West Virginia. The Charleston Area Medical Center says fewer medical students are applying to its residency programs, and fewer students are applying to Marshall University's medical school. "I think the problem is, we have too many frivolous lawsuits," said Ms. Knight. *Sunday Gazette-Mail, Nov. 24, 2002.*

- The state legislature has been trying for more than a year to come up with a solution that will prevent more physicians from curtailing services or leaving the state. A state medical association poll found that 40% of the State's doctors are considering similar action to stop practicing or leave the State.

- "It's a 'code blue' emergency" threatening the state's trauma centers and other health care services in the state, WVSMA President Ahmed D. Faheen, MD, told *The New York Times.*

- Wheeling, West Virginia, has no remaining neurosurgeons, forcing closure of its only trauma center. Trauma patients must be flown by helicopter for care elsewhere.

- Across the State, the pattern is the same, trauma centers are closing or headed in that direction, and there is incredible difficulty in recruiting high-risk specialty residents.

APPENDIX C

Medical Liability Crisis Affects Access to Care

Selected States Showing Problem Signs

THE MEDICAL LIABILITY CRISIS—A NATIONWIDE PROBLEM

Alabama

- The severe liability crisis in the neighboring States of Mississippi. Georgia and Florida has not left Alabama untouched.

- Atmore Community Hospital has had to close its maternity ward because of soaring medical liability premiums, forcing pregnant mothers to travel 15 miles to the nearest hospital with an obstetrics department.

Arizona

- Arizona has not been immune to the medical liability crisis. Serious access problems are already developing.

- The Copper Queen Community Hospital, was forced to stop delivering babies in January after a group of family physicians said they could no longer afford medical liability insurance.

- Pregnant mothers in this part of Arizona must now travel over 35 miles to the nearest hospital – the only hospital left in that County that is still delivering babies.

Connecticut

- The crisis may be spreading to Connecticut as evidenced by the recent decisions of 28 OB/GYNs to stop delivering babies.

- Some OB/GYNs in Connecticut are now paying between $120,000-$160,000 per year in insurance premiums, according to state medical society executive Tim Norbeck.

- Connecticut already is on a "watch" list issued by the American College of Obstetricians and Gynecologists. *Hartford Courant, Jan. 3, 2003.*

- The average payment made by one of Connecticut's major insurers to resolve a claim rose from $271,000 in 1995 to $536,000 in 2001.

- OB/GYN Jose Pacheco, MD's, insurer stopped offering medical liability insurance, and he had to seek another carrier. However, because of the high cost of new insurance—estimated around $60,000—combined with "tail" coverage of $80,000. Dr. Pacheco retired after a 27-year career. *Hartford Courant, Nov. 17, 2002.*

- A recent survey completed by the Missouri State Medical Association found that 31.4 percent of the responding physicians were considering leaving their practice, and 28.6 percent said they would consider limiting their practice because of rising liability insurance premiums.

- This same survey showed an average premium increase for medical liability insurance of 61.2 percent for 2002, on top of a 22.4 percent average increase last year.

- Neurosurgeons in Kansas City are facing an increase in premiums of $12,000 to $42,000 this year, with further increases expected next year.

- The 2002 premiums for Ob-gyns have increased by as much as $50,000 from 2001. Again, further increases are expected next year.

- According to a separate survey by the Metropolitan Medical Society of Greater Kansas City, 40% of practices are looking for new coverage because their insurer has stopped writing medical liability coverage.

- Predictably, an access crisis to needed health care is developing. The St. Joseph Health Center in Kansas City recently lost another trauma doctor. It is now down to three. The situation is even worse because a local nearby trauma center has been virtually shut down, meaning St.Joseph's must treat double the number of patients, and it is having trouble finding other surgeons willing to cover trauma.

- According to the *St. Louis Business Journal*, access issues are spreading. Dr. John Anstey, an obstetrician/gynecologist, recently faced a difficult choice. He knew he had to cut expenses after learning his medical malpractice insurance premium, which cost about $26,000 this year, would jump to $50,000 next year. Consequently, he closed his office in St. Ann effective July 30th. Previously, Anstey and his partner, Dr. Fred Monterubio, Jr., deliver about 400 babies a year through their practice, St. Ann OB/GYN. As a stopgap measure, Drs. Anstey and Monterubio were forced to move their practice to a hospital-based setting where they await news of their 2003 premium by October.

- The current medical liability insurance market in Missouri is extremely tight, with at least three insurers having pulled out of the market over the past year.

- Intermed Insurance Company, based in Springfield, is the largest provider of medical liability insurance coverage in Missouri. The Missouri Department of Insurance said the company had a 34 percent market share in 2001. The company imposed an 18 percent hike, effective July 1, and also put a moratorium on writing new business in Missouri.

- Andy Bennett, president and chief executive of Intermed, said rates went up because the severity, or average amount paid per settlement or verdict, has continued to go up fairly dramatically in Missouri. *St. Louis Business Journal.*

- *The World* cites the example of a Tulsa pediatrician whose malpractice insurance doubled this year. *The Oklahoman*, July 17, 2002

- Oklahoma pediatricians have far less to worry about than the State's obstetricians and surgeons, whose rates in Oklahoma in 2003are expected to rise by 25 percent to 30 percent, says the Oklahoma State Medical Association.

South Carolina

- The medical liability crisis is rapidly spreading to the Palmetto State.

- A 10-physician OB/GYN group in Columbia had to take out a $400,000 loan this year to continue to provide OB services *and* pay malpractice premiums.

- In rural Oconee County, just four physicians deliver babies now, down from 11 physicians one year ago.

- A family practice group in Seneca was forced to drop OB coverage for four of their six physicians because of skyrocketing premiums. There are currently a total of four physicians in Seneca treating pregnant women.

- A solo practitioner practicing geriatrics in Charleston has had to quit treating patients in nursing homes because of high premiums.

Tennessee

- Professional liability premiums for physicians in Tennessee have been steadily rising in recent years.

- According to State Volunteer Mutual Insurance Company, which covers most practitioners in Tennessee, premiums have increased by 45% over the past three years, in order to keep up with rapidly escalating losses in medical liability lawsuits.

- Only approximately 4% of this 45% increase was related to lower investment yield, with the remainder being due to increasing medical malpractice losses. (State Volunteer Mutual Insurance Company is a policyholder owned mutual company with no outside investors).

- In recent years both juries and judges in Tennessee have made multi-million dollar awards for non-economic damages, over and above a patient's actual economic losses.

- A case in point is Manuel Belandres, MD, a general surgeon who was is in the twilight of his career but still practicing until recently when he was unable to obtain tail coverage. He subsequently closed his practice rather than expose himself to open-ended future liability.

- In Virginia's western border, many physicians are no longer treating West Virginia patients who cross the State-line due to aggressive personal injury attorneys attempting to bring suit against Virginia physician in West Virginia courts. This has further aggravated the access problem for pregnant West Virginia Medicaid patients, in particular, and their access to needed care.

Medical Liability Reform - NOW!
October 1, 2003

American Medical Association
515 North State Street
Chicago, Illinois 60610

I. Identification of the Problem

A. Recurrence of an Old Problem?

1. The medical liability insurance system experienced a period of crisis in the early 1970s, when several private insurers left the market because of rising claims and inadequate rates.

2. This exodus of capacity resulted in an availability crisis and created an affordability issue for those physicians and hospitals lucky enough to find insurance.

3. Over the next fifteen years, various attempts were made to ease the explosion in claims costs: tort reform, increased diagnostic testing, improved peer review and increased communication between physicians and patients. Aggressive campaigns to reform state laws governing medical liability lawsuits began in the 1970s and were successful in a number of states including California, Louisiana, Indiana and New Mexico.

4. These efforts appear to have had a positive impact. The number of claims dropped. The severity of verdicts, in the form of the dollar amount, has continued nationwide except for the states that effected reforms

5. Relative to those states which did not enact tort reforms, the per capita supply of physicians increased in those that did.[1]

B. Second PLI Crisis: 1980s

1. During the 1980s, the second crisis – one of affordability – shook the industry, as claim frequency and severity increased again and premiums rose rapidly.

2. The affordability crisis had a dramatic effect. Physicians in specialties such as obstetrics and gynecology cut back on high-risk procedures and high-risk patients to reduce their risks and hold down their premiums.

3. Some physicians closed practices in states where the risk of being sued and the costs of premiums were especially high.

C. The Current Liability Crisis: Trends in Jury Awards

1. Recent data from Jury Verdict Research reported in the 2002 edition of Current Award Trends in Personal Injury, illustrate the problem as it exists today.[2]

2. The median medical liability award in medical malpractice cases jumped 176 percent from 1994 to 2001, topping $1 million.[3]

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[1] Fred Hellinger and William Encinosa, AG. FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS, (July 2003).

[2] JURY VERDICT RESEARCH, CURRENT AWARD TRENDS IN PERSONAL INJURY: 2002 ed. (2003), 18.

[3] *Id.*

3. The average award reached $3.9 million in 2001.[4]

4. But plaintiffs lost the majority of their cases that went to a jury. *Overall, plaintiffs won just 30.5% of medical liability cases in 2002.*[5] Of the 7% of claims that went to jury verdict, the defendant won 82.4% of the time. [6]

5. However, physicians who win at trial still have large fees to pay for their defenses.

   a. Defense costs averaged $77,135 per claim in cases where the defendant prevailed at trial. And in cases where the claim was dropped or dismissed, costs to defendants averaged almost $16,307. [7]

6. The frequency of very large awards is increasing.

   a. In the period 1995-1997, 36% of all verdicts that specified damages assessed awards of $1 million or more. Over the next two years, the relative frequency of these awards increased to 43%. By 2000-2001, 54% of all awards were for $1 million or more. 25% of all awards exceed $2.7 million.[8]

   b. According to a recent study by the Blue Cross/Blue Shield Association, plans in crisis states believe that inappropriately large jury verdicts are the primary factor contributing to increasing malpractice premiums. Non-crisis states attributed the increases mostly to increased patient litigiousness.[9]

D. The Current Liability Crisis: Access to Care

1. A February 2003 poll shows that eighty-four percent (84%) of Americans fear that skyrocketing medical liability costs could limit their access to care.[10]

2. More than 26% of health care institutions have reacted to the liability crisis by cutting back on services and/or eliminating some units.[11]

3. The Blue Cross/Blue Shield survey also shows that rising medical malpractice premiums are causing access and cost problems in crisis states. Access problems are beginning to surface in the remaining states as well.[12]

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[4] *Id.*
[5] *Id.*
[6] *Id.* This figure varies depending on the source. Lawrence Smarr, CEO of Physician Insurers Association of America (PIAA), reports a plaintiff recovery rate at trial of 20%, while the U.S. Dept. of Justice reports a plaintiff recovery rate at trial of 23.4%.
[7] PIAA Claim Trend Analysis, 2002 Ed.
[8] *Id.*
[9] BLUE CROSS BLUE SHIELD ASS'N, THE MALPRACTICE INSURANCE CRISIS: THE IMPACT ON HEALTHCARE COST AND ACCESS 3 (2003).
[10] WIRTHLIN WORLDWIDE, WHAT AMERICANS THINK ABOUT THE HEALTH CARE LIABILITY CRISIS, (Feb. 2003), *at* http://www.hcla.org.
[11] AM. HOSP. ASS'N, TRENDWATCH 1 (2002).
[12] BLUECROSS BLUESHIELD ASS'N, *supra* note 7, at 4.

E. The Current Liability Crisis: Costs

1. Altogether, medical liability adds $60 billion to $108 billion to the costs of health care each year – which means higher health insurance premiums and higher medical costs for all Americans, according to estimates in a recent U.S. Department of Health and Human Services report.[13]

2. On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS's July report had become worse.[14] The federal government reported that:

> The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, **the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.** (emphasis added)[15]

3. HHS also believes that excessive medical liability adds $47 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs.[16]

4. Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003.[17] Tillinghast reported that "The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986," which is "equivalent to a 5% tax on wages."[18] This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

   a. The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents

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[13] OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 7 (July 2002) [hereinafter CONFRONTING THE NEW HEALTH CARE CRISIS].

[14] U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, UPDATE ON THE MEDICAL LITIGATION CRISIS: NOT THE RESULT OF THE "INSURANCE CYCLE," (Sept. 25, 2002), *available at* http://heal-fl-health-care-pdf.netcomsus.com/resources_update_report.doc.

[15] *Id.* at 4.

[16] CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 11, at 7.

[17] TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2002 UPDATE: TRENDS AND FINDINGS ON THE COST OF THE U.S. TORT SYSTEM 4 (2002), *at* http://www.tillinghast.com/tillinghast/publications/reports/2002_Tort_Costs_Update/Tort_Costs_2002_Update_rev.pdf (last visited Mar. 21, 2003)[hereinafter TILLINGHAST-TOWERS PERRIN].

[18] *Id.* at 1.

to compensate for actual economic loss.[19]

b. As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.[20]

c. While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.[21]

d. **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.[22]**

5. The vast majority of medical liability claims, almost 70%, do not result in any payments to patients.[23] Fewer than 1% of cases result in trial victories for plaintiffs.[24]

6. Blue Cross/Blue Shield plans nation-wide report that approximately half of the plans expect ob/gyn and surgical fees to increase as a result of increased professional liability premiums. This was expected in both crisis and non-crisis states.[25]

7. Patients are aware of the impact of lawsuits on healthcare costs. Seventy-one percent (71%) agree that medical liability litigation is driving up healthcare costs.[26]

8. Health care consumers acknowledge the impact of rising insurance premiums on overall healthcare costs. An April 2002 PricewaterhouseCoopers study "The Factors Fueling Rising Healthcare Costs" concluded that litigation accounted for 7% of the increase in rising costs of health insurance premiums. "Litigation" includes the effects of defensive medicine, malpractice premiums, risk management and reinsurance, outsized awards and legal costs, and class action lawsuits.[27]

F. The Current Liability Crisis: Defensive Medicine

1. Defensive medicine practices include unnecessary tests and treatments that are performed to help avoid lawsuits.

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[19] *Id.* at 3.
[20] *Id.* at 4.
[21] *Id.* at 11.
[22] *Id.* at 18.
[23] CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 11, at 9.
[24] PIAA, *supra* note 6.
[25] BLUE CROSS BLUE SHIELD ASS'N, *supra* note 7, at 2.
[26] WIRTHLIN WORLDWIDE, *supra* note 8.
[27] Lee Launer, *The Factors Fueling Rising Healthcare Costs*, PricewaterhouseCoopers, prepared for the Am. Ass'n of Health Plans (April 2002) *at* http://www.aahp.org/InternalLinks/PwCFinalReport.pdf.

a. A majority (59%) of physicians believe that the fear of liability discourages open discussion and thinking about ways to reduce health care errors.[28]

b. **Three-fourths (76%) of physicians believe that concern about medical liability litigation has negatively affected their ability to provide quality care in recent years.**[29]

2. Defensive medicine wastes tens or hundreds of billions of dollars on unnecessary and harmful medical care.

3. Of Blue Cross/Blue Shield plans surveyed, those in crisis states are two and a half times more likely to identify defensive medicine as "already a very serious problem" in relation to cost increases.[30] For the rest of the states, over half of the Blue Cross/Blue Shield plans feel it is an "inevitable" problem.[31]

G. Activity in the Crisis States

1. The federal government update highlights that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damage awards. The government's report states that:

> . . 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. **States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002.** States with reasonable limits on non-economic damages have not experienced the same rate spiking. (emphasis added)

2. The Current Liability Crisis: The Crisis States[32]

a. The AMA has identified the following nineteen states currently experiencing a medical liability crisis: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, Nevada, West Virginia, and Wyoming.

b. Twenty-five states have the potential to be deemed "in crisis."

c. Only 6 states are considered stable; California, Colorado, New Mexico, Louisiana, Wisconsin, and Indiana. Even in some of

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[28] Humphrey Taylor, David Krane, Amy Cottreau & Diana Gravitch, *Common Good Fear of Litigation Study The Impact on Medicine* 30 (Apr. 2002) Harris Interactive, *at* http://ourcommongood.com/library/download/litrpt.pdf?item_id=10032.

[29] *Id.* at 57.

[30] BLUECROSS BLUESHIELD ASS'N, *supra* note 7, at 3.

[31] *Id.* at 8.

[32] AM. MED. ASS'N, AMA ANALYSIS (July 2003) *at* http://www.ama-assn.org/ama/pub/category/7861.html.

these states, there are indications that problems are beginning to develop.[33]

3. The Blue Cross/Blue Shield Association concludes that the "medical malpractice insurance crisis is threatening healthcare affordability and access to care." (Eighty-eight percent of plans agree.)[34]

   a. Blue Cross/Blue Shield recognizes the AMA designation of "crisis" states and acknowledges the impending problems of 30 other states.[35]

   b. The Blue Cross/Blue Shield study validates the conclusion that reduced access to care is a result of the current medical liability crisis.

      i. Fifty-six percent (56%) of Blue Cross/Blue Shield plans in crisis states respond that physicians are refusing some high risk procedures. (In non-crisis states 32% of plans report this finding.)[36]

      ii. Fifty-six percent (56%) of Blue Cross/Blue Shield plans in crisis states report that physicians are leaving practice or retiring. (The response in non-crisis states is 42%.)[37]

      iii. Almost 1/3 of the Blue Cross/Blue Shield plans in crisis states state that physicians are moving practices out of state. (In non-crisis states, 1/5 of plans report that physicians are moving out of state.)[38]

4. Nevada

   a. The only trauma center in Las Vegas – one of the busiest in the nation – closed for 10 days this past summer when orthopedic surgeons couldn't afford professional liability insurance. The CEO of the hospital warned the public to "Drive home carefully."[39]

   b. In Nevada, recent legislation providing a cap on non-economic damages provides hope that the situation will improve. Unfortunately, the cap on non-economic damages is applied per physician, per claimant and not per incident. Thus, multiple caps can be allowed in a single event.[40]

   c. According to a survey of physician members conducted by the Nevada State Medical Association, 76 specialists have closed their practices because of the cost of malpractice insurance. An

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[33] *Id.*
[34] BLUECROSS BLUESHIELD ASS'N, *supra* note 7, at 2.
[35] *Id.*
[36] *Id.* at 9.
[37] *Id.*
[38] *Id.*
[39] J. ECON. COMM., *supra* note 1, *citing to* Tony Batt, *UMC Official Says Crisis Is Far From Over*, L.V. REV.-J., Oct. 12, 2002.
[40] NEV. REV. STAT. § 41.A.0312 (2002).

additional 126 physicians are "seriously considering" or in the process of closing their doors.[41]

5. Pennsylvania

a. The crisis in Pennsylvania began in 1996. At that time, there was a 100% emergency surcharge by the state's Medical CAT Fund. Then, from 1997 until 2001, premiums of major private insurance carriers in Pennsylvania rose between 80.7% and 147.8%. In 2002, the increase in filed premiums ranged from 40% to 50.3%. For 2003, similar increases were filed.

b. Mercy Hospital in West Philadelphia and Methodist Hospital in South Philadelphia closed their maternity wards in the summer of 2002.

c. In the Philadelphia suburbs, Brandywine Hospital closed its trauma center and Paoli Hospital closed its paramedic unit. In January, Abington Memorial Hospital "temporarily suspended" its trauma center because there weren't enough on-call surgeons who could afford liability coverage.

d. Radiologists specializing in mammography are among those hardest hit: the loss of radiologists in the state has resulted in waiting periods for routine mammographies of up to eight months.[42]

e. In the past five years, eight companies have stopped offering medical liability insurance here, with only two remaining.

6. Florida

a. Aventura hospital, a medical center located near Miami, stopped providing maternity care. Each birth at the medical center cost the hospital $1,000 in insurance premiums. The obstetrics program had lost $3.5 million over six years.

b. Palm Beach Gardens Medical Center is a leading provider of brain and spinal surgery. Yet, this hospital has several weeks, every month, when there is no neurosurgeon on-call to treat emergency patients. The hospital, like so many others, has found it increasingly difficult to locate neurosurgeons to cover the emergency department. The physicians are not able to afford the cost of medical liability coverage.

c. Finally, there's Orlando Regional Hospital which reports that the average wait time for women seeking mammography rose from 20 days in 2000 to 150 days in 2002. Many radiologists could not find or afford the necessary liability insurance. In a recent survey of Palm Beach, Miami Dade and Broward Counties, 7 of the 29 radiologists said they had stopped reading mammograms, and 8 others are considering this possibility.

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[41] Ryan Pearson, *76 Medical Practices have Closed*, ASSOCIATED PRESS, Jan. 30, 2003.

[42] J. ECON. COMM., *supra* note 1, *citing to* Marian Uhlman, *Shortage of Radiologists, Technologists Creating Long Waits*, PHIL. INQ., Feb. 11, 2003.

d. The Orlando Regional Medical Center is currently at risk of closing its trauma center because of a lack of neurosurgeons willing to provide services in the emergency room.[43]

e. The situation in Florida has become so dire that Governor Bush created a special Task Force to examine the availability and affordability of liability insurance. This Task Force held nine hearings over a five month period and received extensive testimony and information from numerous, diverse sources. It concluded in one of its recommendations to the Governor that "the Legislature should, in medical malpractice cases, cap non-economic damages at $250,000 per incident...Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, *there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of healthcare.*"[44] (Emphasis added).

f. After four special sessions, Florida's legislature enacted S.B. 2-D, which was signed into law by Governor Bush on August, 14, 2003. In its final form; the bill does not provide the level of reforms advocated by Governor Bush's task force or by the Florida Medical Association (FMA). In particular, the language on non-economic damages and exceptions to the cap added during late stages of negotiations are troublesome. In fact, this clause prohibited FMA from supporting the legislation in its final form.[45]

g. S.B.2-D provides a separate cap on non-economic damages for practitioner and non-practitioners. For practitioners the cap is $500,000 per claimant regardless of the number of defendants. For non-practitioners the cap is $750,000 per claimant regardless of the number of defendants. The cap can increase to $1 million for practitioners and $1.5 million for non-practitioners if the negligence resulted in death or a permanent vegetative state, or if the court finds a manifest injustice would occur if the cap was not increased because the non-economic harm sustained by the patient was particularly severe and the defendant's negligence caused a catastrophic injury to the patient.

7. Texas

a. In the past two years, 62 percent of Texas physicians have begun denying or referring high-risk cases, and 52 percent have stopped providing certain services to their patients. Nearly two-

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[43] J. ECON. COMM., *supra* note 1, *citing to* Margaret Ann Mille, *Manatee Doctors, Nurses Rally for Cap on Malpractice Suits*, SARASOTA HERALD-TRIB., Mar. 1, 2003.

[44] Fla. Dep't of Health, *Governor's Select Task Force on Healthcare Professional Liability Insurance Report, Executive Summary*, at xi (May 4, 2003), *available at* http://www.doh.state.fl.us/.

[45] S.B. 2-D , 2003 Special Session D, Florida Laws (2003) (enacted).

thirds of physicians say the climate for practicing medicine and the fear of malpractice lawsuits have forced them to deny or refer high-risk cases to other doctors (Texas Medical Association, April 2003)

b. Home to about 20 malpractice carriers in 1999, Texas now had only four in 2002 willing to write new policies, according to Insurance Commissioner Jose Montemayor. (Houston Chronicle, Aug. 3, 2002.)

c. Medical liability insurance premiums have jumped anywhere from 50 to 200 percent. This is especially devastating to rural physicians, obstetricians, and emergency and trauma care physicians. (Texas Medical Association)

d. On June 11, 2003 Governor Perry signed HB 4 into law. HB 4 contains sweeping tort reforms, many of which exclusively address malpractice litigation against physicians. Of these reforms, perhaps the most important is the hard cap of $250,000 on non-economic damages per claimant in any judgment against a physician or health care provider, regardless of any applicable theories of vicarious liability, the number of defendants involved, or the number of causes of action asserted as part of the claimant's case against the physician. HB 4 also places a hard cap of $250,000 on non-economic damages per claimant in any judgment against a health care institution in a medical liability cause of action. A judgment against two health care institutions shall not exceed $500,000 in non-economic damages with each institution not liable for more than $250,000 in non-economic damages.[46] All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant.

The new law states the cap on non-economic damages applies per "claimant." This terminology may create some confusion about the scope of the cap. Fortunately, however, the new law defines "claimant" as "a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant." **Therefore, all persons claiming to have sustained damages as a result of injury or death sustained by a single person are considered a single claimant.** The new law also states **the cap applies regardless of the number of defendants or causes of action asserted.** Therefore, the maximum amount a claimant (including all persons that claim damages as a result of injury or death of a single person) can recover in non-economic damages, even if multiple physician defendants are involved and the claimant asserts multiple causes of action, is $250,000. There is also a separate cap for health care institutions whereby a claimant can recover up to an additional $250,000 for one institution and up to $500,000 if more than one institution is

[46] H.B.4,, 78th Texas Legislature (2003) (enacted).

involved. Again this cap applies regardless of the number of causes of action asserted, or persons who claim to have damages from the injury or death of a single person.

The caps provision states as follows:
"(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based. (b) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant. (c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution is, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000 for each claimant."

e. On September 13, 2003, the people of Texas approved Proposition 12, a ballot initiative to amend the state constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in medical and health liability cases. This vote validates the legislature's work in enacting HB 4. The final vote was 51.12% in favor of Proposition 12 and 48.88% against. Thus a decrease in liability insurance premiums can occur immediately rather than a possible 10 year wait for the state supreme court to decide whether caps are allowed under the state constitution. The constitutional change clearly states that the legislature can set a cap on non-economic damages in medical and health care liability cases.

8. West Virginia

a. In West Virginia, the Charleston Area Medical Center had to pay $2,000 daily in malpractice premium subsidies in order to retain the doctors necessary to keep its trauma center open. After the last emergency room neurosurgeon left Wheeling, the local

hospital had to transport trauma patients by helicopter to other emergency rooms.[47]

b. On March 12, 2003, Governor Bob Wise signed H.B. 2122 into law. The key provision of HB 2122 is a $250,000 cap on non-economic damages per claimant regardless of the number of defendants. The cap increases to $500,000 for cases involving (1) wrongful death, (2) permanent and substantial physical deformity, loss of use of limb or loss of a bodily organ system, or (3) permanent physical or mental functional injury that permanently prevents a person from being able to independently care for himself or herself and perform life sustaining activities. The cap will be adjusted annually for inflation, but the $250,000 cap will not exceed $375,000 and the $500,000 cap will not exceed $750,000. HB.2122 also places a cap on total damages for care provided in a trauma center and creates a physicians mutual insurance company.[48]

9. Anecdotes from other crisis states

a. In Mississippi, patients are not able to find a neurosurgeon in the northern half of the state. In April, Leanne Dyess from Vicksburg testified before the House Judiciary Committee speaking in support of reforms. She told the story of her husband Tony, who was in an auto accident and is now permanently brain damaged because there was no neurosurgeon near the scene of the accident.

b. In Arizona, a woman gave birth by the side of the road before she reached the only remaining maternity ward in a 6,000 square mile area.

c. In Washington State, clinics serving 60,000 patients were forced to close under the insurance burden. Increased losses forced Washington Casualty Co., the state's largest provider of malpractice coverage to rural hospitals, into receivership.[49]

d. A recent study of Georgia physicians projected that 2,800 doctors in the state (approximately 1 in 5) would stop providing higher-risk procedures in order to reduce their liability exposure.[50]

e. The Medical Society of New Jersey estimates that 3,000 physicians in the state are at risk of losing coverage due to reduced coverage by insurers. Over a period of less than a year, three insurers – the MIIX Group, Phico, and the St. Paul

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[47] J. ECON. COMM., *supra* note 1, *citing to* Frances X. Clines, *Insurance-Squeezed Doctors Folding Tents in West Virginia*, N.Y. TIMES, June 13, 2002.

[48] H.B.2122, 76th West Virginia Legislature (2003) (enacted).

[49] J. ECON. COMM., *supra* note 1, *citing to* Carol M. Ostrom, *Malpractice Insurer Ordered into Receivership by State*, SEATTLE TIMES, Mar. 8, 2003.

[50] Daniel Yee, *Study: Insurance Rates Affect Georgia Care*, WASH. POST, Jan. 26, 2003.

Companies, who cover 55 percent of the state's doctors – stopped writing coverage for malpractice.[51]

f. In New York State, 16 percent of obstetricians have stopped practicing obstetrics because of the state's medical liability crisis – 40 percent of the state's counties have fewer than five practicing obstetricians – and seven counties in New York State, with as many as 300 births per year, currently have no obstetrician.

g. In Ohio, rising liability insurance costs had an oncologist eyeing retirement, but his patients raised more than $40,000 to pay the premium and keep him in practice.

II. Solutions

A. State Legislative Reforms Demonstrate Lower Costs

1. In a study on the effect of reforms, Stanford University researchers Kessler and McClellan concluded that direct reforms, including caps on non-economic damages, reduced the likelihood that a physician will be sued by 2.1%. Within three years, premiums in direct reform states declined by 8.4%.[52]

2. Another study by Stephen Zuckerman *et al.* looked at several types of reforms and concluded that capping physician liability reduced premiums for general surgeons by 13% in the year following enactment of that reform and by 34% over the long term. Premiums for general practitioners and OB/GYNs were impacted similarly.[53]

3. In fact, not only do reforms lower physicians' premiums, but costs for consumption of health care as well.

a. In a different study by Kessler and McClellan, those researchers found "that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications."[54]

4. These states upheld legislation for caps on non-economic damages: Alaska, California, Colorado, Idaho, Kansas, Maryland, Michigan, Minnesota, Missouri, Nebraska, , Virginia, West Virginia and Wisconsin. (Of them, Missouri, North Carolina, and West Virginia are considered crisis

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[51] J. ECON. COMM., *supra* note 1, *citing to* Lynna Goch, *Medical-Malpractice Tort Reform Trouble Spots*, BEST'S REV., Dec. 2002, and Joseph B. Treaster, *New Jersey Insurer is Leaving Many Doctors Scrambling*, N.Y. TIMES, May 10, 2002.

[52] Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, LAW & CONTEMP. PROBS. 60, 81-106 (1997).

[53] Stephen Zuckerman, Randall R. Bovbjerg & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, INQUIRY 27, 167-182 (1990).

[54] Daniel P. Kessler & Mark B. McClellan, *Do Doctors Practice Defensive Medicine*, NAT'L BUR. OF ECON. ANALYSIS Working Paper 5466 (Feb. 1996), 2.

states.)[55]

a. It is important when looking at the effectiveness of caps on non-economic damages to make the comparison on equal terms, *i.e.*, apples to apples. For example, a fixed cap, like the $250,000 cap found in California's MICRA, is not comparable to the cap provided in the Missouri law.[56] The Missouri cap increases with inflation. Originally set at $350,000 in 1986, the cap on non-economic damages in Missouri is $557,000 as of February 1, 2003. In addition, the Missouri law applies the cap individually to each defendant and each plaintiff. Thus, the cap on non-economic damages in Missouri law has not been as effective as the cap under MICRA.

b. Tillinghast-Towers Perrin confirms this conclusion. In a current study, Tillinghast-Towers Perrin finds savings could be expected with a $250,000 cap on non-economic damages. The study further states that a cap of $500,000 is likely to be of very little benefit to physicians.[57]

5. Among the many findings in the report released on January 29, 2003, **the Governor's Task Force in Florida found that the level of liability claims paid was the main cause of the increases in medical liability insurance rates.** The Task Force ultimately concluded that "the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages."[58]

6. Indiana, Louisiana and New Mexico upheld caps that encompass both economic and non-economic damages.[59] Louisiana's cap, akin to New Mexico, does not include medical expenses, which are paid as incurred.[60]

7. The following states struck down caps on non-economic damages: Alabama, Georgia, Illinois, Kansas, New Hampshire, North Dakota,

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[55] *See* Evans v. State, 56 P.3d 1046 (Alaska 2002); Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985); Scholz v. Metro. Pathologists P.C., 851 P.2d 901 (Colo. 1993); Kirkland v. Blaine County Med. Ctr., 4 P.3d 1115 (Idaho 2002); Samsel v. Wheeler Transport Services, Inc. 246 Kan. 336 (Kan. 1990); Murphy v. Edmunds, 601 A.2d 102 (Md. 1992); Zdrojewski v. Murphy, 202 Mich. App. Lexis 1566 (2002); Adams v. Children's Mercy Hosp., 848 S.W.2d 535 (Mo. Ct. App. 1993); Linder v. Smith, 629 P.2d 1187 (Mont. 1981); Prendergast v. Nelson, 256 N.W.2d 657 (Neb. 1977); Gourley ex. rel. Gourley v. Nebraska Methodist Health System, 633 N.W.2d 43 (Neb. 2003); Etheridge, et. al. v. Medical Ctr. Hosp., 367 S.E.2d 525 (Va. 1989); Robinson v. Charleston Area Med. Ctr., 186 W.Va. 720 (W. Va. 1991); Verba v. Ghaphery, 552 S.E.2d (W. Va. 2001); Guzman v. St. Francis Hosp., 623 N.W.2d 776 (Wis. Ct. App. 2000).

[56] MO. REV. STAT. § 538.210 (2002).

[57] Letter from James D. Hurley and Gail E. Tverberg, to Ray Cantor, Dir. of Gov't Affairs, Med. Soc'y of N.J., (Jan. 7, 2003) (on file with the Am. Med. Ass'n).

[58] Fla. Dep't of Health, *Governor's Select Task Force on Healthcare Professional Liability Insurance Report, Executive Summary*, at xi (May 4, 2003), *available at* http://www.doh.state.fl.us/.

[59] Johnson v. St. Vincent Hosp., 404 N.E.2d 585 (Ind. 1980); Butler v. Flint Goodrich Hosp., 607 So.2d 517 (La. 1992), Fed. Express Corp. v. United States, 228 F. Supp. 2d 1267 (N.M. 2002).

[60] LA. REV. STAT. § 40:1299.42(B)(1) (2003).

Oregon, Washington (Of them, Georgia, Illinois, Oregon, and Washington are considered crisis states.)[61]

8. In Florida and Texas, caps were upheld, but with some restrictions (Florida and Texas are crisis states.)[62]

B. Favorable State Case Law Establishes Rationale for Supporting Legislative Reforms - Failed Legal Challenges Brought Against Caps on Non-economic Damages[63]

1. Equal Protection Clause

a. Under the "deferential rational relationship" test, a number of courts have upheld damages caps as a permissive and rational means of achieving the legitimate state goal of reducing insurance premiums paid by physicians.

b. Other societal goals supporting the implementation of caps that have been upheld by the court include; (i) ensuring the availability of physicians in the state, (ii) the continued existence of state compensation funds, (iii) the continued existence of insurance for physicians in the state, and (iv) assurance of medical related payments to all claimants.

c. Courts have held it constitutional for damage caps to differentiate between medical malpractice tort claimants who have suffered injuries valued at a level below the damages cap, and those who have suffered damages valued above the damages cap amount based upon the legitimate purpose of the legislature.

2. Due Process Clause - Court analysis of due process challenges has also proceeded under the rational relationship test, where damages caps have been found to be neither arbitrary nor irrational legislative goals.

3. Right to Trial by Jury

a. After a plaintiff is awarded damages up to the amount of the statutory cap, the determination of damages is removed from consideration by the jury and given to the court. This is not a denial of the right to trial by jury, since the jury has already completed its fact-finding mission, determining that the plaintiff is owed compensation. Deciding how much a patient will recover is a question of law for the court. The court implements the policy decision of the legislature.

b. Reviewing courts have also held that it is within the legislature's power to modify common law and statutory rights and remedies,

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[61] *See* Moore v. Mobile Infirmary Ass'n, 592 So.2d 156 (Ala. 1991); Denton v. Con-Way S. Express, Inc., 402 S.E. 2d 269 (Ga. 1991); Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997); Kan. Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988) new law enacted in 1988; Carson v. Mauer, 424 A.2d 825 (N.H. 1980); Arneson v. Olson, 270 N.W.2d (N.D. 1978); Lakin v. Senco Products, Inc., 987 P.2d 463 (Or. 1999); Sofie v. Fibreboard Corp., 771 P.2d 711 (Wash. 1989).

[62] *See* Univ. of Miami v. Echarte, 618 So.2d 189 (Fla. 1993); Lucas v. United States, 757 S.W.2d 687 (Tex. 1988); Rose v. Doctors Hosp., 801 S.W.2d 841 (Tex. 1990).

[63] *See* cases cited *supra*, note 50.

as was done with the caps.

4. Open Court Challenge - The courts have struck down the argument that a damage cap impermissibly allows the legislature to intrude on the judicial process. Instead of being an impermissible barrier to the courts, the cap is merely a limit on recoveries.

5. Intrusion on the Rulemaking Power of the Judicial Branch - The courts did not find that caps allow the legislature to overstep its constitutional powers. Instead, the courts found that the legislature has full purview over questions of policy, as opposed to procedural questions. Damage caps are questions of policy, properly within the legislature's scope of power.

C. California's Solution: MICRA

1. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of medical liability litigation in that state.[64]

2. The United States Supreme Court dismissed a challenge to the non-economic damages cap in MICRA for want of substantial federal question.[65] However, a federal law is required to ensure that reforms will be effected in all states. The Supremacy Clause, principles of preemption and the language of H.R. 5, would protect states with existing caps, yet provide a federal standard for a non-economic cap, even if such caps are barred by a state constitution.

3. HR 5, also known as the HEALTH Act, is based on MICRA and does the following:

   a. Ensures that patients receive 100 percent compensation for their economic losses, including medical expenses, rehabilitation costs and lost wages, if harmed by a physician's negligence;

   b. Establishes periodic payments of future damages;

   c. Maximizes the amount of money juries award for patients -- not trial lawyers; and

   d. Places a $250,000 cap on non-economic damages, and also allows states the flexibility to establish different caps.

4. Now, in California, claims are settled in one-third less time than in states without caps on non-economic damages.[66] This not only decreases the cost of litigation, it also means injured patients are indemnified much faster in California.

5. California's experience with MICRA shows that tort reform works. MICRA has been held up as "the gold standard" of tort reform, and a model for repeated attempts at Federal reform legislation. See attached chart that

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[64] CAL. CIV. CODE § 3333.2 (2003).

[65] Fein v. Permanente Medical Grp., 474 U.S. 892 (1985).

[66] *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce*, 107th Cong. 88 (2002) [hereinafter Anderson statement] (statement of Richard E. Anderson, Chairman of the Doctors' Co. for the Physician Ins. Ass'n of Am.).

clearly demonstrates cost savings realized, by specialty, on premiums comparing California to other states without reforms.

6. According to Phil Hinderberger of Norcal Mutual, before MICRA was passed, "California physicians paid 25% of all medical liability premiums paid in the U.S., while they represented only about 10% of all practicing physicians in the U.S. Today, California physicians pay about 10% of all medical liability premiums paid in the U.S., which represents a fair share."[67]

7. According to the National Association of Insurance Commissioners, while total premiums in the rest of the U.S. have risen 569%, California premiums have risen only 182% since 1976.[68]

8. Since 1975, The Doctors Company, one of the 45 carriers that comprise the Physician Insurers Association of America (PIAA), has lowered its medical liability premium rates in California by 40% in constant dollars.[69]

9. One argument put forth by opponents to MICRA is that Proposition 103, not MICRA, kept medical liability premium rates affordable in California. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down the provision that would have only allowed rates and premiums that were reduced between November 8, 1988 and November 8, 1989 pursuant to subdivision (a) to be increased if the commissioner found, after a hearing, that an insurer was substantially threatened with insolvency.[70] The rest of the law was upheld. Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter."[71] However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner."[72] Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.[73]

10. According to Californians Allied for Patient Protection, the not-for-profit group devoted to protecting MICRA, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates."[74] This illustrates that Proposition 103 is not responsible for keeping medical liability premiums

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[67] Posting of Phil Hinderberger, phil-hinderberger@norcalmutual.org, Sr. Vice President and General Counsel, Norcal Mutual Insurance Company, to asmac-1@unity.ama-assn.org (Jan. 20, 2003) (copy on file with author).
[68] National Association of Insurance Commissioners Reports of Profitability by Line by State, 1976-2001.
[69] Anderson statement.
[70] Calfarm Inc. Co. v. Deukmejian, 48 Cal. 3d 805, 771 P.2d 1247 (1989).
[71] CAL. INS. CODE § 1861.05(a) (2003).
[72] *Id.* at § 1861.05(b) (2003).
[73] *Id.* at § 1861.05(c) (2003).
[74] "Why MICRA, and not Prop. 103, keeps medical liability insurance rates reasonable in California," Californians Allied for Patient Protection, attachment to posting of Catherine Hanson, chanson@cmanet.org, California Medical Ass'n, to asmac-1@unity.ama-assn.org (Jan. 16, 2003) (copy on file with author).

down; rather it is MICRA that has been the force behind California's success.

11. According to HHS, the number of large jury awards has been declining in California, although the total number of claims has not.[75] "The percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients."[76] "Premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois, and Nevada."[77]

D. Joint Economic Committee supports caps on non-economic damages

1. In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[78]

2. The study points to California, which under MICRA has a $250,000 cap on non-economic damages, binding arbitration on disputes, collateral sources offsets, limits on contingency fees, advance notice of malpractice claims, statute of limitations, and periodic payment of damages. The Joint Economic Committee praises California as "perhaps the most successful example of reform at the state level," noting its slower rate of growth in malpractice premiums (167percent versus 505 percent in the rest of the country from the period 1976 to 2000).[79]

3. After observing the failure of our current system to achieve either of its central goals, *i.e.*, to compensate those who are truly negligently injured and to deter negligent behavior, the study concludes: "This indictment of the tort system serves as the basis for medical liability reform...If adopted, the federal reform discussed here could yield budgetary savings of more than $19 billion per year, reduce the number of Americans without health coverage by up to 3.9 million, and lead to an environment that is significantly more receptive to efforts to improve patient safety and reduce medical errors."[80]

E. Agency for Healthcare Research and Quality demonstrates a cap on non-economic damages helps protect patients' access to care

1. The July 3, 2003 study from the Agency for Healthcare Research and Quality[81] looked at the distribution of physicians across states with and without caps on non-economic damages since 1970. After adjusting for multiple factors. AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without damage caps.

2. Additional key findings include: caps are effective in improving the supply of physicians and patients' access to care.; the lower the cap, the greater its effectiveness in ensuring patients' access to care.

F. National Legislation

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[75] U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 12.
[76] *Id.*
[77] *Id.*
[78] J. ECON. COMM., U.S. CONG., LIABILITY FOR MEDICAL MALPRACTICE: ISSUES AND EVIDENCE 19 (May 2003).
[79] *Id.* Note: the updated figures according to the NAIC, through 2001, are 182% and 569%, respectively.
[80] *Id.* at 24.
[81] Hellinger and William Encinosa , *supra* note 1.

1. The HEALTH Act (Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003), is modeled after the successful MICRA statute.[82] On March 13, 2003, the House of Representatives passed the HEALTH Act by a vote of 229-196.

2. The vote was largely along party lines with 213 Republicans and 16 Democrats supporting the bill. Nine Republicans, 186 Democrats and 1 Independent opposed the bill. One Republican voted "present." Eight members did not vote on H.R. 5.

3. H.R. 5 would safeguard patients' access to care by enacting common sense reforms that provide a $250,000 cap on non-economic damages, thus reasonably limiting damages without preempting existing state law.

   A 2003 Congressional Budget Office study on H.R. 5 (108th Congress) indicates that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical liability insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 5 would significantly lower premiums for medical liability insurance from what they would otherwise be under current law.[83]

4. The HEALTH Act would have real results because it gets to the root of the problem and also addresses ancillary issues.

   a. The source of the problem lies not in incompetent physicians, as some would argue, but rather in large jury verdicts that award exorbitant amounts of non-economic damages in medical malpractice cases.

   b. As a result of these large jury verdicts, insurance companies are forced to raise their premiums—otherwise face insolvency.

   c. Escalating insurance premiums, such as the $249,000 premium for obstetricians in Florida, mean it is no longer economical for many physicians to purchase insurance. Therefore, physicians choose to narrow the range of services they offer, withdraw from practice altogether, or relocate to a state where insurance premiums are less. All of these actions lead to lower quality care to patients who can not get access to care, regardless of their health insurance coverage or plan.

   d. The HHS Agency for Healthcare Research and Quality (AHRQ) has illustrated this phenomenon in a formal study. AHRQ revealed that states that have enacted limits on non-economic damages in medical lawsuits have about 12 percent more physicians per capita than states without such a cap. According to the study's authors, Fred Hellinger, Ph.D. and William Encinosa, Ph.D., "these findings demonstrate that state laws limiting non-economic damages in medical malpractice cases

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[82] Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003), introduced on Feb. 5, 2003, by Rep. Jim Greenwood (R-PA).

[83] CONG. BUDGET OFFICE, *H.R. 5 Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003* (March 10, 2003). *at* http://www.cbo.gov/showdoc.cfm?index=4091&sequence=0.

increase the number of physicians who practice in the states."[84]

e. H.R. 5 would allow patients injured due to negligence to be awarded unlimited economic damages, which include medical expenses, lost wages and benefits, lost earning capacity, long term care, assisted living devices, childcare, household services, lost time, and special medical damages. It would also help stabilize medical liability insurance premiums by limiting non-economic damages to $250,000 (*e.g.*, pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill.

f. The HEALTH Act also ensures that more of the award goes to the person actually injured, the patient. The bill would minimize the incentive of plaintiffs' lawyers to bring a suit of questionable merit because their contingent fee would be reduced; rather than receiving one-third (or greater) of the total recovery plus costs, an attorney would receive 40% of the first $50,000, one third of the next $50,000, one fourth of the next $500,000, and 15% of any amount over $600,000. So for example, if a jury awarded damages of $1 million, instead of getting $333,333 plus costs, a plaintiff's lawyer would receive $221,667 plus costs.

5. President Bush continues to be a strong advocate for medical liability reform.

6. In the Senate, Senator John Ensign (R-NV) introduced S. 11, the "Patients First Act of 2003" on June 26. S. 11 is similar to H.R. 5, except that it includes a provision to reform expert witness requirements.

   In early July 2003, Senators opposed to S. 11 blocked the bill from being debated and voted on by the full Senate. Republicans lacked the sixty votes needed to overcome a Democratic filibuster that prevented them from bringing the measure up for a formal vote. Forty-nine voted in favor of breaking the filibuster, while forty-eight voted against. Despite support from President Bush, the House of Representatives, 72% of the American public,[85] and the Senate leader, the measure failed.

   Sen. Feinstein (D-CA) remains interested in developing a bill based on the proven reforms in MICRA. Discussions on a Senate bill continue and the Senate leadership plans to bring a bill to the floor later this year.

7. Tillinghast-Towers Perrin, in reviewing proposed legislation in New Jersey on medical malpractice liability reform, concluded that a $250,000 cap on non-economic damages would be expected to result in 5%-7% savings for physicians. If the number of large malpractice claims is trending upward rapidly, a $250,000 non-economic cap may also help to flatten out the rate of increase in the number of claims.[86]

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[84] Agency for Healthcare Research and Quality, *Study Links Higher Physician Supply to Limits on Non-Economic Damages*, HHS Press Release (July 7, 2003) *at* http://www.ahrq.gov/news/press/pr2003/tortcapspr.htm.

[85] *See infra*, note 82.

[86] Letter from James D. Hurley and Gail E. Tverberg, to Ray Cantor, Dir. of Gov't Affairs, Med. Soc'y of N.J., (Jan. 7, 2003) (on file with the Am. Med. Ass'n).

8. Seventy-three percent (73%) of those surveyed in a Wirthlin Worldwide poll favor a law that would guarantee an injured patient full payment for lost wages and medical costs and place reasonable limits on awards for "pain and suffering" in medical liability cases.[87] A recent Gallup poll confirms this public opinion. The poll results, released February 4, show that 72% of Americans support limiting the amount patients can be awarded for "pain and suffering." In addition, 74% believe medical liability insurance in health care to be a crisis or major problem.[88]

III. Responding to Other Arguments

A. Public Citizen and Other Anti-tort Reform Groups' Concerns

1. Physicians are victims of insurance companies that made bad business decisions and are now trying to make up their losses.[89]

Rebuttal: Professional liability carriers had actually been subsidizing their premiums. Figures reported by A.M. Best representing 76% of the industry show that 80% of investments by PIAA companies between 1995 and 2001 were in high-grade bonds, with the remainder divided among stocks, mortgages, real estate and working cash. However, with plunging interest rates, investment yields on these bonds have declined, and there are no longer profits with which insurers can subsidize premium rates the way they once did.[90] Increased losses on claims are the primary contributor to higher medical liability premium rates. Insurers are not charging and profiting from excessively high premium rates. None of the insurance companies studied experienced a net loss on investments.[91]

2. Insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses.[92]

Rebuttal: Annual Statement data summarized in Best's Aggregates & Averages, Property-Casualty, 2002 edition, showed that the Investment Yields of medical malpractice insurers have been stable and positive since 1997. Those returns have ranged from 5.0-5.5%, and include income from interest, dividends, and real estate income. Medical malpractice insurers have approximately 80% of their investments in the bond market. Therefore, their total returns on invested assets are strongly influenced by bond market performance, and less so by stock market performance. Best's Aggregates and Averages indicates that insurers' total returns on invested assets has fallen by only 3.2 percentage points over that period. The facts simply don't justify anyone trying to place blame on the insurance

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[87] WIRTHLIN WORLDWIDE, *supra* note 8.

[88] Gallup Poll News Serv., *Tort Reform* (Feb. 4, 2003), *at* http://www.gallup.com/poll.

[89] *See* Pub. Citizen, *Medical Misdiagnosis: Challenging the Malpractice Claims of the Doctors' Lobby* (Jan. 2003), *at* http://www.citizen.org/congress/civjus/medmal/index.cfm.

[90] *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care?: Hearing Before the Subcomm. on Commercial and Admin. Law of the Comm. on the Judiciary*, 107th Cong. 64 (2002) (statement of Lawrence E. Smarr, Pres. of Physician Ins. Ass'n of Am.).

[91] U.S. GENERAL ACCOUNTING OFFICE, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (June 2003) at 15, 32, 25.

[92] Ams. for Ins. Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates*, (Oct. 2002), *at* http://www.insurance-reform.org/StableLosses.pdf.

industry for an out-of-control legal system.[93]

According to the Ohio Department of Insurance, the vast majority of invested assets are fixed-income instruments such as treasury, municipal, and corporate bonds whose losses have been minimal.[94]

The Ohio Department of Insurance also refutes this misconception by stating that there is no provision in its regulations that allows insurance companies to increase their rates in order to recoup past costs resulting from pricing mistakes, larger than expected claims, adverse court decisions, or other unexpected costs.[95]

Brown Brothers Harriman & Co. (BBH) released a report ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. **BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand.**[96]

In addition, BBH released an addendum to this study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. **BBH concluded that "investments did not precipitate the current crisis."**[97]

3. The crisis was created by the "insurance cycle." Reform should focus on preventing such insurers investment practices, not restricting claimants' rights.[98]

Rebuttal: It is not the underwriting cycle that drives the problem but the growing size of jury awards. The U.S. Department of Health and Human Services argues that if the insurance cycle were the cause of the current crisis, "then all states would be equally experiencing a crisis."[99] Insurers are not leaving other markets. They are leaving the medical liability market because of the risk of unbounded payouts in that sector, particularly in non-reform states.[100] As a case in point, "St. Paul Companies, which was the

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[93] BEST'S AGGREGATES AND AVERAGES - PROPERTY/CASUALTY, QUANTITATIVE ANALYSIS REPORT, MEDICAL MALPRACTICE PREDOMINATING 166 (2002).

[94] "Medical Malpractice Insurance," Presentation by Holly Saelens, Asst. Dir., OH Dep't of Ins. 19 (n.d.).

[95] *Id.* at 18.

[96] Raghu Ramachandran, *Did Investments Affect Medical Malpractice Premiums?*, BROWN BROTHERS HARRIMAN & CO. (Jan. 21, 2003), at http://salsa.bbh.com/news/Articles/MedMal.html.

[97] Raghu Ramachandran, *A Note on Investment Income of Medical Malpractice Companies*, BROWN BROTHERS HARRIMAN & CO. (Feb. 4, 2003), at http://salsa.bbh.com/news/Articles/medmal2.html.

[98] *See e.g.*, Meg Green, *Consumer Groups Blame Premium Hikes on Regulatory Inaction*, BESTWIRE, Aug. 1, 2002, *available at* http://www.consumerwatchdog.org.

[99] U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 12.

[100] *Id.* at 2.

largest malpractice carrier in the U.S. (covering 9% of physicians), announced in December of 2001 that it would no longer offer coverage to any doctor in the country."[101]

4. The insurance cycle is evidence of the breakdown in the state regulatory system. Regulators need to keep rates from being both excessive and inadequate.[102]

Rebuttal: Even the American Association of Health Plans finds that "all state insurance departments and other state governmental agencies heavily regulate and monitor the solvency of medical malpractice carriers and require extensive reporting."[103] These regulators place strict limits on the types and riskiness of investments insurers can purchase. Also, the insurers are required to report annually on the status of their investments. The AAHP also reasoned that if the stock market were to blame, the crisis would resonate across the country to all medical malpractice insurers. This is not the case, as evidenced by the fact that it is mostly physicians that practice in states without meaningful medical malpractice reform who are significantly affected.[104]

B. Trial Bar Explanations

1. Tort reforms unfairly penalize patients and are ineffective in holding down premiums for physicians and hospitals.[105]

Rebuttal: But do patients with a claim get the right amount of compensation? Awards of non-economic damages that are given are out of scale with equity or need are not fair to anyone, given that economic compensatory damages are unlimited. Thus, legislators must consider the needs of the greater public welfare to ensure access to care for all.

Tort reforms hold down premiums. Compare California's premiums with those of the other large states. For example, 2001 annual premiums for surgeons in California ranged from $14,000 to $42,000, while premiums for surgeons in Florida ranged from $63,000 to $159,000.[106]

2. Rather than tort reform, more efforts should be directed at removing incompetent physicians and improving quality of care.

Rebuttal: Removing "incompetent" physicians based on how many times they have been sued or have been found liable for negligence would be an extreme and ineffective method of trying to resolve the crisis because of the randomness of the litigation system. The few cases that do result in

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[101] *Id.* at 3.

[102] *See* Ams. for Ins. Reform, *Americans for Insurance Reform Launched to Fight Insurance Industry Mismanagement and Price Gouging* (July 2002), *at* http://www.insurance-reform.org/pr/AIRRelease.pdf.

[103] Am. Ass'n of Health Plans, *"Lawsuit Lottery" Causes Medical Malpractice Crisis – Suggestions that Poor Investments Led to Crisis Don't Pass Smell Test, at* http://www.americanbenefitscouncil.org/documents/refutingstockmarketargument.pdf (n.d.).

[104] *Id.*

[105] *See* Ass'n of Trial Lawyers of Am., *Medical Malpractice Fibs and Facts, at* http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/medmalfibsfacts.aspx (n.d.).

[106] CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 11, at 13.

huge jury awards encourage a "lottery" mentality among plaintiffs and lawyers.[107]

Also, according to HHS, researchers have found that most errors are system failures, rather than failures of individual physicians. That is to say, even if physicians perform their job correctly, most errors would still occur. A better approach to fixing the problem of system errors would be to dispel the fear by physicians, hospitals and nurses that open discussion on adverse events would be discoverable in lawsuits. This could be accomplished through state peer review statutes that protect confidentiality of such discussions.[108] A federal statute that allows confidential peer review, with expedited systems for correction including dissemination of de-identified information, is a model that works for the Aviation Safety Reporting System and should be replicated for health care.

The AMA supports bipartisan efforts in the House and Senate to advance legislation that would establish the statutory framework to create a "culture of safety" whereby information on health care errors could be reported in a confidential and legally protected manner. In the 108th Congress, the House has passed a patient safety bill and a key Senate committee has cleared legislation for a full Senate vote. The two bills are similar in many respects, and after the Senate votes on its patient safety bill a conference committee will meet to reconcile the differences.

In the Senate, Senators Jeffords (I-VT), Breaux (D-LA), Frist, MD (R-TN), and Gregg (R-NH) introduced S. 720, the "Patient Safety and Quality Improvement Act of 2003." On July 23, 2003, the Senate Committee on Health, Education, Labor, and Pensions reported (approved) S. 720 (as amended by the chairman's mark) by a unanimous vote of 20 yeas to 0 nays. This clears the way for the bill to be debated and voted on by the full Senate. The AMA strongly supports S. 720 as amended by the HELP Committee.

The bill reported by the HELP Committee would create a confidential, voluntary reporting system in which physicians and other health care providers could report information on errors to entities to be known as Patient Safety Organizations (PSOs). The PSOs would collect and analyze unique "patient safety data" and provide feedback on patient safety improvement strategies. This legislation would:

- create a confidential, voluntary reporting system in which physicians, hospitals, and other health care providers could report information on errors to organizations known as Patient Safety Organizations (PSOs).
- Allow PSOs to collect and analyze unique "patient safety data" and then provide feedback on patient safety improvement strategies.
- Provide that "patient safety data" would be confidential and legally protected.

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[107] *Id.* at 8.
[108] *Id.* at 22.

- Not limit or affect the availability of any information or evidence that is currently available from sources other than the PSO and can be collected under existing law.
- Provide for appropriate penalties for unlawful disclosures.
- Recognizes and preserves the protection of confidential patient information under the Health Insurance Portability and Accountability Act of 1996.
- Not preempt other state and federal peer review laws.

This legislation strikes the proper balance between maintaining confidentiality and legal protections for unique patient safety data, and the need to ensure accountability throughout the health care delivery system. Such a balance was envisioned in the 1999 IOM report, *To Err is Human.*

On March 12, 2003, the House of Representatives passed H.R. 663, the "Patient Safety and Quality Improvement Act," by a near unanimous vote (418-6). This bill would establish a system for reporting health care errors in a confidential and legally protected manner that is similar to the Senate bill.

3. Tort reform will only benefit insurance companies and physicians.

Rebuttal: Tort reform, such as capping non-economic damages, would lower insurance premiums. If physicians have the reassurance that their premiums are lower, they are less likely to practice defensive medicine or limit the procedures they perform. This is well illustrated by the fact that because of skyrocketing insurance premiums, physicians have opted out of performing high risk procedures such as those involved in obstetrics and other surgery.[109]

C. Additional Reflections of the Insurance Industry

1. The only way insurers can assure financial viability is to increase revenue, or, in other words, raise rates.

The medical malpractice combined ratio, a measure of profitability, reached 153.3 in 2001, compared with 115.7 for all lines combined. That means, for every $1 insurers received in premiums, they paid out $1.53.[110] This deterioration occurred in spite of a rise in premiums of 8.7 percent that year. Estimates show that in 2002 the combined ratio continued to worsen, reaching 165.[111]

2. Insurers blame jumps in big jury awards and large settlements.

Even though plaintiffs lost the majority of their cases that went to a jury

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[109] BLUE CROSS BLUE SHIELD ASS'N, *supra* note 7, at 2.
[110] Insurance Information Institute, *Medical Malpractice* (June 2003) *at* http://www.iii.org/media/hottopics/insurance/medicalmal/.
[111] *Id.*

trial,[112] the average cost of defending any claim is about $27,009.[113] And, this number does not account for the time lost to the physician in defending the case, the cost of defensive medicine and other inefficiencies in the healthcare system when resources are diverted from patient care.

In addition, "sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court."[114] Taken together with the percentage of claims where the doctor prevailed at trial, in two-thirds of all claims the individual physician was found to be not at fault. Considering the cost to the system of bringing a claim and the number of claims without merit, it is apparent the total cost could be staggering.

PIAA, which represents about 60% of the professional market, expressed support for tort reform, stressing that the shrinking availability and rising costs of medical professional liability insurance eventually will harm patients.[115]

D. GAO Reports

1. **While verifying that the liability crisis has affected access to health care services, the GAO made several determinations in its August 2003[116] report relating to the extent of the liability crisis that the AMA believes do not accurately reflect the severity of the current crisis in real time. Numerous changes to the GAO methodology would strengthen the basic findings of this report. Among the data sources, measures, or analytical methods that could be improved are the following:**
   a. ***Examination of all crisis states.*** **The GAO only examined five of the 19 crisis states. The current medical liability crisis is far more widespread, extending to the additional 14 states as well.**
   b. ***Appropriate measurement of physician mobility.*** **Physician counts were based on state licensure data, which do not accurately reflect the number of physicians practicing in a given location. Actual physician practice location information must be used instead.**
   c. ***More accurate counts of physicians by specialties and local markets.*** **Physician/population ratios that aggregate physicians across local markets and specialties obscure the significant market-specific or specialty-specific changes in the supply of physicians and availability of critically important medical services.**
   d. ***Use of multi-payor data to accurately measure access to health care services that Medicare data alone do not capture.*** **Utilization statistics based exclusively on data from a single payor (Medicare) exclude data for obstetric and emergency care, and fail to capture the impairment of**

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[112] Patient *Access Crisis: The Role of Medical Litigation, Hearing Before the S. Comm. on the Judiciary*, 108th Cong. (2003) (testimony of Lawrence E. Smarr of Physician Ins. Ass'n of Am.).

[113] PIAA Claim Trend Analysis, 2002 Ed., Exhibit 1.

[114] Patient *Access Crisis: The Role of Medical Litigation, Hearing Before the S. Comm. on the Judiciary*, 108th Cong. (2003) (testimony of Lawrence E. Smarr of Physician Ins. Ass'n of Am.) at 16.

[115] White House Writers Groups, *National Quorum Survey Results* (Apr. 2002), *at* http://www.thepiaa.org/pdf_files/hcla_2002_poll.pdf.

[116] U.S. GEN. ACCOUNTING OFFICE, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* (August, 2003) GAO-03-836.

access among other vulnerable populations, such as Medicaid patients.

e. ***Use of current source of data to capture the magnitude of the access problem in real time.*** **The GAO accorded no weight to current sources of data which reflect the magnitude of impairment of patient access today.**

E. The Current Liability Crisis and Patient Safety

1. Quality of care improves when there is greater access to physicians.

2. A culture of safety requires a legal environment that encourages professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.

3. The current litigation system does little, if anything, to help improve our health care system. But it does plenty to threaten it, including:

   a. Encouraging defensive medicine.

   b. Creating an almost lottery mentality throughout the nation's court system.

   c. Enriching certain trial lawyers at the expense of patients and physicians.

4. The Harvard Medical Practice Study found that "one malpractice claim was filed by a New York patient for every 7.5 patients who suffered a negligent injury."[117] A critique of the study concluded that "a substantial majority of malpractice claims filed are not based on actual provider carelessness or even iatrogenic injury." This means that negligence had occurred in only one-sixth of the matched tort claims.[118] The results of the study are also questionable because although the two reviewing physicians were trained for the project, they did not necessarily specialize in the care areas that they reviewed. There was also a high rate of disagreement between the two physicians as to whether an adverse event was, in fact, a negligent adverse event.

   One of the authors of the Harvard Study, Troyen A. Brennan and two colleagues, later conducted another study released in 1996. The follow-up study was conducted because the authors acknowledged the original study "lacked information on the eventual outcomes of the cases."[119] In the 1996 study, researchers concluded that the only significant predictor of payment to medical malpractice plaintiffs in the form of a jury verdict or a settlement was disability, and *not* the presence of an adverse event due to negligence.[120] In other words, the severity of a patient's disability,

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[117] A.R. Localio, A.G. Lawthers, T.A. Brennan, N.M. Laird, L.E. Hebert, L.M. Peterson, J.P. Newhouse, P.C. Weiler & H.H. Hiatt, *Relation between malpractice claims and adverse events due to negligence: Results of the Harvard Medical Practice Study III*, 325 N. ENG. J. MED. 245, 245-51 (1991).

[118] HARVARD MED. PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990).

[119] Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963, 1963 (1996).

[120] *Id.* at 1965.

regardless of any adverse event due to negligence, was predictive of payment.

The study's authors found that "serious injuries can lead to settlements even when there is no negligence, as happened in one case involving a neurologic injury that followed a vascular procedure. In that case, the patient's injuries were so serious that the insurer thought the jury would compensate the patient, even though the medical care met the expected standard."[121] Brennan *et al.* discuss other cases that involved settlement payments to plaintiffs simply because the physicians in question would have made poor witnesses. In addition, the authors point out that in cases where there was no evidence of negligence, 43 percent of claims resulted in payment for the claimant. Finally, he questions "whether tort law is the most effective system of compensating injured patients and creating rational mechanisms of preventing injuries."[122]

5. In a more recent article published in the New England Journal of Medicine, Brennan questions the conclusions of the Institute of Medicine report "To Err is Human" (the "IOM Report") that discusses the high rate of deaths in hospitals each year due to medical errors. Brennan highlights the lack of determination of preventable error as the primary reason for questioning the IOM's statements regarding the incidence of injuries.[123]

   Keep in mind that the IOM Report did not undermine or attack physicians themselves; indeed, it is entitled "To Err Is Human." Instead it points the finger at the systems that can cause problems in patient care. The report recommends that rather than focusing on a "bad apple" problem, the focus should shift to examining elements of the health system. This could take the form of something as simple as automated medication order entry systems, enabling physicians to rely less on memory.[124]

   Brennan further emphasizes the improvements that are being realized in patient safety. In fact, Brennan finds that systems improvements and other quality activities have led to increased safety and better patient outcomes.[125]

6. Other research confirms these conclusions. McDonald *et al.* find that the underlying studies of the IOM report were "observational," not intended "to describe causal relationships." The authors state "The Harvard study includes no information about the baseline risk of death in these patients or information about deaths in any comparison group. Therefore, it cannot be determined whether adverse events are correlated with, let alone whether they cause, death." The authors comment that "reliance on studies without controls to make headline claims about huge numbers of preventable deaths was one error it did not catch."[126]

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[121] *Id.* at 1966.
[122] *Id.* at 1967.
[123] Troyen A. Brennan, M.D., J.D., M.P.H., *The Institute of Medicine Report on Medical Errors – Could It Do Harm?*, 342 N. ENG. J. MED. 15, 1123-1125 (2000).
[124] COMM. ON QUALITY HEALTHCARE IN AM., INST. OF MED., *To Err is Human*, Executive Summary (Linda T. Kohn et al. eds., National Academy Press 2000).
[125] Brennan, *The Institute of Medicine Report on Medical Errors – Could It Do Harm?, supra* note 115.
[126] Clement J. McDonald, Michael Weiner & Siu L. Hui, *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report* (July 5, 2000), 284 J. OF THE AM. MED. ASS'N, 93.

Consider also the comments of another researcher. Dentzer finds "First, in the vast majority of the coverage, there was an undue focus on the numbers of likely deaths from medical errors, and this tended to give the projections a misleadingly totemic significance. Second, much of the news media simply equated medical errors with malpractice--perpetuating the notion that most of the bad stuff going on in medicine can be attributed to the negligence of incompetent professionals. Third, many journalists never moved beyond this blame game to a broader understanding that many errors result from systems failures, which are amenable to systemic solutions. Collectively, these media mistakes and misjudgments may have led the public to draw false or simplistic conclusions about a serious problem that is already proving difficult to fix."[127]

7. AMA policy is to be part of the solution, not the problem. The AMA believes that one preventable error is one error too many. In fact, the AMA helped launch the National Patient Safety Foundation in 1996, well before publication of the IOM report. The Foundation's approach is to create a culture of cooperative learning and mutual improvement, as opposed to a culture of shame and blame.

8. Opponents of liability reform claim that 5% of physicians are responsible for 54% of malpractice in the U.S. Public Citizen's analysis of the National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, found that 5.1% of physicians have paid two or more malpractice awards to patients. According to Public Citizens' analysis, these physicians are responsible for 54% of all payouts reported to the Data Bank. Public Citizen finds that of these, only 7.6% have ever been disciplined by state medical boards. Public Citizen further asserts that even physicians who have made 5 payouts have been disciplined at only a 13.3% rate.[128]

   Rebuttal: First of all, the NPDB collects both settlements and verdicts. It goes without saying that a settlement is not an admission of negligence. In fact, many meritless cases are settled because of the risk a jury may make a huge award on the basis of a desire to compensate a patient without regard to whether negligence occurred. In other words, the jury provides for adverse outcomes that had nothing to do with malpractice. Yet these settlements generate reports to the NPDB and go into the count of incidents of malpractice.

   In addition, the validity and reliability of the NPDB is questionable according to a study conducted by the General Accounting Office.[129] Therefore, any analysis performed using the NPDB database should be scrutinized. Further, these data and related reports do not account for specialties commonly known for high risk procedures. Thus, specialties such as orthopedics, ob/gyn and neurosurgery are not identified and analyzed appropriately.

   Finally, it is common knowledge that the count of reported cases in the

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[127] Susan Dentzer, *Media Mistakes in Coverage of the Institute of Medicine's Error Report,* EFFECTIVE CLINICAL PRACTICE, (Nov./Dec. 2000), *available at* http://www.acponline.org/journals/ecp/novdec00/dentzer.htm.

[128] Pub. Citizen, *Bush's Medical Malpractice Disinformation Campaign: A Rebuttal to the HHS Report on Liability* 21 (Jan. 2003), *at* http://www.citizen.org/documents/Bush's_Disinformation_Campaign_Report.pdf.

[129] U.S. GEN. ACCOUNTING OFFICE, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability* (Nov. 2000) GAO-01-130.

NPDB is often overstated by the generation of more than one report per physician. For example, cases in which a patient receives a payment from the insurance carrier, a payment from the CAT fund, and a payment from the physician, all for the same adverse event, have frequently been represented in the NPDB database by three separate reports. Therefore, three "occurrences" may be recorded even though they may all relate to a single incident.

MEDICAL MALPRACTICE INSURANCE

A STUDY OF MARKET CONDITIONS

DRAFT REPORT

PRESENTED TO THE NAIC'S PROPERTY AND CASUALTY (C) COMMITTEE

ERIC NORDMAN

DAVIN CERMAK

December 3, 2003

MEDICAL MALPRACTICE INSURANCE

A STUDY OF MARKET CONDITIONS

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INTRODUCTION

The NAIC decided that it was important to study the market conditions for medical professional liability insurance, often known as medical malpractice, in light of declining industrywide financial results, withdrawal of significant national carriers, and the financial decline of other individual medical malpractice insurance providers. In some states the market problems are so pronounced that access by the public to essential health care services has been affected. This is particularly true for trauma services and high-risk medical specialties such as neurosurgeons, obstetrics and neonatal care. While the NAIC members are hopeful that reasons for the rising prices and declining availability of coverage will be addressed, it recognizes that diversity of state tort laws and unique state market participants might make it difficult to do so on a national basis. Countrywide data has shown that medical malpractice insurance providers are finding it difficult to operate profitably. However, the financial results vary when one looks at individual state results. That offers hope for researchers as it allows them to review the characteristics of those states that have been successful in hopes of learning lessons that may be applied in other states that appear to be in crisis.

Since the late 1990s, there have been substantial rate increases for medical malpractice insurance in many states, while rates remained stable in others. These rapid increases led to complaints from the medical community about the affordability of coverage. This, coupled with the inability of physicians to pass these costs to patients because of managed care arrangements, has led to evidence that physicians have curtailed their practice in certain states or certain medical specialties to avoid these spiraling costs.

There appears to be general agreement that there is a problem, however, there is debate about causes and solutions.

This study is based on a review of historical data collected and compiled by the NAIC as well as a review of other studies of medical malpractice. In addition, a hearing was conducted by the NAIC's Market Conditions Working Group in an attempt to assess the extent of the problem, learn about various stakeholders perspectives and evaluate suggested solutions to address the situation. This report presents the findings and public policy recommendations of the Market Conditions Working Group. The principal researchers are NAIC Economist Davin D. Cermak, NAIC Director of Research Eric C. Nordman, CPCU, CIE, and Kenneth McDaniel, MBA, ARM, CFE (Fraud), of the Texas Department of Insurance. The role of the researchers was to gather the information and present their evaluation of the market to the Market Conditions Working Group so that the working group could develop the public policy recommendations. The recommendations contained in this report represent a consensus of the working group members.

MEDICAL PROFESSIONAL LIABILITY

Doctors and other health care providers are involved in the medical profession. As professionals, they are held by the public and the courts to a higher standard of care than if they operated in other businesses. In the medical arena, the courts commonly recognize physicians, nurses, dentists, and pharmacists and other highly trained practitioners as professionals. Professionals are generally expected to possess special knowledge or skills

the set them apart from the rest of society. This special knowledge and skill generally comes from a person's education and experience.[1] "Professionals are bound by law to (1) perform the services for which they were engaged and (2) perform these services in accordance with appropriate standards of care. The first duty is primarily contractual; the second duty arises from the principles of tort laws."[2]

Medical providers might be determined by a court to be liable if their action or inaction led to injury to a patient. Negligence occurs when harm results from a medical provider's failures to treat a patient to the same standard of care, as the patient would expect from a well-qualified medical professional.[3] This is the risk the medical provider seeks to insure when purchasing a medical liability policy.

It is important to note that there is a difference between medical malpractice and a bad medical result. Malpractice involves negligence on a medical provider's part. A bad outcome for the patient can occur from known and unavoidable medical risk, an unforeseeable adverse patient response or a medical misadventure that does not rise to the level of negligence. This complexity sets medical liability insurance apart from other liability coverages in that a higher percentage of premium dollars goes toward defense and cost containment expenses. Medical liability insurers spend substantial funds defending claims where there is a bad patient outcome not resulting from medical provider negligence.

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[1] Malecki, et al; Commercial Liability Risk Management and Insurance. The American Institute for Property and Liability Underwriters. 2nd Ed. Chapter 12.
[2] Ibid.
[3] Ibid.

The Medical Professional Liability Insurance Market

For purposes of this report, medical liability will encompass insurance purchased by health care providers, hospitals, nursing homes and other institutions that provide health services. It is also important to know that many health care providers and health care institutions choose to retain the risk of loss from medical mistakes rather than transfer it through insurance. Sometimes self-insurance, as retention is commonly known, is combined with an excess insurance policy that attaches at some level of loss and indemnifies the policyholder above that amount. There are also state-specific, statutorily enabled mechanisms that effectively function as insurers and provide coverage for medical error.

In the insured markets, the predominant form of coverage offered is a claims-made policy. The evolution from occurrence policies to claims-made policies began during the medical malpractice crisis of 1975. An occurrence policy is a liability policy where the coverage trigger is based on when the event takes place (in medical malpractice, the occurrence of medical error that leads to harm). Coverage applies if the medical error occurred while the policy was in force, regardless of when reported to the insurer. In contrast, a claims-made policy is a liability policy where the coverage trigger is the reporting of a claim. Coverage applies if the medical error is reported to the insurer while the policy is in force. A medical misadventure must also occur within the current or prior policy period with the same insurer, unless an insured purchases prior acts coverage to extend coverage of medical error retroactively.

Medical malpractice insurers operate much like other types of insurers. They collect premiums from policyholders and assign them to either the unearned premium reserve or other reserves. When losses occur, they either pay the loss or establish a loss reserve. Funds remaining after expenses and taxes ultimately flow to surplus. The long time it takes to pay malpractice claims allows insurers an opportunity to earn investment income that helps offset the need for income from underwriting operations. Insurers are able to invest amounts held in surplus, unearned premium reserves and loss and loss adjustment expense reserves. Accounting rules require that insurers post their best estimate of the ultimate settlement value of reported, but unpaid losses. In addition, insurers are required to consider expected payments that have occurred, but are not yet reported (Incurred, But Not Reported or IBNR).

Loss adjustment expenses play a key role in medical liability coverage. Insurers are required to account for loss adjustment expenses in two separate categories—Defense and Cost Containment (DCC) and Adjusting and Other (AO). DCC expenses are particularly important in medical liability because many claims reported to insurers are determined to be noncompensable through negotiation or trial

It is important to note that property and casualty rates, including medical liability rates, are made on a prospective rather than a retrospective basis. Thus, a common claim that rising medical liability insurance rates are attributable to recoupment of prior losses is inaccurate. While increases in the frequency and severity of claims are recognized in

ratemaking, the rates charged are required to be neither excessive, nor inadequate nor unfairly discriminatory for the future period when they will be charged.

State Regulatory Systems

States vary widely in both regulatory framework and regulatory philosophy. **Table 1** provides definitions of the various regulatory frameworks that are in common use today. Seventeen jurisdictions employ a prior approval law for medical liability rates. Twenty-two states use a file and use system; nine have a use and file system. In Massachusetts, the commissioner of insurance sets rates for medical malpractice coverage. In Missouri, only informational filings are required. In Oregon, a flex rating system (modified prior approval) applies. A state can administer a file and use system with a waiting period in much the same way a state can administer a prior approval system with a deemer provision. Further, some states offer choices to insurers regarding the system that they wish to use for rate filing purposes.

Some researchers have studied the effects of different systems on the medical malpractice **[NO FOOTNOTE?]** market. Zuckerman, Bovbjerg and Sloan (27 Inquiry 180) found "clear evidence that requiring prior approval of premiums is an effective way of lowering physician malpractice costs" but cautioned that "the effectiveness of prior approval regulation in controlling premiums could have an adverse impact on the availability of insurance in the state..." Rizzo found that non-competitive rating laws have had little independent effect on underwriting results, but that direct medical malpractice insurers fare better in states with non-competitive rating laws that they do under competitive

rating laws.[4] Rizzo also found a stronger correlation between direct insurer market share and the loss ratio in competitive rating law states that that of insurers in non-competitive rating states.[5]

Non-Standard Market Mechanisms

Non-standard market mechanisms exist in medical liability insurance to fill voids left when standard, or primary, insurers cannot or will not insure a particular risk. Three major types of non-standard mechanisms provide significant amounts of coverage in the medical liability market. First and most prevalent are surplus lines insurers, which are exempt from rate and policy form regulation. Second is the residual market mechanism. Typically, these are mechanisms established either by state legislation or by the state insurance regulator. These mechanisms include state insurance funds, patient compensation funds (PCFs); state mandated insurance pools and joint underwriting associations (JUAs). The existence of residual market mechanisms in most states reflects policymakers' recognition that there is a need to ensure that medical liability coverage will be available where such coverage is mandatory or needed to provide stability to the market when availability or affordability is suspect. Third is a risk retention group established under the Federal Liability Risk Retention Act to offer medical liability insurance to medical provider/owners. Table 2 provides some useful definitions of the types of ownership identified in NAIC data.

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[4] Rizzo, John. "The Impact of Medical Malpractice Insurance Rate Regulation." The Journal of Risk and Insurance 56.3 (1989): pg 482-499.
[5] Ibid. p. 482

Self-Insurance

Risk managers know self-insurance as retention. It occurs when a medical provider or a hospital chooses to pay for its own losses as they occur without involving an insurer or other risk transfer mechanism. Where a provider has no insurance or formal plan of retention, it is known simply as going bare. This is rare among physicians, as for the most part, retention is not an option for medical providers. To receive privileges to operate in a hospital, the medical provider is generally required by the hospital, or perhaps state law, to obtain approved professional liability insurance. The low frequency and high severity nature of medical professional liability makes the self-insurance option unattractive to most medical providers, even if hospitals or state government would accept that option. However, there are reportedly increasing numbers of nursing homes bare, without insurance.

Self-insurance may be a viable option for some large hospitals, nursing homes and other institutions that provide medical services. With assistance from a professional risk manager, a hospital or other large institution can establish a formal program where it sets aside adequate funds to pay for medical liability claims or pay claims as they occur and are adjudicated. There is no formal reporting mechanism to gather information about self-insured entities. The tax treatment by the IRS of funds held to pay claims is different when an entity is self-insured. Reserves for a self-insured cannot be set-aside on a tax-deferred basis until they are paid out to a claimant. This makes comparison of self-insured operations with those purchasing medical liability policies difficult. Further, there is no central source of information on self-insured operations.

Ratemaking for Medical Liability Insurance

The basic building blocks for medical malpractice rates are the same as that of other property and casualty insurance products. The rate consists of the loss costs, or pure premium, plus the expenses of the insurer and a factor for profit and contingencies. Insurers use historic (past) loss and expense information to forecast and adjust current rates to those needed for a future period.

Insurance Department Activity to Prevent Inadequate Rates

Since regulators are charged with assuring that rates are not excessive, inadequate, or unfairly discriminatory. It is incumbent on them to periodically review rate levels to see that they meet all three rating standards. This task is difficult as the typical workflow of an insurance department involves the review of rate filings that are developed and submitted by insurers at a time selected by the insurer. The task of the regulator is to review the filings received. If an insurer has not changed rates and does not choose to submit a new filing, there is a time lag between the period where inadequate rates might be charged and the discovery of the rate inadequacy. The regulatory framework further complicates this. There are not generally specific time periods where an insurer is obligated to make a rate filing. As a result, there are occasions where inadequate rates are charged for a period of time.

It should also be noted that in many jurisdictions, a finding of rate inadequacy is allowed under some circumstances. The NAIC's Property and Casualty Model Rating Law (File

and Use Version) specifies "a rate is not inadequate unless such rate is clearly insufficient to sustain projected losses, expenses and special assessments in the class of business to which it applies and the use of such rate has or, if continued, will have the effect of substantially lessening competition or the tendency to create monopoly in any market." If the regulator is unable to prove that the inadequate rate will lead to insolvency or monopolistic behavior, in these jurisdictions, there is little that can be done.

Some attribute a perceived lack of attention to the inadequate rates as one cause of the underwriting cycle that is observed in all property and casualty lines of business. Some reports have been critical of insurance regulators for failure to intervene when rates are inadequate to pay for future losses.[6] The Americans for Insurance Reform observe that the "unwillingness of regulators to disapprove rates that are...inadequate—despite their statutory authority to do so—is also a cause of the cycle."[7] It is also a political problem for insurance regulators. Health care providers do not complain when rates are lower than they should be, however it would take a very strong person to order an insurer to raise rates when the regulator believes the rates are inadequate, and an insurer is not motivated to raise rates at that time.

The Role of Reserving and Possible Reserve Deficiencies

One of the most difficult and important tasks for the casualty actuary is the estimation of the necessary future dollars needed to cover the unpaid liabilities of the insurer to claimants. This task is of critical importance to a medical liability insurer. "Loss

[6] See July 23, 2002 letter from the Americans for Insurance Reform to the nation's insurance commissioners, Page 4.
[7] Ibid.

reserving is the term used to denote the actuarial process of estimating the needed amount of loss reserves. A loss reserve is a provision for an insurer's liability for claims" (Wiser, 197). **[FOOTNOTE?]** According to Wiser, the total loss reserve of an insurer is comprised of five elements:

- "Case reserves assigned to specific claims;
- A provision for future development on known claims;
- A provision for claims that re-open after they have been closed;
- A provision for claims that have occurred but have not yet been reported to the insurer; and
- A provision for claims that have been reported to the insurer but have not yet been recorded. (197)"

It should be noted that for most practical purposes, including financial reporting, the last four elements are combined into what is generally referred to as the broad definition of incurred but not reported (IBNR) losses.

A lengthy claim settlement process characterizes the medical liability insurance line of business. Thus it is critical for the casualty actuary to make the best estimate possible of the ultimate settlement value of all losses that the insurer faces. One of the key elements in medical liability claims is loss development. If juries in a particular jurisdiction change awarding patterns, all known claims tend to be adjusted accordingly by the insurer's claims department adjusters to reflect the new pattern of damage awards. Actuaries then rely on these revised estimates in their evaluations of the insurer's liabilities. This can result in significant increases in loss reserves if juries are tending toward larger damage awards. It should be noted that few claims actually go to trial, however the damages awarded by juries in those few trials affect the settlement agreements for the claims that do not go to trial. This is why the reserves on many known claims are adjusted.

Actuaries often use a process that involves the development and use of loss triangles where data is collected and compiled in what is known as a loss development triangle. The use of a loss development triangle assists the actuary in developing a best estimate of the ultimate settlement value on the claims. Various reports of claims -made years of data are reviewed annually as they change over time. Often eight or more years of loss development is used so that the actuary can calculate factors as the data changes over time. This process allows the actuary to apply factors to recent accident years that are based on historical loss development patterns of the insurer. The loss triangles can be applied to a variety of useful data sets. Some of the more common used data sets include: paid losses, incurred losses (typically paid losses + case reserves), closed claim counts, reported claim counts, etc. Thus, using historical valuations of the loss reserving accuracy of the insurer's claims personnel, the actuary can more accurately predict the ultimate settlement value of recent data years.

It should be noted that a similar process applies to the estimation of loss adjustment expense reserves. This can be an important component of pricing for medical liability insurance, as loss adjustment expenses are a major part of a medical liability premium.

THE PUBLIC HEARING ON MEDICAL MALPRACTICE

On March 8, 2003, the Market Conditions (C) Working Group held a public hearing on medical malpractice markets. The working group heard from three invited speakers. Dr. Donald Palmisano testified on behalf of the American Medical Association (AMA). Dr. Richard E. Anderson, President and CEO of The Doctors Company provided the perspective of a medical liability insurance provider. Jay Angoff, a Missouri attorney

provided a lawyer's perspective on behalf of the American Trial Lawyers Association (ATLA). Not surprisingly, there was not a consensus as to the causes of the medical malpractice crisis or appropriate remedies to address the situation.

The AMA recommends the adoption of a uniform federal approach to resolve the crisis. This would include prompt and fair compensation to patients that are injured when a medical provider breaches the generally accepted standard of care. The AMA believes that these injured patients should receive full payment for out-of-pocket "economic" losses and reasonable compensation for "non-economic" losses. The AMA supports the HEALTH Act (H.R. 5), which has passed the House of Representatives earlier this year. The AMA also supports reform that would encourage health care providers to report health care errors without fear of reprisal so they can be studied to improve patient safety and quality of care.

Dr. Anderson believed that California's MICRA reforms were effective in providing a balance between adequate patient compensation for negligence by health care providers and constrained costs of medical liability insurance. He believed that increasing severity of losses caused the current medical liability crisis. He presented statistical information from the Doctors Company to support his contentions. He blamed managed care for an erosion of trust that was present in doctor-patient relationships. He was also very supportive of patient safety efforts.

Jay Angoff believed that it was Proposition 103 that makes California's law work, not

MICRA. He provided statistics to indicate that caps of non-economic damages are ineffective. He believed that there were several causes to insurance underwriting cycles that could be addressed by insurance regulators. He observed that changes in insurers' investment performance, the cost of reinsurance, lack of diligent enforcement of rating laws by insurance regulators and the anti-trust exemption enjoyed by insurers were the primary reasons that underwriting cycles occur. He believed that if these four elements were addressed, the periodic wide swings in availability and affordability would be alleviated.

A complete transcript of the hearing along with accompanying slides for two of the speakers is available from the NAIC.

MARKET ANALYSES FROM OTHER STUDIES

Much research has been published examining market phenomenon of past as well as current medical malpractice insurance crises. Conning and Company, a consulting and actuarial firm, produced a series of strategic studies of the medical malpractice insurance industry. In 1994, it reviewed the state of the market and concluded that while profits had been strong for a number of years prior to the report, there was evidence that competitive pricing, increasing current-year claims experience, declining investment yields and declining loss reserve redundancies may reduce company profits in the future.[8] The study also found that markets were becoming less fragmented – insurers were having an

[8] Conning and Company, Challenges in Medical Malpractice: Capital, Consolidation, and Managed Care. Hartford, CT: Conning and Company, 1994.

increasingly difficult time writing specialized risks – and that volatility was increasing as new types of risks emerged.[9] Conning also argued that smaller insurers were experiencing increasing pressure to consolidate with other companies in order to survive in the increasingly competitive market.[10]

In 2000, Conning released another report that discussed the deteriorating conditions that the market had experienced.[11] Conning presented three conclusions about why the market had deteriorated. First, the industry was not prepared to deal with the competitive pressures and increasing loss severity and that many insurers appear unable to price, underwrite or manage losses.[12] Second, because insurers surveyed indicated that they both intended to raise rates and grow their business, the lack of clear and focused strategies to reduce claims cost paired with continued competition driven by market share growth goals, it would be unlikely that the potential increase in rates would be sufficient to make the industry profitable.[13] Third, the report suggests many of the industry's challenges are a result of an increased awareness of the occurrence of medical errors and frustration with increasing costs and reduced benefits of health insurance.[14]

In 2002, Conning released an even more extensive report than the 2000 report.[15] The report finds that the medical malpractice insurance market had deteriorated rapidly for

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[9] Ibid.
[10] Ibid.
[11] Conning and Company, Medical Malpractice Insurance: Ills Diagnosed, Cures Elusive. Hartford, CT: Conning and Company, 2000.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Conning and Company, Medical Malpractice Insurance: A Prescription for Chaos. Hartford, CT: Conning and Company, 2001.

several reasons: volatile year-to-year change in premium; aggressive reserve takedowns and significant increases in equity investments in the bull market disappeared; rapidly deteriorating loss ratios as a result of dramatically increasing severity and claims payment as well as increasing defense and investigation costs; an increasing reliability on reinsurance; and the development of a large reserve deficiency.[16] The report also found that although all customer markets were producing very poor underwriting results by year-end 1999, commercial markets (i.e. hospitals, nursing homes and managed care organizations) had the greatest problems.[17] The research found that since the 1970s crisis, the market had divided into three separate segments of insurers, traditional insurers, provider-owned insurers, and captives and risk retention groups, each having their own business interests[18]. Conning also found that when it came to growth strategies, insurers that had the most difficult time in the market were those that grew most aggressively between 1992 and 1997 as well as traditional insurers that entered the medical malpractice market in the 1990s.[19] Conning identifies several factors that have historically contributed to the growth of medical malpractice that are anticipated to impact future growth: loss trends driven by innovation and technology; increased agreement on defined standards of care; increased spread of medical malpractice insurance; contingency fee lawyer reimbursements; citizen juries; and nature of tort pleadings in the US courts.[20] The report suggests that in coming years, three forces will define the changing medical malpractice market: reinsurance affordability and availability; the 'federalization' of health care oversight and managed care legislation or

[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] Ibid.

court decisions; and the increased use of the Internet by consumers, providers and insurers.[21]

The Americans for Insurance Reform, examining how much money insurers have taken in and what they have paid out over a 30-year period, reported two major findings.[22] First, they found that the amount medical malpractice insurers have paid out, including all jury awards settlements, directly tracks the rates of medical inflation.[23] Second, they found that insurance premiums (in constant dollars) increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the gains or losses experienced by the insurance industry's market investments and their perception of how much they can earn on the investment 'float' that doctors' premiums provide them.[24]

The American Medical Association (AMA) issued a 2002 report of the medical professional liability (PLI) market.[25] The report finds that while the underwriting cycle can account for the periodic nature of rate escalations, it does not fully account for the overall upward trend in premiums or the extremely high levels to which they rise.[26] These outcomes are attributable to trends in claims severity and other factors, such as jury awards and settlements and rate ranges by specialty and geography that drive those trends.[27]

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[21] Ibid.
[22] Americans for Insurance Reform. Medical Malpractice Insurance: Stable Losses/Unstable Rates. New York: Americans for Insurance Reform, 2002.
[23] Ibid. p.1
[24] Ibid.
[25] American Medical Association. "Medical Professional Liability Insurance." Health Care Financial Trends Report. Chicago: American Medical Association, April 2002.
[26] Ibid.
[27] Ibid, p.5

In 1973, the Secretary of the US Department of Health, Education and Welfare (HEW) established a Commission to study the medical malpractice insurance market. The Commission published several findings and recommendations with respect to the insurance regulatory structure.[28] Many of these issues persist into the current medical liability crisis. At the time, the Commission found that medical liability was available and that the insurance market was competitive, even though individual practitioners may have more difficulty locating insurance sources.[29] With respect to rating making and rate classification, the Commission found that rates based on groups of physicians and institutions for rating purposes may not be equitable for all medical providers, and under some circumstances affect cost and availability, or in the best interests of the public.[30] The Commission also found inadequacies in the collection and analyses of appropriate data precluded the development of sound actuarial practices and rates and that state regulators are generally inadequately equipped to effectively monitor the medical liability ratemaking process.[31] The Commission recommended the NAIC work with the insurance industry to establish uniform statistical reporting system for medical malpractice insurance and that data be reported to a single data collection agent who will compile it, validate it and make it available to state insurance regulators, carriers and other interested parties.[32]

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[28] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.
[29] Ibid. p. 38
[30] Ibid. p. 43.
[31] Ibid. p. 45
[32] Ibid.

In a 2003 report, the Government Accounting Office (GAO) examined the factors contributing to the current medical liability crisis.[33] It found that several factors could be attributed to the crisis in seven states that it studied. Those factors include: rapidly increasing claims; decreasing investment income; vigorous competition in the medical malpractice market; and rapidly increasing reinsurance rates for medical malpractice insurers. While the report to Congress did not recommend any executive action, it does recommend that Congress encourage NAIC and state insurance regulators to 'identify and collect additional data necessary to evaluate the frequency, severity, and causes of losses on medical malpractice claims.[34]

REVIEW OF MEDICAL MALPRACTICE INSURANCE MARKET, 1992-2002

Over the past several years, physician complaints about the increase in premiums have increased drastically. The American Medical Association (AMA) indicates that 19 states are currently experiencing a crisis in their medical liability insurance markets.[35] From an analysis perspective, insurance regulators are interested in understanding how effectively a market functions from two perspectives. The first is to determine whether or not the medical liability market is providing the consumer with a reliable product at an affordable price. The second is to make sure that insurers remain solvent to protect the integrity of the market as well as ensuring that consumers will have their claim paid when

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[33] United States. General Accounting Office. Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. Washington, DC: GPO, 2002.
[34] Ibid. p. 7
[35] American Medical Association, States in Crisis (http://www.ama-assn.org/ama/pub/article/6282-7347.html)

needed.

Although the NAIC collects extensive financial data annually from most insurers in the U.S., several insurance providers are not required to file annual statement data to the NAIC, either because of exemptions granted by insurance regulators or because entities created by state laws are exempt from reporting data to the NAIC. Since the database used is known to be incomplete, analyses of this data will look at average values ~ in particular mean and median insurer values ~ to provide a picture of what the average insurer is facing in the market. It can be reasonably assumed that insurers not required to file annual statement data with the NAIC have similar experiences in the marketplace as those whom do.

There are also other caveats about the data that need to be considered. One concern is that affiliated insurers within an insurance group do not directly compete against one another; therefore it would be more appropriate to examine insurers on a by-group basis.[36] However, because of data limitations, this report examines insurers on a legal entity basis and not by group. The data also contains insurers that may have withdrawn from the market or suspended writing new business. These insurers continue to provide financial data to the NAIC but do not indicate their status in the market. With the caveats noted, it is the only national insurer financial database available.

Premium, Losses and Profitability

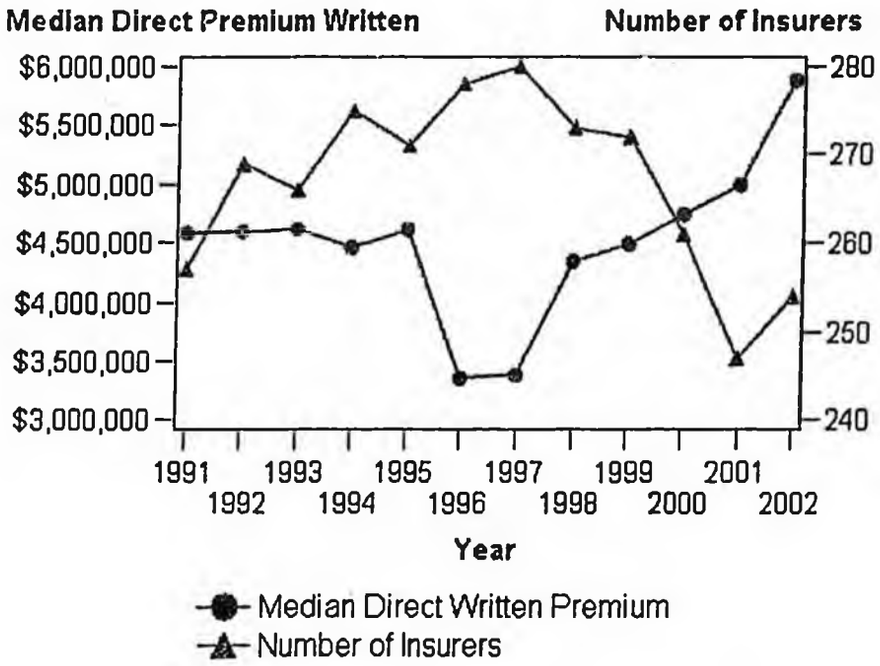
[36] The term 'insurer' refers to a legal entity writing medical liability insurance premium. This figure is based on insurers filing annual financial statements with the NAIC.

Long-run profitability is one of the most important indicators of market problems in an insurance market. Profits that are extraordinarily high over a period of years may indicate that competition in the market is stifled and prices are artificially high; that is that some insurers are able to charge higher rates than if there were additional insurers in the market driving prices down. Conversely, low profits over a number of years may indicate that there are competitors in the market charging inadequate prices in order to gain market share. It could also indicate an inability to raise premium to cover costs. An insurer's profitability is determined by the difference between its revenues and costs. This section will examine both of these components as well as the profitability of insurers.

Premium

Long-run premium growth in insurance markets is generally a constant phenomenon, but may fluctuate in the short-run. **Figure 1** shows the trend in median insurer countrywide direct premium written from 1991 to 2002, adjusted for overall inflation, as well as the number of insurers reporting medical liability insurance. The mid-1990s shows a period of growth in the number of insurers reporting medical liability insurance premium coupled with a decrease in the median insurer premium written, followed by number of years where the number of insurers decline while the median insurer premium increases.

Figure 1 - Countrywide Direct Premium Written
(In 2002 $USD)



Source: National Association of Insurance Commissioners.

Table 3 shows that, when adjusted for general inflation, the median insurer premium for an individual insurer was $4,588,622 in 1991 and $5,880,374 in 2002. Median insurer premium reached a low of $3,355,900 in 1996. Median insurer premium increased 75.22% between 1997 and 2002. Data from **Table 3** also shows a strong negative correlation (-0.7814) between the number of insurers reporting medical liability insurance premium and the median insurer premium. This may be because insurers have entered and exited the market because of competition for existing business and not opportunities for market growth.

Table 4 shows a large standard deviation relative to the mean across nearly all states in 2002. This indicates that several large insurers write a majority of the premiums written in the market. California had the highest median insurer premium written with

$1.375,828. North Dakota had the lowest median insurer premium written with $29,137. There is a strong positive correlation (0.7576) between the number of insurers and the median insurer direct written premium, indicating that the size of the market, as determined by premium volume, attract a larger number of insurers than states with smaller volumes of business.

Losses

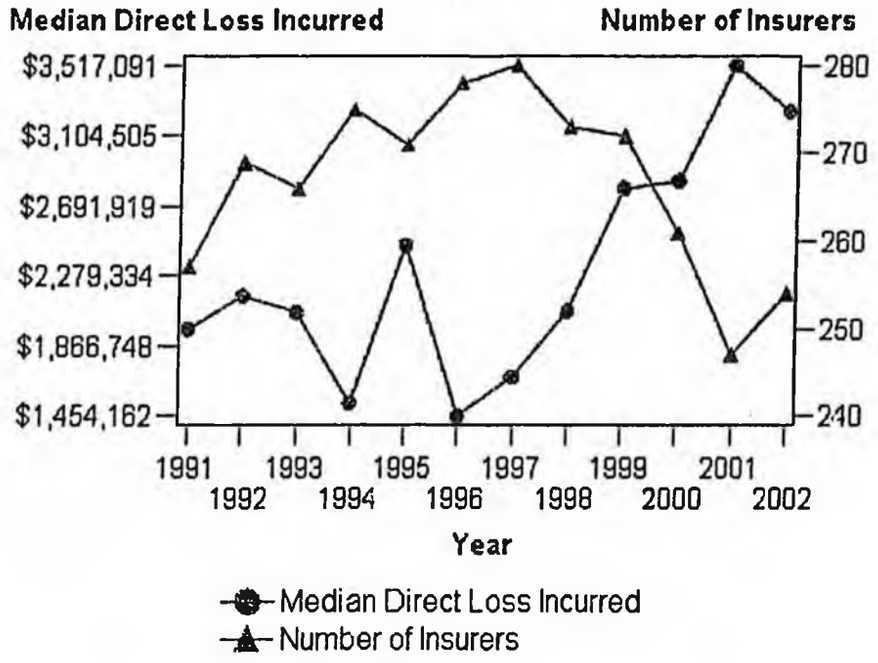
Losses are the major contributing factor in determining medical liability rates. Insurers consider historical patterns in both incurred loss and paid loss for ratemaking purposes. Incurred losses are the insurer's estimate of the total value of all its insurance claims received during the annual statement year. Paid losses are the actual losses paid by an insurer during the annual statement year regardless of when the claim was filed with the insurer.

Figure 2 shows the trend in inflation-adjusted median insurer direct losses incurred from 1991 to 2002 as well as the number of insurers reporting medical liability insurance. Median insurer incurred losses experienced strong variations in the early-1990s before smoothening out. The median insurer loss increased 123.5% from 1996 to 2001.[37] A major limitation on loss data is that it may take several years before many medical malpractice claims are submitted to an insurer. Since the data used in this analysis is reported on a calendar-year basis, incurred losses are recorded when they are filed with the insurer and not necessarily for the year that the claim occurred.

[37] Insurers included in this analysis had positive direct premium written during the year. Several insurers that no longer write direct medical liability insurance continue to provide loss data to the NAIC for several years after exiting the market.

Figure 2 – Countrywide Direct Losses Incurred

(In 2002 $USD)



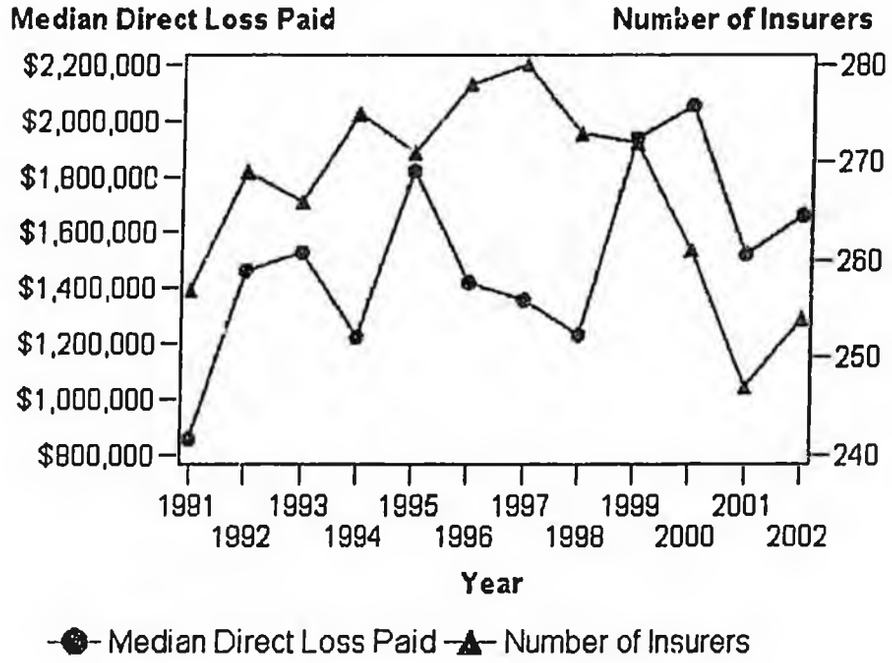
Source: National Association of Insurance Commissioners

Table 5 shows that inflation-adjusted median insurer direct losses incurred were $1,963,228 in 1991 and $3,250,035 in 2002. Median insurer incurred loss reached a low of $1,454,162 in 1994. The data shows a strong negative correlation (-0.7818) between the numbers of insurers reporting medical liability insurance premium and the median insurer incurred loss, indicating that insurers take on risk of other insurers when they enter the market.

Figure 3 shows the trend in median insurer direct losses paid for 1991 to 2002. Median insurer losses paid trended steadily upward, but with irregularity during the analysis period.

Figure 3 - Countrywide Direct Losses Paid

(In 2002 $USD)



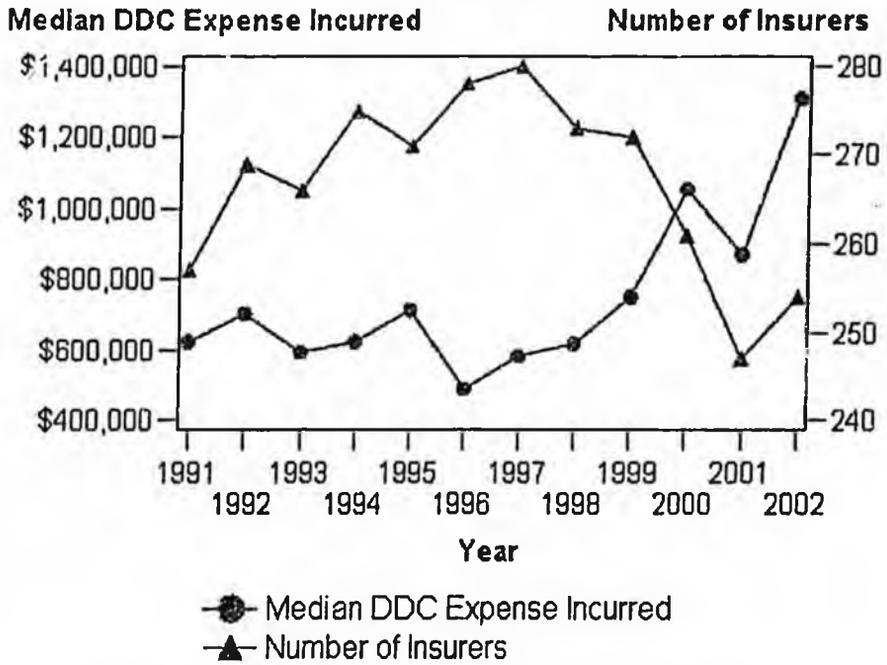
Source: National Association of Insurance Commissioners

Table 7 shows summary direct losses paid data countrywide. There is a weak negative correlation (-0.070) between the number of insurers and median insurer direct losses paid, indicating that something other than competitive forces determine whether or when an insurer pays a loss. **Table 8** shows direct losses paid by state in 2002. Most striking from this data is that in most states a majority of insurers reported little or no direct losses paid during the year. This result may be attributed to insurers that have recently left the market or possibly recent new entries. However, the data does not allow for the identification of these entities. These are probably insurers that have left the market or, less likely, recent new entries.

Loss and Other Expenses

Insurers incur other costs in addition to claims payments. One of the largest costs to medical liability insurers is defense cost and containment expense (DDE), also known as loss adjustment expense (LAE). These are expenses the insurer incurs as a result of adjusting a claim, researching the validity of a claim, or its costs for defending a claim in the event of litigation. **Figure 4** shows the trend in DDC expenses and number of insurers from 1991 to 2002. Median insurer DDC expenses incurred increased 167.3% between 1996 and 2002.

Figure 4 - Countrywide Defense and Cost Containment Expenses Incurred (In 2002 $USD)



Source: National Association of Insurance Commissioners

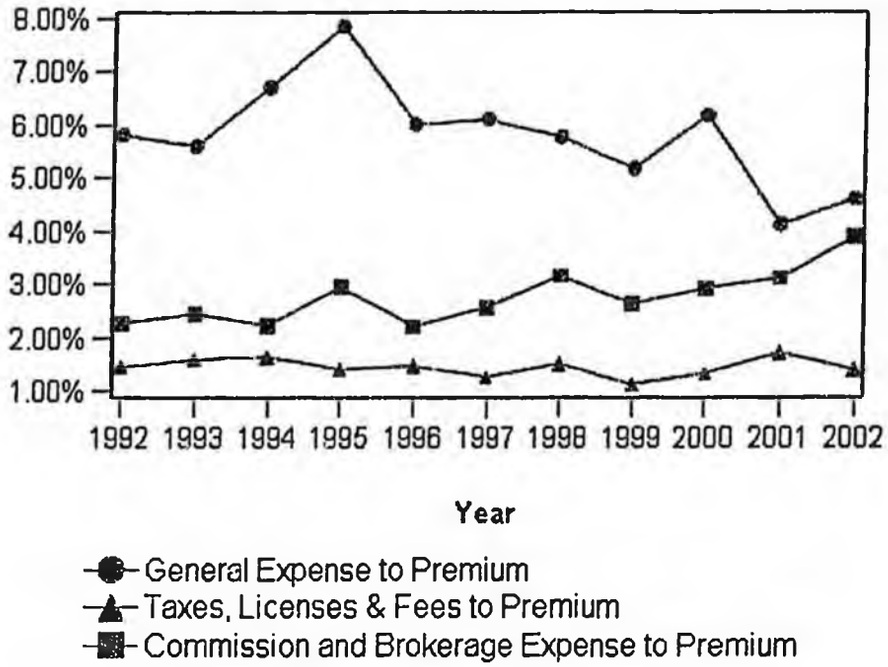
Table 9 shows that the inflation-adjusted median insurer DDC expenses were $857,547 and $1,660,748 in 1991 and 2002 respectively. The large standard deviations relative to

the mean and the disparity between the mean and median insurer DDC expenses indicate that there are a relatively few insurers with a large portion of DDC expenses. **Table 10** shows DDC expenses by state for 2002. California had the highest median insurer DDC expenses incurred with $312,897 and South Dakota with the lowest with $364. Evidence of large standard deviations relative to the mean and the difference between mean and median indicates that, in most states, a few large insurers incur most of the DDC expenses. The data shows a negative correlation (-0.6601) between the median insurer DDE expense incurred and the number of insurers reporting medical liability insurance. This may occur because as the number of insurers in the market decrease, the remaining insurers will assume a larger portion of the DDC expenses. An alternate explanation is that coverage for physicians, hospitals, and other high-risk exposures is concentrated in a few carriers per state.

Insurers also incur other expenses related to medical liability insurance. **Figure 5** shows inflation-adjusted trends in other expenses from 1992 to 2002 as a percent of earned premium. Median insurer general expenses to premium trended downward throughout this period, while median insurer commission and brokerage expenses to premium increased slightly. Median insurer taxes, licenses and fees have been relatively stable. The decreasing general expenses could be credited to cost-cutting efforts of insurers. **Table 11** shows the median insurer expenses in dollar terms as well as a percent of premium. Both taxes, licenses and fees expense (-0.7728) and commission and brokerage expense (-0.7703) show strong negative correlation to the number of insurers with written

premium. Median insurer general expenses show no significant correlation (0.1304) to the number of insurers reporting medical liability insurance.

Figure 5 - Countrywide Medical Malpractice Expenses to Premium



Source: National Association of Insurance Commissioners

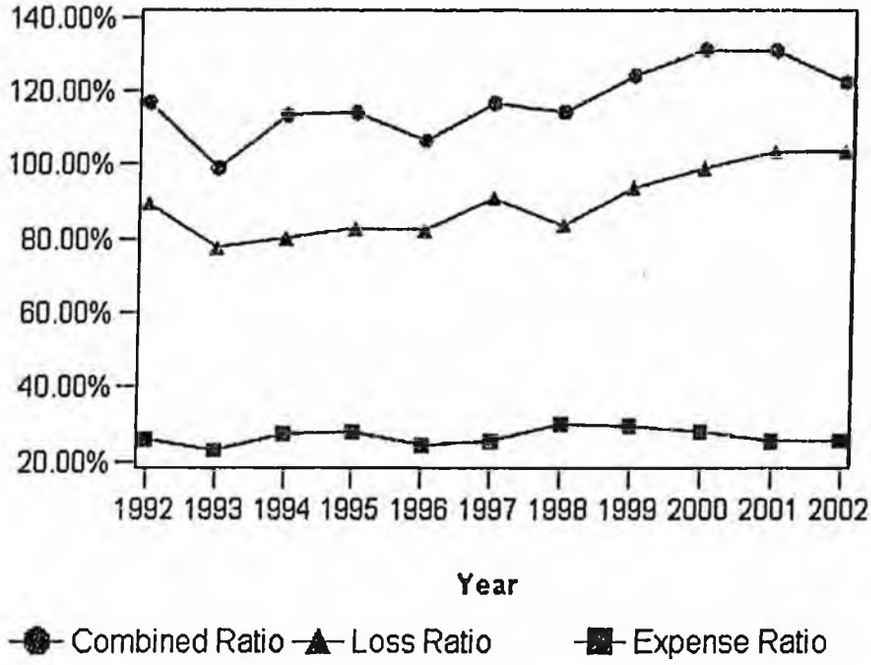
Profitability

Increased insurance prices can be caused by a number of things including higher loss and expense costs, lower interest rates, reserve adjustments, decreased competition and regulation. An important question is whether premiums have been sufficient to cover insurers' costs, including their cost of capital. Unfortunately, it is not easy to measure insurers' profitability for any specific line of insurance. Multi-line insurers do not confine their operations to one type of insurance, so it is necessary to allocate expenses and investment income from insurers' total operations to estimate profits for a specific line of

insurance. An additional complication is the fact that insurers' surplus by insurance line must be allocated in order to estimate total profits and a rate of return on net worth. Further, insurers report financial data primarily on a calendar-year basis, but calendar-year profits can be an imperfect measure of insurers' performance, as premiums are collected over the term of the policy, but claims payments associated with that policy term can stretch out over years.

Since insurer profitability is measured after considering reinsurance, the following analyses will look at factors on a net-of-reinsurance basis. **Figure 6** shows median insurer combined, loss and expense ratios from 1992 to 2001 on net insurance. Both the median insurer combined and loss ratios have steadily trended upwards since 1993. Median insurer expense ratios remained steady during the analysis period.

Figure 6 - Countrywide Medical Malpractice Combined, Loss and Expense Ratios



Source: National Association of Insurance Commissioners

Table 12 shows the median industry profitability results for medical liability from 1991 to 2001. The industry has experienced median insurer underwriting losses and median insurer pretax losses in each year of the analysis period. It has also experienced median insurer total losses in 2001 and 2002. Over the course of the analysis period the data shows that countrywide, medical liability insurance has not been consistently profitable for many insurers and that the market has become less profitable. The data covers all forms of medical liability, including some lines remaining profitable. This may obscure losses sustained by the many insurers specializing in physicians, hospitals, and nursing homes for 1997 through 2000.

Table 13 shows profitability results by state for 2002. Maximum and minimum earned premium were $888,290,000 and $6,891,000 respectively with a mean earned premium of $137,629,630 and a median insurer earned premium of $63,526,000. Maximum and minimum ratios of loss incurred to earned premium were 215.6% and 31.6% respectively with a mean ratio of 98.95% and a median ratio of 95.20%. Maximum and minimum ratios of loss adjustment expenses to earned premium were 96.4% and 18.8% respectively with a mean ratio of 36.3% and a median ratio of 34.0%. Maximum and minimum ratios of underwriting profits to earned premium were 12.7% to --214.9% respectively with a mean ratio of 57.87% and a median ratio of –53.1. The range of investment gains to earned premiums was 43.5% to 12.2% with mean and median ratios of 22.1% and 20.8% respectively. Return on net worth as a percent of earned premium

ranged from 16.6% to –44.6% with mean and median ratios of –6.41% and –5.5% respectively.

Understanding the limitations of measuring profitability directly, one can use several different tools to identify profitability. The traditional measure is the combined ratio, which is equal to the ratio of losses and loss adjustment expenses incurred to net premiums earned plus the ratio of general expenses and dividends to policyholders to net premium written. A combined ratio that exceeds 100 percent implies negative underwriting profits, i.e. premiums are less than loss costs and expenses.

Table 14 presents the combined ratio by state for 2002. The combined ratio ranges from 54.02% to 184.80% with a mean and median of 105.54% and 104.44% respectively. Loss adjustment expense - expenses incurred by an insurer to research, litigate and settle medical liability claims - is a significant expense to medical liability insurers. A comparison of loss adjustment expenses to premiums ranges from 6.32% to 47.62% with mean and median ratios of 24.97% and 24.90%. This means nearly one-fourth of the medical liability premium paid in 2002 was directed to LAE expenses.

The combined ratios do not reflect the investment income insurers earn on policyholders' funds held until claims are paid, nor the effect of federal taxes. The operating ratio partially adjusts for this to the degree that it reflects investment income attributable to insurance transactions, i.e. loss reserves, loss adjustment expense reserves and unearned premium reserves, albeit measured on a calendar-year basis. The operating ratio is equal

to the combined ratio minus the ratio of investment income attributable to insurance transactions to net earned premiums. A ratio in excess of 100 percent implies negative operating profits, i.e. premiums and investment income attributable to insurance transactions are insufficient to cover loss costs and expenses. Although the operating ratio provides more information than the combined ratio, it does not reflect federal income taxes or insurers' total return, which also includes investment income attributable to surplus. While an operating ratio in excess of 100 percent implies that insurers are not earning a return sufficient to cover their cost of capital, it is difficult to assess the extent of the deficiency without looking at total rate of return on net worth.

Table 15 shows the combined ratio, operating ratio and return on net worth data from the NAIC Profitability Report for 2002.[38] The investment gain as a percentage of earned premiums ranged from 6.78% to 33.66%, with a mean of 15.72% and a median of 15.08%. The operating ratio ranged from a low of 36.66% to a high of 168.49% with a mean and median of 89.82% and 90.00% respectively. Return on net worth in 2002 ranged from –6.80% to 4.85% with a mean of –0.74% and a median of –1.15%.

Industry Investments

Assets

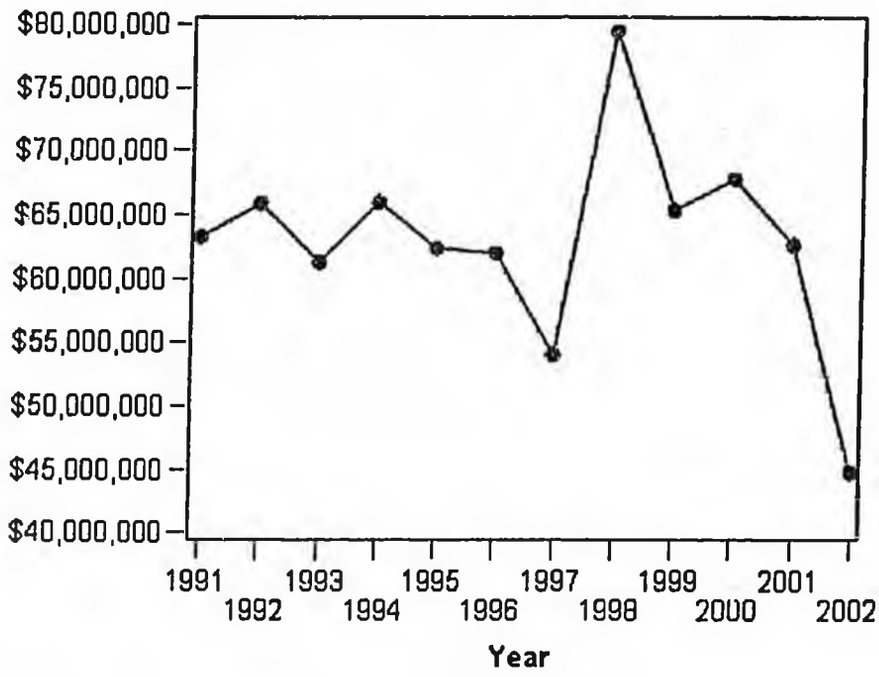
The values of assets an insurer reports are an important part of its market capacity. Capacity, or the ability to insure risk, is determined by the amount of insurer surplus, which is the difference between its assets and liabilities. Capacity defines whether an

[38] As of the draft of this report, the data from the NAIC Profitability Report is preliminary

insurer is able to continue writing its current business as well as add new risks to its portfolio. If assets are paid out in claims or their value declines, surplus also will decline proportionately, assuming liabilities have not changed. In the case of medical liability insurance in the past several years, the industry witnessed a period of declining increased claim payments, investment asset values, and increasing liabilities.

Figure 7 shows the trend in median insurer total invested asset values from 1991 to 2002, adjusted for inflation. The median insurer was relatively stable from 1991 to 1996. Since 1997, the median insurer has fluctuated greatly annually, reaching a high of $80 million in 1998 and then dropping to $45 million in 2002. Most leading indicators of stock and security value did not decline until 2001. Most leading indicators of stock and security value did not decline until 2001.

Figure 7 - Countrywide Median Insurer Invested Asset Values
Insurers with >50% of Business in Medical Liability Insurance
CPI_U Adjusted



Source: National Association of Insurance Commissioners.

Table 16 and show analysis of asset values for medical liability insurers from the 1991 to 2002 NAIC annual statements for insurers with at least 50% of their business written in medical liability. The large difference between the mean and median insurer values indicates that insurers with large assets earn a proportionately large share of the total investment income.

Table 17 and **Table 18** show the median insurer value of total assets held by these insurers increased throughout much of the 1990s, but has declined significantly since 2000. The percent of assets held in bonds remained steady throughout much of this period, only to decrease in 2002. While the median insurer value of bonds has decreased, the median insurer value of the cash and short-term investments has increased. This change is likely due to claims payments, insurers moving assets to shorter-term

investments, or both. The median insurer value of stocks increased during the late-1990s and then decreased in 2000. In 2002, the median insurer value of the common stock holdings was back to 1996 levels. However, from 1991 to 2002, the median insurer value of common stock never climbed above 5% of total invested assets. Cash and short-term investments decreased throughout the 1990s before starting to increase in 2001.

The proportion of assets invested by medical malpractice insurers in stocks is small. This means changes in surplus due to stock market losses are small compared to changes in the surplus due to reserve changes (e.g., if these companies suffered a 50 percent drop in the value of their stock portfolio, this would be equivalent to a 10 percent reserve deficiency). A 10 percent reserve deficiency is not an extraordinary event. However, a sudden 50% increase in reserves due to increased claims would be much more serious.

Capital Gains (Losses)

[TO BE ADDED.]

Investment Income

Future investment income is included in insurer premium rate calculations, which in effect subsidizes the losses an insurer expects. If the insurer miscalculates its expected income while its losses increase, it can increase its loss ratio, significantly in some cases.

Table 20 shows the summary information total investment income. The median insurer investment income has stayed relatively stable throughout the analysis period, but did

show a 52.7% decrease from 2000 to 2002. Again, the large difference between the mean and median values indicates there are a few insurers, likely large insurers by premium volume, which earn a large share of the aggregate investment income. **Table 21** shows trends in median insurer investment income by type of investment from 1991 to 2002. Most insurers in the medical liability market earn investment income from bonds and cash and short-term investments. Median insurer investment income from bonds grew through much of the 1990s before declining by 89.0% from 2000 to 2002. Median insurer investment income in cash and short-term bonds has risen 96.3% from 1997 to 2002. **Table 22** and **Table 23** show the total and median insurer investment income by type of asset, respectively, for the same period. Median insurer total investment income ranged between 8.47% and 10.81% from 1991 and 1997, but saw a significant decline beginning in 1998 through 2002. Again, investment income from bonds makes up a significant portion of this ratio. While investment income is included in the rate making process, significant changes in investment income have an overall small impact on total insurer income. For example, suppose that an insurer expects that for every $1.00 of premium it will earn an investment income of $0.08, such that:

Total Income = $1.00 + $.08

Suppose that investment income an insurer earned is 50% less than anticipated. The impact on its income is then:

Impact = -.04 / (1.00 + .08),

Impact = -.04 / 1.08 = -3.70%

Thus, a 50% decrease in investment income will decrease the insurer's income by 3.70%.

Given the relatively small impact of investment income on the overall income of insurers, this study concludes that underwriting losses, not a declining stock market, were the major factor influencing the rate increases experienced by physicians and health care providers. The U. S. General Accounting Office reached a similar conclusion in a report published in June 2003.[39]

Surplus Analysis

Insurer surplus analysis can provide information about two important aspects of an insurance market. First, the capacity of an insurer to provide insurance is reflected in its policyholder surplus. If surplus increases over time, this may indicate that insurers are more able to take on additional risks in the market. Conversely, if surplus decreases, it may indicate that insurers are unable to not only write new business, but may have problems renewing its existing business. Secondly, a company's surplus ratio – the ratio of policyholder surplus to total assets – gives an indication as to whether an insurer has adequate reserves for unexpected losses.

Figure 8 shows the trend in median insurer policyholder surplus from 1991 to 2002 for insurers reporting medical liability insurance premium adjusted for general inflation. The median insurer value increased 100% from 1991 to 2002, but decreased 17.73% between 1999 and 2002. The graph suggests that insurers were able to expand capacity throughout much of the 1990s, but then capacity declined after 1999.

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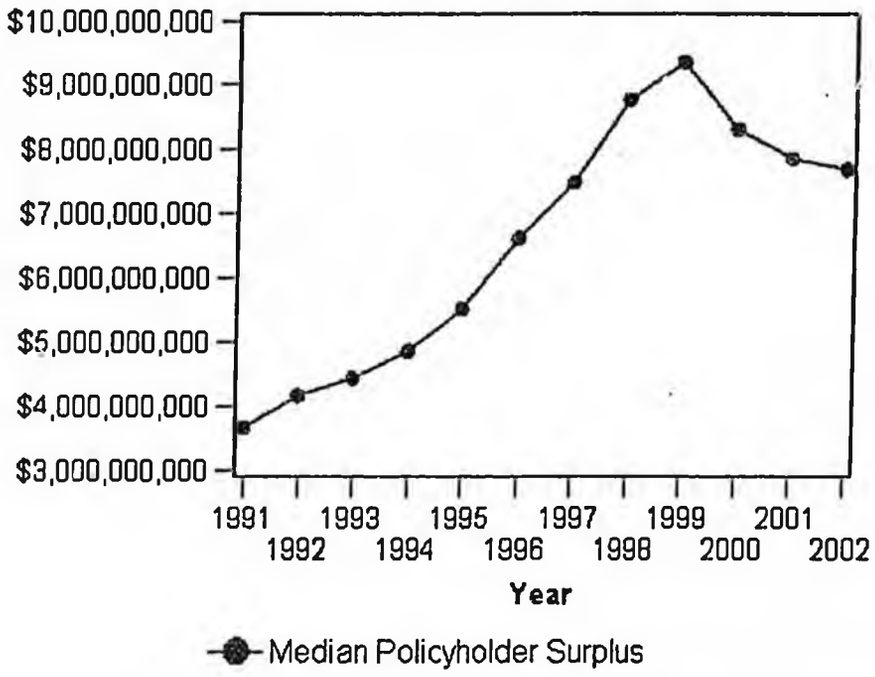
[39] United States. General Accounting Office. Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. Washington, DC: GPO, 2002

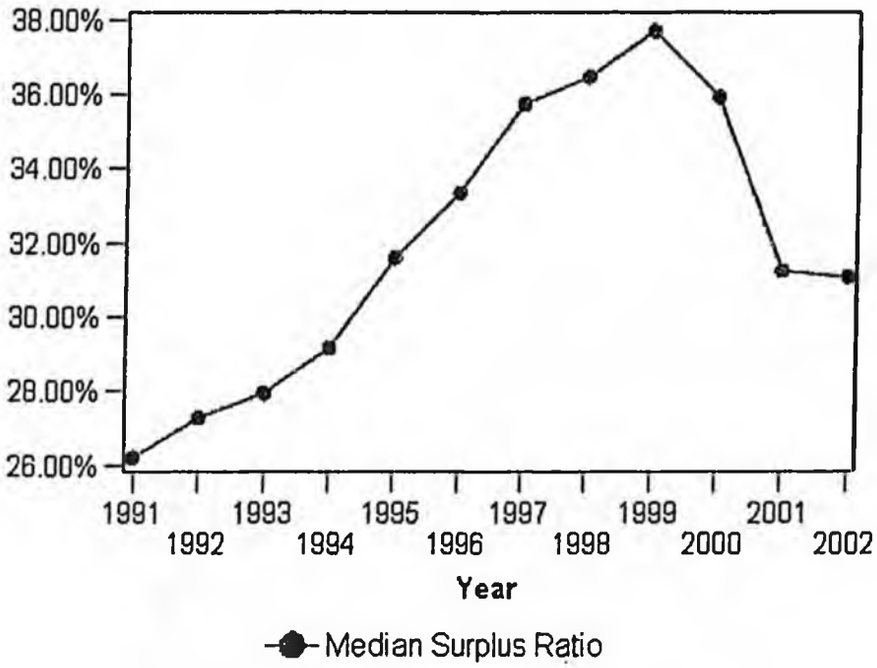
Figure 8 – Countrywide Median Insurer Policyholder Surplus



Source: National Association of Insurance Commissioners.

Table 24 shows additional detailed statistics on insurer surplus. The difference between the mean and median again suggest there are a few insurers in the market with large surplus and several with smaller amounts. Curiously, the number of insurers reporting medical liability is only slightly correlated with total surplus (0.1743) while there was a weak *negative* correlation with median insurer surplus (-0.0132). This seems counterintuitive since the first correlation indicates adding insurers in the market does not increase the capacity of the market. One possible explanation for these results would be that several large multi-line insurers with large surpluses have left the market while smaller single-line writers with smaller surpluses have entered the market to replace the larger insurers.

Figure 9 - Policyholder Surplus to Total Assets, Countrywide



Source: National Association of Insurance Commissioners.

Figure 9 shows the trend in the surplus ratio for 1991 to 2002 for medical liability insurers. Overall, the surplus ratio increased by only 18.58% from 1991 to 2002. However, the ratio increased 43.80% from 1991-1999 and declined 17.11% from 1999 to 2001. The surplus ratio suggests that insurers were able to prepare themselves relatively well for unexpected losses during much of the 1990s, but that ability decreased sharply beginning in 2002. **Table 25** shows detailed surplus ratio statistics. The data shows only weak correlations between the numbers of insurers reporting medical liability insurance premium with the mean surplus ratio (0.1168) and median surplus ratio (0.3467).

Reserve Analysis

[TO BE ADDED]

Reinsurance Analysis

Insurers enter into reinsurance contracts with other insurers to limit their exposure to potential losses. Generally, insurers entering into reinsurance treaties will share a proportionate amount of premium and potential losses with a reinsurer. Limiting exposure allows insurer with small market capitalization the opportunity to write business they would not be able to write themselves because of insufficient surplus. Capacity to write business can decline when primary insurers are no longer able to obtain reinsurance in the market. This usually occurs when reinsurers no longer have capacity themselves to expand their business or when they perceive a particular line of insurance as too risky to provide coverage at the contract price the primary insurer is offering.

[ANALYSIS TO BE ADDED]

Competition

Medical liability markets, however, tend to be more geographically restricted than most other insurance markets, which means insurers tend to write business within a particular region or state. According to the U. S. General Accounting Office, "physician-owned and/or operated insurers now cover 60 percent of the market."[40] There are now very few truly national medical malpractice carriers. **Table 27** shows the number of insurers reporting direct written premium and premium data by state for 2002. Examining the

[40] United States. General Accounting Office. Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. Washington, DC: GPO, 2002. p. 6.

number of companies reporting direct written premium to the NAIC, Illinois had the most with 102 insurers. Texas and Pennsylvania had the next largest number of insurers reporting direct premium with 99 and 95 respectively. New York had the most direct premium written with $1.08 billion. Florida and California were next with $825 million and $798 million of written premium respectively. These same three states also had the largest mean written premium per insurer with $14.8 million, $9.27 million and $9.06 million per insurer, respectively. When looking at the median value, California had the largest with half of its insurers reporting at least $1.27 million. Florida and New York were next with median premium of $940 thousand and $912 thousand respectively. These numbers do include some medical liability insurers known to have left the market.

Market concentration is measured typically in terms of 'concentration ratios', which represent the combined market share of some given number of the largest sellers, or in terms of the Herfindahl- Hirschman Index (HHI), the sum of the squares of the percentage market share of each firm. The HHI reflects both the distribution of the leading firms' market shares as well as the composition of the rest of the market. The HHI also weights the market shares of the larger firms more heavily, which better reflects their relative market power.

While neither economic theory nor experience establishes a critical level of concentration for the existence of oligopoly in a particular industry, the U.S. Justice Department has established merger guidelines for certain industries using the HHI (DOJ, 1984). Under these guidelines, a post-merger market with an HHI in excess of 1,800 is considered

highly concentrated. A proposed horizontal merger between two firms that would result in such a market is likely to provoke a challenge from the Justice Department, depending on other circumstances. A post-merger market with an HHI between 1,000 and 1,800 is considered moderately concentrated. A post-merger market with an HHI of less than 1,000 is not considered concentrated. A horizontal merger resulting in such a market is unlikely to encounter opposition.

The Justice Department looks at a number of additional factors in determining its position on a particular merger. It also should be pointed out that these criteria have been developed to evaluate mergers in national industries, broadly defined. The purpose here is to evaluate the structural competitiveness of medical liability insurance by state, which is more narrowly defined. There are a number of industries with HHI values in excess of 2,000 at the national level that are considered competitive. While Justice Department guidelines provide some perspective, they should not be used as absolute standards to determine the competitiveness of a market or to determine whether additional market regulation is warranted.

Table 27 shows concentration ratios and HHI values for the medical liability market countrywide for 1991-2002. Market concentration in the medical liability market increased slightly countrywide in the mid-1990s and began decreasing by the late-1990s, continuing through 2002. The number of insurers peaked in 1997 and then declined 10.6% between 1997 and 2001 and recovered slightly in 2002. While the number of insurers declined, it appears the largest insurers gained some market share during this

time.

While examining countrywide data over a period of years gives a general idea of how the competitive nature of the medical liability market has changed, examining statewide data tells more about whether a particular market may lack competition. This is particularly true in medical liability since companies tend to be geographical in nature. However, a word of caution is necessary when looking at statewide data insurers provide to the NAIC. The data contains many insurers, often captive insurers that do not actively write insurance in the market. Captive insurers may write insurance for a specific group of hospitals, nursing homes or medical specialties and hence do not directly compete for market share.[41] The data also includes insurers that may write insurance exclusively in certain markets, such as hospitals or certain medical specialties. Theoretically, a state may have many insurers indicating strong competition, but each insurer could have a monopoly in its niche market, thereby creating the appearance of competition. Additionally, some insurers may not write new business, for a variety of reasons, including surplus limitations that prevent them from market activity. These aspects should be taken into consideration when assessing the competitive nature of a market.

Table 28 compares market share for three different ranges and the HHI by state. The mean and median number of insurers reporting medical liability insurance premium was 65 and 61 respectively. Illinois had the most insurers with 102 and Alaska the fewest with 39. The mean and median market concentration of the four largest insurers was 65.9%

[41] Such insures may be indirectly competitive in some markets. For example, physicians may choose to leave a private practice for a facility that provides coverage through a captive or group policy because the physician feels coverage in the private practice has become prohibitively expensive.

and 67.1% respectively.[42] The range of market concentration ratios for the four largest insurers was 30.8% to 86.4%. The mean and median market concentration of the eight largest insurers was 80.4% and 81.0% respectively with a range of 55.1% to 93.6%. The mean and median market concentration of the 20 largest insurers was 94.4% and 95.3% respectively ranging between 85.0% and 99.2%. As would be expected from economic theory, there is an approximately inverse correlation between the numbers of insurers writing premium in a market with the concentration of business they write. In other words, states with a larger number of insurers writing business appear to have less market concentration among the largest insurers. It also appears that, from the data, states with smaller populations have more concentrated markets than states with larger populations.

The mean and median HHI was 1,877.61 and 1,617.38 respectively, ranging from 498.91 to 4338.19. Twenty-one states had a HHI greater than 1,800, which would be considered highly concentrated by the DOJ's guidelines for review of merging markets. Twenty-one states have a HHI between 1,000 and 1,800, which are considered moderately concentrated by the DOJ's guidelines. As discussed above, these numbers may be misleading because many of the insurers included in the HHI may not be writing new business, or are not directly competitive. If these insurers could be identified and removed from the HHI calculations, the indices would likely increase significantly. However, since captive insurers may indirectly compete in the market, it is reasonable to assume that the DOJ's guidelines for competitive markets would be at least indicative of the competitiveness of a particular market.

[42] Market concentration is calculated as the percent of market share of the four largest insurers to the rest of the market in terms of direct written premium.

Entries and Exits

The initial investment in physical facilities needed to start an insurance company is relatively small compared to more capital-intensive industries such as manufacturing. The minimum capital and surplus requirement to become licensed to write medical malpractice insurance in most states is $2 million or less, which is not a significant sum by itself in relation to most insurers' premium volume. However, there must be at least a dollar of surplus for every dollar of premium volume a new insurer intends to write. This raises the financial requirement considerably for a new insurer intending to acquire a significant market share in a large state. **Table 29** lists minimum capital and surplus requirements by state for medical liability insurers.

In addition, there are non-monetary barriers to entering the medical malpractice market. Some can be readily overcome, but others present more difficulty.

1. Regulatory constraint. A medical malpractice insurer may not sell across state lines without filing for license or eligibility. Rates and forms must be adjusted to local requirements.
2. Insured resistance. Insurers operating on a mutual or reciprocal exchange basis may face difficulty convincing member insureds to support moving to new markets, whether a new state or a different provider line. Insureds of provider-owned or operated insurers (60% of national medical malpractice market) may be averse to risking capital gathered over years in a home market.
3. Lack of specialty market experience. Underwriting, pricing, and defending claims

in a new market, whether new state or specialty, requires specialized and local knowledge.

4. Lack of locally knowledgeable staff. Staffing a start-up insurer or an expansion office means selecting from a small pool of experts. Employees skilled in the facets of operating a medical malpractice insurer are scarce on the national level and scarcer still in local markets.
5. Exit costs. The known cost of exiting a line of medical malpractice may be daunting to a start-up insurer or an existing insurer considering entry into a new market.
6. Pricing difficulty. Third party liability insurance is subject to socio-legal developments that can rapidly render assumptions on future losses obsolete. Medical malpractice is very volatile.
7. Adverse financial history. There have been three major medical malpractice crises since 1975, each with adverse financial effects on insurers of the time. The provider-owned or operated insurers mentioned above came into existence beginning with the 1975 crisis when traditional stock commercial insurers did not return in number to the medical malpractice market place.

There are other costs involved with exit. Unique to medical malpractice markets is the long tail associated with malpractice claims. It can take up to twenty years to run off all claims incurred during active participation in a medical malpractice market. This keeps insurers committed to claims expenditure long after premium income has ceased. Regulators further require that withdrawing insurers offer coverage for this run off to

non-renewed claims-made insureds, now a majority of medical malpractice policyholders. Insurers will also lose the value of any sunk investments they have made in establishing operations in the market from which they are withdrawing.

The prospect of such costs can sometimes serve as a deterrent to entry altogether. They also may induce insurers to sustain inadequate profits for a period while assessing the need to withdraw. **Table 30** and **Table 31** show the number of insurers entering and exiting the medical liability line countrywide and median by state, respectively, for 1992-2002.

Regulatory exit restrictions pose a different issue. A number of states impose some limitations on insurers' ability to withdraw from the market for liability lines. These restrictions take various forms including requirements to give policyholders advance notice, delayed withdrawal requirements, residual market assessment obligations and 'lock-in' provisions, i.e., prohibitions against selectively withdrawing from some lines of business while continuing to write others.

Standard vs. Non-standard Markets

Table 32 and **Table 33** provides 2002 medical liability direct premium written by state by type of company. Countrywide, stock insurers wrote 35.05 percent of all direct medical liability premiums. Mutual insurers and reciprocals wrote 19.28% and 14.81% respectively of the countrywide direct premium. Non-standard markets made up 30.45% of the direct premium written in 2002, with surplus lines insurers writing 24.60% of all

premiums countrywide. It should be noted that states do not require all insurers to report data to the NAIC. This is particularly true for medical professional liability.

Caution should also be taken when looking at data for risk retention groups. The NAIC does receive filings for such entities, but it is not known how many of these groups file annual statement data. This is likely a particular problem when analyzing state markets as opposed to countrywide analyses. Bear in mind also that surplus and excess lines insurers typically price products significantly higher than standard markets, so their relative premium volume likely does not equate to their percentage of exposures in the marketplace. The NAIC currently does not have data to examine this facet of the market, so such a statement remains hypothetical.

Availability

Availability is a very important aspect of insurance market performance. It is a general term that can be interpreted in various ways. In crisis periods, medical liability insurance coverage is often available through non-standard market mechanisms. However, this market presents a number of disadvantages and is generally not a desirable source of coverage. Availability in non-standard markets is not an indicator of medical malpractice market health.

A more meaningful indicator is the availability of medical liability coverage in the admitted market. Yet, even this variable is not easily quantifiable from readily available data. The number of insurance carriers willing to offer coverage and the terms they would

offer can vary dramatically among different medical specialties and states. A commonly used proxy for availability is the proportion of total premiums written through the residual market, which are shown in **Table 32** and **Table 33**. This is a less than perfect proxy for availability. Some risks may actually choose to obtain coverage through the residual markets when they could purchase coverage in the voluntary market.

Insurers contend that residual market growth and operating losses can be caused by inadequate voluntary market rates. If these insurers are unable to charge a premium to an insured sufficient to provide a fair return on investment, they may be disinclined to offer coverage. The greater the degree of rate inadequacy, in this view, the greater the number of insureds thrust into the residual market.

If premiums in the residual market are insufficient to cover losses and servicing carrier fees, then an operating deficit results. This deficit, in turn, may in some states be recovered through assessments on voluntary market insurers. To the extent that insurers are able to recover the assessments through higher voluntary market rates, the burden of the residual market is borne by purchasers of medical liability insurance from voluntary market insurers. This may increase purchaser incentives to self-insure, if that is a viable option. Alternatively, to the degree that insurers are not allowed to recover assessments through higher rates, insurers may be influenced to decrease their voluntary market business. This can lead to a situation in which growing residual market losses cause further shrinkage of the voluntary market, which in turn increases residual market losses. Regulators do not deny the potential for this cycle, but they also raise other issues about

performance of the residual market. There are concerns about the quality of service that residual market risks receive and the incentives servicing carriers have to properly administer policies and control costs.

Solvency

Solvency is critical to the integrity of the insurance contract. State insurance regulators' primary responsibility is to protect policyholders and claimants against insurer insolvencies. This responsibility is met through financial regulation and state guaranty funds.

State regulators seek to reduce, but not necessarily eliminate the incidence and cost of insolvencies. There is a presumed need to balance insolvency risk with the cost and availability of insurance. Some possibility of failure is inherent in a competitive market. State guaranty funds ensure that insurance claims are paid according to statutory benefit provisions. These insolvency costs are passed back to solvent insurers through assessments on premiums. Some states allow insurers to recoup guaranty fund assessments through higher rates while others allow premium tax offsets. Claimants may suffer inconvenience if forced to recover through a state guaranty fund, but insureds are insulated from most adverse effects unless a catastrophic claim has occurred. For former claims-made insureds, including retired providers, the risk is that they may lose run-off coverage and become exposed to uncovered suits.

Beginning in 1994, property and casualty insurers began submitting risk-based capital

filings annually to the NAIC. The risk-based capital system, established under the Risk-Based Capital for Insurers Model Act, uses a formula establishing a minimum capital (RBC) requirement for insurers based on the insurer's size and risk. Comparing the insurer's RBC requirement to its own statutory capital indicates whether an insurer is at risk of becoming insolvent. The model law allows regulators to intervene when capital requirements are not met.

Under the model act, the first level of regulatory intervention is the Company Action Level triggered when the total adjusted capital (TAC) to authorized control level (ACL) RBC falls below 200 percent. At this action level, insurers are required to submit an RBC Plan to the domiciliary regulator identifying both problems and corrective actions the insurer intends to take to bring its RBC level above 200 percent. The second level of regulatory intervention is the Regulatory Action Level triggered by a TAC to ACL RBC fall below 150 percent. The insurer is required to revise its RBC Plan and submit to the domiciliary regulator's request to perform examinations or analyses of its assets, liabilities and operations. The third action level, the Authorized Control Level, is triggered when the TAC to ACL RBC falls below 100 percent. At this level, the insurer must comply with the requirements of the first two levels. It also gives the domiciliary (home state) regulator the discretionary authority to place the insurer under regulatory control through its rehabilitation or liquidation act. The fourth and most severe level, Mandatory Control Level, is triggered when the TAC to ACL RBC falls below 70 percent. At this level, the company is placed under the control of the domiciliary regulator in accordance with the state's rehabilitation and liquidation act.

Table 34 shows the number of medical liability insurers that have reached RBC triggers since 1994, when the NAIC first began RBC filings. The number of insurers in each of the action levels remained consistent between 1994 and 2000. However, coinciding with the hardening insurance markets and recession in 2001, more insurers triggered the Mandatory Control Level than in past years. Surviving medical liability insurers may have been financially stronger during this period than in past crises. However, some hospitals report having to ease credentialing requirements as insurer rating services downgrade many insurers below A or excellent ratings.

Other Market Performance Dimensions

Prices, profit, availability and solvency are not the only dimensions of market performance that are of concern. Quality of service, efficiency and innovation are also important parameters in terms of how well markets are served. Unfortunately, it is difficult to obtain data or measure performance in these areas.

Quality of service encompasses a number of different variables including the accuracy/timeliness of policy issuance and rating adjustments, loss prevention and safety engineering and claims adjustment. In a competitive market, insurers should be spurred to provide the highest level of services commensurate with what insureds are willing to pay for these services. Insureds may differ in their demand or preference for different services. Consequently, insurers may differentiate themselves in terms of the level of service they provide based on insureds' preferences and adjust their rates accordingly.

Economists describe this type of market structure as monopolistic competition (Scherer, 1980, pp. 15-16).

Similarly, efficiency and innovation are important parameters, but are difficult to measure. Some analysts have used expense ratios (i.e. expenses divided by premiums) to measure efficiency, but expense ratios can be misleading for a number of reasons. Because statutory accounting requires insurers to book expenses when they are paid, as opposed to when related income is earned, expense ratios can be misleading when insurers are either growing or contracting. Lower expenses could also reflect diminished quality of service, rather than greater efficiency.

Innovation can be targeted at improving efficiency and lowering loss costs and expenses, developing new products and services or improving the insurers ability to more accurately manage estimates of future loss costs. Medical liability insurers face certain statutory and regulatory constraints in their ability to develop new products and services. Market pressures on prices may further induce some carriers to become more innovative.

SURVEY OF MARKET INTERVENTIONS

Tort Reform

Claims paid by medical liability insurers are based on the civil justice system of each state where they operate. Tort reform initiatives, particularly medical malpractice reform, generally refer to the variety of solutions states have introduced to change the legal environment for compensating claimants. The goal of these reforms is generally to limit

the frequency of lawsuits and/or the amount paid per claim. Reductions in these subsequently reduce costs to insurers, which in turn restrain premium increase over time.

In this section, we discuss several of the more common types of tort reform states have tried. It is also important to note that the U.S. Congress has considered legislation to enact specific tort reforms that would affect states in dramatically different ways. In fact, the House of Representatives passed the Help Efficient, Accessible Low-Cost, Timely Healthcare (HEALTH) Act of 2003. A similar bill was introduced in the Senate; however, no action has been taken on it. These bills contain damage limitations that would limit recovery of non-economic damages.

The US Department of Health and Human Services produced a report on the medical malpractice crisis in 2002.[43] The report argued that patient access to care and safety had been impacted by the most recent medical liability crisis.[44] The report also argued that health care costs had increased as a result of the crisis and the litigation system was responsible for the crisis.[45] The report also concluded that the crisis was less acute in states that had tort reforms in place.[46] The report recommends federal reforms that: improve the ability of patients to receive unlimited compensation for economic losses; cap recoveries for non-economic damages by a reasonable amount ($250,000); reserve punitive damages for cases that justify them; provide for payment of judgments over

[43] United States. Department of Health and Human Services. Confronting the New Health Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System. Washington, DC: GPO, 2002.
[44] Ibid. p. 2
[45] Ibid. p. 7
[46] Ibid. p. 14

time; provide that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury; inform the jury if a plaintiff has another source of payment for the injury, such as health insurance; and provides that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.[47]

There has been a significant amount of literature written on tort reform in general. The authors take very different approaches in their analysis. Much of the research focused on the impact of tort reform measures on claim costs to insurers and subsequently premium to consumers. Viscusi, et al (Journal of Risk and Uncertainty: 1993, p181-3) found that "tort reforms intended to constrain costs and enhance profitability did neither. Yet, these results suggest that premiums were dampened by the introduction of a reform measure." The authors offer two explanations for this observation. First, "if liability reforms stabilized insurance companies' expectations about the losses that would be experienced for policies currently being written, this could restrain premiums even though current losses are unaffected." Second, "the reform measures were correlated with states in crisis; there is the possibility that insurance was being rationed in those states." In contrast, Viscusi and Born (Journal of Legal Studies: 1995, p 496) found that "liability reforms increased insurer profitability (that is, decreased the loss ratios), where the main mechanism of influence was through decreasing losses. The quantile regression estimates imply that the greatest effects of liability reform are on the most unprofitable firms and that the effect is not uniform across the entire market." The authors also find that "the

[47] Ibid. p. 19

influence of the liability reform variables on loss ratio is accompanied by a comparable pattern of influence on loss levels. In contrast, premiums seem only modestly affected by the liability reform measures, so that the main mechanism has been to reduce the losses associated with policies as opposed to raising the price that can be charged." Viscusi and Born (Journal of Legal Studies: 1995, p 496) also state that "liability reform not only enhances profitability but also diminishes uncertainty by having its greatest effect" on the must unprofitable insurers. The AMA also found that professional liability insurance (PLI) premium increases are driven in large part by verdict awards and settlement costs and that the relative frequency of very large awards is increasing.[48] The report found that manual PLI rates for California, which caps damages, are less than half those in the largest states that do not have effect tort reform. The AMA offers three policy options: the most promising tort reform proposals may be those that focus on elements such as award caps; policy initiatives to stabilize supply, finances and operations of carriers may offer a more productive approach to mitigating PLI crises; and that local initiatives must take into account the local drivers of premium increases that predominate within individual jurisdictions.[49]

Hunter and Doroshow, in discussing the impact of tort reforms on medical malpractice insurance rates from 1985-1998, argue that tort law limits enacted since the liability insurance crisis of the mid-1980s have not lowered insurance rates in the ensuing years.[50] The authors also argue that states with little or no tort law restrictions have experienced

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[48] Ibid, p.7
[49] American Medical Association. "Medical Professional Liability Insurance." Health Care Financial Trends Report. Chicago: American Medical Association, April 2002.
[50] Hunter, J. Robert, and Joanne Doroshow. Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Prices. New York: Center for Justice and Democracy, 2002.

the same level of insurance rates as those states that enacted severe restrictions on victims' rights.[51] In their analysis of tort reform impacts on medical malpractice rates, Hunter and Doroshow argue the existence of an "apparent difference between levels of tort law change and overall rate/loss cost impact."[52] Hunter and Doroshow (2002, p. 16) state "the underlying costs, which ultimately drive insurance prices, are impacted upwardly by mid-range medical malpractice tort law changes..." Hunter and Doroshow argue that "one reasonable conclusion is that no clear evidence of tort law change impacting insurance prices is determinable" from the data that was analyzed.[53] Zuckerman, Bovbjerg and Sloan found that "other than imposing caps or reducing the time available to initiate claims, tort reforms are not observed individually to lower premium."[54]

Another goal of tort reform measures are to reduce budgetary costs to health care providers. Danzon (Handbook of Health Economics, Volume 1: 2000, p 1371) argues that the outcome such reforms "is likely to result, at best, in simply shifting costs from medical providers to patients and taxpayers; at worst, total social costs may actually increase if, for example, deterrence incentives are weakened." Thorton (Applied Economics, 1999, pg 215) found that "tort signal effects appear to prompt primary care physicians to work longer hours in an effort to devote more time and attention to patients..." which "...may well reduce the incidence of negligence and increase the quality of care. Evidence from simulations also suggests that the impact of these

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[51] Ibid. p. 2
[52] Ibid. p. 16
[53] Ibid. p. 17
[54] Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums." Inquiry 27 (Summer 1990): p. 180.

defensive actions on utilization and fee, at the margin, may be relatively minor." Kessler and McClellan (NBER Working Paper No. 6346: 1998) found that their analysis results "suggest that reforms in law affect physicians' attitudes, both by reducing the probability of an encounter with the liability system and by changing the nature of the experience of being sued, for those physicians who defend against malpractice claims."

States have tried a variety of legislative changes to control medical malpractice insurance costs. Several of these are identified and discussed in the following subsections.

Several researchers have studied the impact of tort reforms enacted following prior medical liability crises. In 1986, the GAO performed a case study of six states (Arkansas, California, Florida, Indiana, New York and North Carolina) that had enacted tort reform measures following the crisis in the 1970s.[55] The study involved surveys of organizations representing physicians, hospitals, insurers and lawyers.[56] The study found that in two states, those groups surveyed believed that tort reforms had helped to moderate upward trends in the cost of insurance as well as the average amount paid per claim.[57] Those surveyed in the other four states felt that tort reforms had little effect in their states.

In a report to the Senate on the impact of tort reforms on medical malpractice frequency and severity following the medical malpractice crisis of the 1970s, Danzon reported that three studied reviewed suggest that caps on awards and collateral source offset had significantly reduced claims severity and that collateral source offset and shorter statute

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[55] United States. General Accounting Office. Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms. Washington, DC: GPO, 1986.
[56] Ibid. p. 2
[57] Ibid. p. 2

of repose have significantly reduced claim frequency.[58] Danzon also reported that arbitration statutes appeared to increase claims frequency and reduce average severity, while reforms including screening panels and limits on contingency fees appeared to have no systemic impact on claims frequency and severity.[59]

Viscusi et al. researched the impact of tort reforms following the 1980s medical liability crisis and found that insurance regulation variables had little apparent effect on medical liability insurance prices (Journal of Risk and Uncertainty 180). The study also found that while reforms modifying joint and several liability, limits on liability, limits on non-economic damages and limits on punitive damages did not constrain costs or enhance profitability, the reforms appeared to dampen changes in premium.

Viscusi and Born found that liability reforms on average, and in particular the damage cap provisions, contributed to a downward shift in the loss ratios, which implies a rise in the profitability of insurers.[60] They note that the effect is not uniform across all insurers, but that insurers that had been the least profitable benefited the most from reforms.[61] They also discovered that liability reforms were more influential on reducing losses and less so on increasing premiums.[62] The authors conclude that medical malpractice reform

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[58] Danzon, Patricia M. The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims: A Summary of Research Results. U.S. Senate Committee on the Judiciary. Washington, DC, March 26, 1986. p. 9.

[59] Ibid.

[60] Viscusi, W. Kip and Patricia Born. "Medical Malpractice Insurance in the Wake of Liability Reform." Journal of Legal Studies 24 (1995): p. 490

[61] Ibid.

[62] Ibid.

consequently generated a variety of diverse effects that one would expect from a sound reform agenda.[63]

Damage Limitations, Caps

Payments made to individuals to compensate for damages because of medical error are generally divided in two categories. First are economic damages. Economic damages usually consist of past and future medical expenses to provide care and rehabilitation and lost wages or earnings potential. These damages are measured in monetary terms, often using objective or third party standards such as wage receipts, medical bills, or expert estimates of degree of disability. The second major category is that of non-economic damages. Non-economic damages are not readily measurable and are subjective in nature. They consist of payments for such intangible damages as past and future pain and suffering, loss of consortium, mental anguish and in some cases, punitive damages.

Table 35 lists states that have enacted damage limitations. A few states enacted statutory limitations on total damages but much less frequently than limitations on non-economic damages. It is important to note that when evaluating a total damage limitation, one must be aware of how it is applied. For example, while Indiana's $1,250,000 is a cap on all damages regardless of cause or source, the $500,000 cap in Louisiana is for non-medical damages only. Further, there are other areas of tort law that affect the settlement outcome such as whether the cap applies on a per occurrence basis for each health care provider or health care institution individually or collectively.

[63] Ibid. p. 491

A more common approach is for states to limit non-economic damages that an injured party can receive. There are many who believe that the limitation on non-economic damages is the most effective single reform that a state can enact. It should be noted this contention is still the subject of debate. Doctors, hospitals and insurers tend to favor such limitations, while the plaintiffs' bar and many consumer advocates are opposed.

Studying the effect of non-economic damage limitations is very difficult, as there does not appear to be reliable data to base an effective evaluation. First, courts do not routinely require that judgments distinguish between economic and non-economic damages when a judge or jury decides a case. Further, if a settlement is negotiated out of court, the insurer and the parties to the agreement are not inclined to separate the economic and non-economic aspects of the settlement. It is safe to say that enacting a non-economic damages limitation will have an impact on settlements or adjudicated claims with award values that reach levels exceeding the threshold of limitation. For most states, there is ample evidence that juries have awarded significant amounts; however, evaluating actual cost savings requires analysis on data that does not exist. At best a rudimentary estimate could be performed.

Damage caps or limitations provide insurers and the marketplace with information about the maximum dollar amount of loss any one insurance claim can be awarded, generally for noneconomic damages. When insuring a physician, insurers will assess the probability that he/she will have a claim filed against them and estimate how much the claim will cost the insurer. Without caps, insurers are forced to estimate what courts will,

in the future, award a plaintiff in a medical liability case. Recent years have seen large variations in the amounts of damages awarded in some cases, making such predictions difficult and inaccurate. The implementation of caps allows insurers to more accurately predict its costs arising from a claim and adds some stability to insurance prices in the market.

Caps on damages have two major impacts on individuals who potentially have a medical malpractice claim. First, total caps, that is caps on economic, noneconomic and punitive damages, may not make enough money for medical care necessary to reverse damages caused by medical mistakes or for any ongoing or life-long treatments the injured party may need. Some argue that noneconomic caps, in some cases, may be insufficient to appropriately compensate a victim for the intangible effects of the injury that has occurred. Secondly, caps may create a case of adverse selection when it comes to pursuing a claim. Since the costs of researching and arguing a medical malpractice case can be very large, awards available once caps are introduced may not, in some cases, cover even the costs associated with pursuing a claim.

Caps on noneconomic damages have been researched more than any of the tort reforms reviewed in this report. Danzon (Handbook of Health Economics, Volume 1: 2000) found that "caps directly constrain only a small percentage of cases, because roughly five percent of cases account for 50 percent of dollars paid." Danzon (ibid.) goes on to say that limits "are unlikely to undermine deterrence, because very high awards are typically not used for rating individuals (as opposed to class) liability premiums, being viewed as random bad luck." The Employment Policy Foundation (2003) argues, "states without

effective ceilings on non-economic damages experienced increases in medical malpractice premiums 3.7 times greater than states with ceilings." The Government Accounting Office (Medical Malpractice Insurance, 2003, p 43) found that, because of data limitations, "it is not possible to quantify the impact of a cap on noneconomic damages on insurers' losses. Similarly, it is not possible to show exactly how much a cap would affect claim frequency or claims-handling costs." Viscusi, et al (Inquiry: 1990, p 176), found that noneconomic caps had statistically significant effects on premium, frequency or severity.[64] Weiss (Medical Malpractice Caps: 2003) found that while caps on noneconomic damages did reduce insurer payout on claims, insurers continued to increase premiums, leading to the conclusion that more important factors such as medical inflation, the insurance business cycle, insufficient reserves, declining investment income, financial safety and supply and demand, drove the rise in medical malpractice premiums. Viscusi, et al (Journal of Risk and Uncertainty: 1993, p181) found that for the liability reform variables (specifically modified joint an several liability, limits on liability, noneconomic damages, or punitive damages, or other reforms) examined showed "no statistically significant effects appear on losses... Only one measure, limits on noneconomic damages, significantly depresses losses, resulting in a 14.7% decrease in 1985 loss levels." Ross (30 Ind. L Rev. 594), examining whether a state's independent interpretation of its equal protection laws should be considered when damage caps have been implemented, argues that caps "arbitrarily discriminate against those most severely injured. Furthermore, they are unlikely to effectuate their intended purpose of lowering malpractice insurance premiums and health care costs." Yoon (3 Amer. Law &

[64] The authors found that noneconomic damages were a significant at a 10% level of confidence when measured in the frequency and severity model.

Economics Review 199) found that "the average relative recovery by Alabama plaintiffs decreased by roughly $20,000 after the Alabama legislature enacted [total] damage caps and increased roughly double that amount after the Alabama Supreme Court ruled them unconstitutional." Sloan and Hoerger (4 Journal of Risk and Uncertainty 419) found that "more serious injuries were relatively undercompensated, and plaintiff who incurred high losses in cases in which defendants appeared to be innocent of wrongdoing were paid no more than those in which plaintiffs incurred a relatively minor loss. This undercuts the rationale for ceilings on payments for noneconomic loss or total loss." In an analysis of the effect of tort reforms on premiums stemming from the 1970s crisis, Zuckerman et al. found that; only reforms imposing a cap on the amount of physician liability or reducing the amount of time a plaintiff has to initiate a claim significantly lowered medical malpractice premiums; premium are lower in states that require prior approval of rates; and not as strong a link between the determinants of premiums, claims and awards as was expected.[65]

Collateral Source Rules

Collateral source rules are provisions that allow or require the introduction of evidence concerning the plaintiff's recovery of medical and disability expenses from "collateral sources" such as health insurance, workers' compensation, Social Security, auto insurance medical payments or no-fault coverage and disability insurance. This allows a jury to consider the other sources of compensation available to a plaintiff before setting an award amount. Some states also allow or require consideration of compensation

[65] Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. "Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums." Inquiry 27 (Summer 1990): 167-182. p. 167/

received from multiple defendants as a collateral source of recovery. A number of other states, however, still observe the common-law collateral source rule that obligates a tortfeasor to pay the full amount of a plaintiff's damages without regard to whether other sources mitigated those losses. In these states, tort awards are not offset by compensation amounts received from other sources.

Collateral source rules recognize that double recovery for all or part of a plaintiff's damages unnecessarily adds to the expense of medical malpractice insurance. Changes to collateral source rules would be considered an effective tort reform if the changes provide just compensation while eliminating duplicative expenses. Limiting subrogation rights would provide that collateral benefit providers do not seek to recover the monies they contributed to the settlement. However, most health and disability policies have provisions stating that the policyholder must refund policy benefit payments to the insurer that that they also collect through the tort system. This theoretically would eliminate most double recovery situations. Under this situation, the issue of double recovery is eliminated. The issue then becomes whether the source of the payments to the plaintiff are made appropriately, i.e. whether the plaintiff should pay for a portion of the damages or whether the defendant is responsible for all of the damages.

The Secretary's Commission on Medical Malpractice recommended 1973 that an in-depth analysis be made to identify the cost of overlapping health insurance benefits and to identify methods of using resources to assure more complete coverage to all.[66] Danzon

[66] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.

(Handbook of Health Economics, Volume 1: 2000) argues that "collateral sources offset undermines deterrence by shifting costs from the tort defendant to other insurance programs and by reducing the plaintiff's incentive to bring a claim because of the lower expected award." Danzon (Journal of Law and Economics: 1984, Law and Contemporary Problems: 1986) found empirically that "collateral source offset rules have not only reduced claim severity but also claim frequency, consistent with the prediction that lower awards reduce the incentive to file." Viscusi, et al (Inquiry: 1990, p 176), found that neither permissible nor mandatory collateral offset had statistically significant effects on premium, frequency or severity.[67]

Periodic Payment of Future Damages

Traditionally, medical liability insurers have paid tort settlements as one lump-sum settlement equal to the expected value of future losses. Periodic settlements allow for tort settlements to be paid over a course of many years, typically the expected lifetime of the plaintiff. Currently, several states mandate periodic payments, where several others provide an option to do so, either by request of the parties involved or the courts depending on the state statute requirements. Periodic payments are typically funded by annuities purchased from insurance companies. These annuitized payment arrangements are known to most as structured settlements.

A medical malpractice insurer can benefit by spreading the payments out over a longer period. An unused portion may be returned to the funding insurer. An insurer could also

[67] The authors found that mandatory collateral offset was a significant at a 10% level of confidence when measured in the frequency and severity model.

purchase an annuity where the present value of the future stream of payments is much less that a lump sum indemnity of the damages. Periodic settlements thus allow insurers to more accurately predict its loss expenses, which in turn allows them to set more consistent insurance rates for insureds. Periodic settlements may also be advantageous to the claimant because it guarantees a fund stream that will not be dissipated and will be available for future needs of the claimant. On the other side of the coin, it can be argued that periodic settlements take away the claimant's right to be compensated fairly because the claimant may not outlive the term of the periodic payments, which would preclude the claimant from being 'made whole'. In the event that an insurer becomes insolvent and has periodic payments settlement obligations it cannot meet, the cost of that obligation then shifts to either the state guaranty fund or, in the event the insurer is not covered by such a fund, to the claimant in terms of lost payments.

Henderson (32 Ariz. L. Rev. 76), argues that a "well designed periodic-installment judgment plan offers a number of opportunities to make significant improvements in the way tort victims are compensated."

Legislative Strategy Regarding Bad Faith

Although every state's tort system is different, a common thread for insurers is the issue of bad faith. Insurers can be held liable for amounts that are in excess of the policy limit if the policyholder asks the insurer to settle with a claimant and the insurer proceeds to take the case to court and loses. Bad faith claims occur when the judgment against the policyholder exceeds the policy limit and the insurer foregoes the opportunity to settle at the policy limit or less. At the extreme, bad faith claims have the potential to be larger

than an insurer's surplus.

Perhaps more than any other element the insurance industry maintains that the bad faith provisions of law, currently found in many insurance codes, are subject to abuse by those representing people allegedly injured due to malpractice. Although the evidence is generally anecdotal, the insurance industry is united in its assertion that no medical malpractice reform would be effective without changing the ease with which bad faith allegations can be made. On the other hand, those representing victims allege that insurers were prone to play games with records, witnesses, and availability to delay legal proceedings. Interestingly, insurers also make the same allegations relative to victims and their representatives. Those representing victims also expressed concern that the financial strength of insurers could allow them to "wait-out" a victim for purposes of an inequitable settlement. The working group believes that those considering medical liability reform should evaluate possible changes to the laws regarding bad faith claims. The appendix contains a summary of changes recently made to Florida law related to bad faith claims.

Sykes (25 Journal of Legal Studies 443) concludes that "the courts seem to find tortuous conduct on the part of insurers who have bona fide disputes with their policyholders over the terms of the policy or over factual issues essential to the insured's right to recover. The ability of the courts to identify opportunistic behavior in such cases is very much in doubt, and the distinct possibility arises that bad faith doctrine here does little to police misconduct while doing much to cause uneconomic increases in the premiums that policyholders must pay."

Alternative Dispute Resolution & Mediation

There are many ways to resolve disputes between two parties. The traditional method for medical liability claims is for the courts to hear from both sides and have either a judge or a jury decide what damages, if any, should be awarded. At the other end of the spectrum, is a settlement offer. This is a very informal process where the insurer, with the health care provider's permission, makes an offer to the plaintiff to settle the case before a trial becomes necessary. There are other methods that fall somewhere between these two extremes. Taking advantage of them offers opportunities to save time and expenses that are associated with a full trial in a court of law.

Some argue that one of the significant cost drivers of medical liability insurance is the sympathy factor. In cases where there is an adverse medical outcome that is not the result of a medical error, it can be argued that a compassionate jury would like to find a way to compensate those who have experienced a bad medical outcome and tend to sympathize with the plight of the victim. Care must be taken to strike a balance between the interests of the health care providers and those that have been victims of true medical malpractice. Establishing a balanced pre-trail screening process offers the potential to save both parties expense dollars by sorting out those cases that are likely to lead to an award from those that are simply unfortunate medical outcomes.

Further, expert witness reforms may contain costs if high standards are maintained. One option may be to use medical experts to certify the validity of the claimant's case so that

non-meritorious claims are eliminated before they reach a court. This process may also aid in settlement discussion, as many facts will come to light early in the process so that an offer of settlement can be tendered on cases with merit before going to trial.

Typically, loss adjustment expenses are higher for medical liability insurance than for other liability lines of insurance. This offers the potential for some savings if efforts to constrain costs are successful. Possible loss adjustment controls include the use of mediation or other alternative dispute resolution processes. Mediation or arbitration can be a successful loss adjustment control strategy. A state could consider adopting mediation or arbitration standards that treat all parties fairly. This would begin with a disclosure designed to alert the patient that he is agreeing to arbitration in lieu of a jury trial if that is the case. The disclosure must be clear and concise and should be agreed to by all parties. Arbitration can be either binding or non-binding and these conditions must be disclosed in advance. Rules regarding arbitration should consider whether the parties each have appropriate bargaining strength and whether they can bind others to the arbitration result in the case of joint and several liability. It should be noted that if there is discord surrounding an arbitrated dispute and either party can take the case once arbitrated to court, it is possible that arbitration might create an added layer of bureaucracy and actually add to expenses rather than diminish them.

In 1973, the Secretary's Commission on Medical Malpractice recommended that persons other than attorneys and members of the profession involved in the disputes be included as members of any mediation board or panel.[68] Danzon (Handbook of Health Economics,

[68] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.

Volume 1: 2000) agues that "theory and evidence indicate that mandatory screening, without significant penalties for appeal and without the panel's findings being admissible evidence in court, may simply add an additional tier of delay and costs." Danzon (Handbook of Health Economics, Volume 1: 2000) also argues that an "early binding offer system, combined with the English rule [the side that wins a suit is entitled to recover its expenses], creates incentives for each part to act on their true information, whereas bluff and strategic manipulation are penalized. By contrast, screening and mediation, without significant penalties for strategic post-screening behavior, simply increase delay and costs." The *authors* (Impact of Legal Reforms on Malpractice Costs, p72-3) note that the reluctance to use alternative dispute resolution programs "when it is not mandatory, coupled with questions about its constitutionality when mandatory, suggests that binding alternative dispute resolution (ADR) is unlikely to have much of an impact on direct malpractice costs." Viscusi, et al (Inquiry: 1990, p 176), found that allowing arbitration agreements did not have a statistically significant effect on premium, frequency or severity. Nelson (10 Am. Journ Trial Advoc. 362) questions whether "statutorily mandated mediation panels achieve any useful purpose. These panels may merely add another costly level to an already expensive and cumbersome litigation process. On the other hand, legislative attempts to encourage settlement, such as H.R. 3084, may provide benefits to both health care consumers and providers." Farber and White (23 Journal of Legal Studies 805) conclude, "patients involved in cases initiated through incident reports are less litigious ("more peaceful") than patients who initiated cases on their own either through a complaint or a lawsuit." Farber and White (23 Journal of Legal Studies 805) found that cases "initiated by patients through the complaint

process are not resolved (dropped, settled, tried to a verdict) significantly different from cases initiated by lawsuits, controlling for observable case characteristics." Farber and White (23 Journal of Legal Studies 806) suggest that "the complaint process is a cost-effective "front-end" for the litigation process that provides information to patients regarding the quality of their medical care and, hence, the likelihood of negligence." Vidmar And Rice (78 Iowa L Rev. 897) examined the results of several jury and mediated court decisions and found "no support to the widely held view that jurors are more generous than judges or arbitrators in awarding noneconomic damages. Moreover, the data do not support the view that the reasoning of laypersons calculating the award is substantially different from that of legally trained persons." Stevens (50 Dispute Resolution Journal 65) argues that the "potential contributions of ADR in various dispute-management settings depend in important part on how its adjudication function fits in as an integral part of the larger alternative dispute management system with which it is associated. Arbitration of these disputes would greatly facilitate adopting contract (rather than tort) as the legal basis for claims. In turn, contract – coupled with grievance procedures and arbitration – would provide a superior dispute management system for malpractice disputes in HMOs."

Contingency Fee Limitation

Perhaps the most controversial reform involves limitations on attorney contingency fees. The lawyers for the plaintiff in medical liability cases are generally compensated on a contingency fee basis. In lieu of an hourly charge for services rendered, the attorney agrees to accept a percentage of the damage award if the lawsuit is successful. These

contingency fee arrangements can be as high as 50% of the award.

The arguments for contingency fee limitation are that it delivers more of the award to the person who sustained the injury and thus is fairer to victims of malpractice. Further, it helps weed out non-meritorious claims as attorneys are less inclined to take a chance on a doubtful recovery if their stake in the claim would be less. There are some who oppose contingency fee limitations. They argue that these limitations deny innocent victims their day in court as plaintiff's attorneys would be less inclined to take on cases with small potential dollar values regardless of its validity. Further, they say that it is unfair to attorneys to limit their earnings potential. While there are states that have implemented restrictions on the use of contingency fees, limiting the income of plaintiff attorneys is often a tough battle in a state legislature. California is an example of a state that has successfully implemented contingency fee limitations for medical liability insurance

Danzon (Handbook of Health Economics, Volume 1: 2000) found that "theoretical analysis predicts that the number of claims filed would be higher with a contingent fee, but appropriately so, because risk aversion would deter many plaintiffs from filing valid claims with an hourly fee." Danzon (Handbook of Health Economics, Volume 1: 2000) also found that the "objective of limits on contingent fees is unclear and effects of such limits on claims frequency and disposition... are uncertain." Danzon (Bell Journal of Economics: 2001) found that "given certain assumptions about the nature of competition, the contingent fee system induces the amount of attorney effort that would be chosen by a fully-informed, risk-neutral plaintiff who was paying an attorney by the hour." Danzon (Bell Journal of Economics: 2001) also states that if the "benchmark of optimal

expenditures on litigation is that which would be chosen by fully informed, risk-neutral plaintiffs, then regulation or prohibition of contingent fees will, if effective, result in suboptimal investment in pursuing claims." The Employment Policy Foundation (2003) argues, "if a claim is dropped before any cash settlement is offered, the plaintiff's lawyer gets nothing. The result is an increasingly prolonged and costly process of discovery that consumes physician's time, distracts them from patient care and raises the effort and cost of claims adjusters and defense attorneys on behalf of malpractice insurers." Viscusi, et al (Inquiry: 1990, p 176), found that attorney fee controls did not have a statistically significant effect on premium, frequency or severity. Public Citizen (Medical Misdiagnosis: 2003, p 22) argues that non-frivolous lawsuits are not common because of the costs associated with pursuing a medical malpractice case. Public Citizen (Medical Misdiagnosis: 2003, p 24) found in a review of several studies that there is a "consistent relationship between the severity of the injury and the size of the verdict. Uniformly the authors concluded that their findings did not support the contention that jury verdicts are frequently unpredictable and irrational." Spagnoli (19 Loyola Los Angeles L Rev 683) notes that while California courts have ruled that regulation on attorney's fees affect first amendment rights, "the court failed to conclusively establish that recognition of such rights would prevent regulation of all attorney fees." McMullen (1990 Journal of Dispute Resolution 384) states that "the effort to employ mediation as a method to resolve medical malpractice disputes" is hampered by the attorney's "standard philosophical map, the perceived economic threat, the lack of confidentiality laws, the lawyers' general lack of education in mediation, and the perception that mediation does not enforce social norms as well as the court system." Reames (62 Chi. Kent L. Rev. 271) argues,

"limitations on attorney fees proscribed by section 6146 [of the California Business and Professional Code] seriously abridge first amendment rights. By limiting contingency fees, the statute limits the number of qualified attorneys willing to petition on behalf of medical malpractice victims. Without a qualified attorney, a malpractice victim's right to petition for redress is a nullity."

Other Legislative Measures

There are several other measures that state legislatures might consider to help with the medical liability situation.

Special Courts

Kozak (19 Seton Hall Legis. J. 647) argues that "it is necessary for reform to focus on streamlining the [litigation] process by eliminating unnecessary or duplicative discovery, restricting the time to claims resolution, and screening claims before they have on opportunity to clog the court system."

The establishment of special courts dedicated to hearing medical liability disputes offers an opportunity for improvement. A jury is often not well positioned to make an informed decision about whether a medical error has occurred or to decide on an appropriate level of compensation. Further, judges who only occasionally hear a medical liability case are in no better position to make an informed decision than are juries. A remedy for that deficiency is the creation of special courts that are designed to hear medical liability cases exclusively. The judges in these special courts will, over time, gain a familiarity with

medical jargon and will have comparative experience from a variety of medical liability cases to serve as a common basis for evaluation of medical liability disputes. While this is not an immediate solution to a current crisis, over time establishment of a special court should prove beneficial.

Advance Notice of Claims

Another potential legislative remedy is the introduction of a requirement that the plaintiff provide advanced notice of a claim. A claimant could be required to given defendants advance notice of intent to file a suit. A time period should be specified. A 90-day period should be sufficient. During the advance time period, both sides are expected to perform due diligence regarding the potential claim. There are many who believe that this advance notice period would often result in settlement of meritorious cases. Further it provides attorneys from both sides an opportunity to meet and exchange documents that will help them resolve the matter.

Other Reforms

Poythress, Weiner and Schumacher (16 Law & Psych Rev 111) argue the "tort system's current punishment model should be revised in favor of an information-feedback model that clearly identifies the specific behaviors to be changed as the result of the finding of negligence. Fines for compensatory and/or punitive purposes will be much more effective in a framework in which the behaviors sanctioned are announced with sufficient precision that the defendant doctor and other members of the relevant profession can identify those practices that are unacceptable."

Patient Compensation Funds

One reform adopted in some states is the use of patient compensation funds (PCF). **Table 36** lists states that have enacted PCFs. States with PCFs cap health care provider claims at a specified monetary level. Further redress is available to injured parties through a PCF for amounts above the monetary cap. PCFs generally limit the dollar amount they will provide in compensation. Except for its cap, a PCF by itself does not necessarily alter a state's tort system.

Patient Compensation Funds offer certainty to health care providers and their insurers by establishing a limit on the magnitude of losses a health care provider must bear. The cap on loss severity adds predictability to pricing medical liability insurance coverage. If frequency does not rise, medical liability premiums should remain relatively stable. The challenge involved with establishing a PCF revolves around funding. The debate generally is whether funding should come from private or public sources. There are those who believe that PFCs are not a good solution, as they do not change the claiming dynamics.

In 1973, the Secretary's Commission on Medical Malpractice recommended federal funding for one or more demonstration projects in order to test and evaluate the feasibility of possible alternative medical injury compensation systems as well as a federal feasibility study of establishing a patient injury insurance program, similar to

workers' compensation insurance, to provide designated compensation benefits for injuries arising from health-care, whether caused by medical malpractice or not.[69]

Statutory Risk Sharing Mechanisms

State legislatures are often called to address availability and affordability of essential insurance products when the private sector fails to provide adequate coverage at prices acceptable to those paying the premium. It is generally the preference of state governments to allow the private sector to provide insurance coverage if it is willing to do so. Auto, property and workers' compensation insurance are the three most widely known examples of essential insurance coverage. Auto and workers' compensation are compulsory in most states. Property insurance is necessary for an economy to function, as financial institutions will not lend money if a person or business cannot secure the financial institution's interest through property insurance.

Medical liability insurance may be considered an essential insurance coverage as a medical care provider can lose hospital-attending privileges if insurance is unavailable. Thus, the health care system relies on the availability of affordable medical liability insurance. When coverage is unavailable or believed to be too expensive, medical care providers may consider limiting their practice, changing to a lower risk specialty, retiring or moving to another state with more favorable medical liability rates.

When the legislature senses that medical liability coverage is either unavailable or

[69] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.

unaffordable, one of the measures developed to remedy the situation is a risk-sharing mechanism. These are often residual market mechanisms that serve as a market of last resort. A common risk-sharing mechanism is the Joint Underwriting Association or JUA. A JUA typically is a risk sharing mechanism where the state either authorizes or requires one or more servicing carriers to issue medical liability policies to health care providers that are unable to obtain insurance from the voluntary market insurers. The premiums and losses associated with providing coverage through the JUA are shared by an association of the entire admitted market, or a significant portion of it. This is done through either assessment or a less common distribution of excess funds. The servicing carrier issues the policy, settles claims and provides other customary policyholder services. For that service, the servicing carrier is compensated at a fixed rate. A JUA is an effective means to provide coverage availability. JUA establishment by itself does not address the price or affordability of the insurance product. A JUA's insureds are usually those rejected by the voluntary market and may trend toward higher claims costs.

JUAs are valuable to a market because it provides a mechanism in which anyone that needs to obtain insurance coverage can do so. Insurance coverage from JUAs is typically more expensive than coverage in the traditional insurance market; hence these entities are used when there are availability issues in the market. JUAs have limited benefits in markets where affordability of existing coverage is the most pressing problem.

Alternative Treatment of Trauma Centers and High Risk Specialties

Access to essential health care is becoming an issue in some states for certain high-risk specialties. There is a much higher incidence of medical liability claims observed in

certain specialties. Included in the high-risk specialties are delivery of newborns by obstetricians, performing brain surgery by neurosurgeons and treatment of trauma cases. The high cost of medical liability insurance can drive health care providers from these needed skill areas. This is particularly true for trauma centers, as the health care providers in these centers do not have the same continuing doctor-patient relationship as one would have with their primary care physician.

One of the potential legislative remedies that a state might consider is developing a different tort framework for these high-risk areas. One way to implement a tort framework would be to cap losses for these high-risk specialties at a specified amount and provide a patient compensation fund for the amount in excess of the cap. Taxpayers, health care providers or the insurance industry could finance the fund. Such a framework could provide certainty in pricing since the maximum possible loss is known in advance, leaving only a frequency component as a variable. However, as with any tort reform measure, there is always a question about whether limiting a claimant's right to full compensation through the tort system is a fair and equitable public policy goal.

Patient Safety Measures & Data Reporting Issues

The American Medical Association (AMA) supports a change to the existing culture of blame and punishment to one where patient safety is paramount. The current tort system does not encourage health care providers to report and evaluate health care errors. Rather, it discourages health care providers from sharing information for fear that the information could someday be used against them in a lawsuit. This culture means that mistakes in

practice are not disclosed and others that could benefit and avoid repeating the error are not made aware that anything has occurred.

Some argue that one should replace such a system where health care providers are encouraged to report medical errors to a central source without fear of retribution. This would allow medical experts to evaluate alternative treatment parameters and disseminate information to the medical profession to avoid the occurrence of similar mistakes in the future. This is the model for the federal Aviation Safety Risk Analysis Program, which has successfully reduced aviation accidents in the U.S. since 1958. However, some argue that such information should be made available to the legal systems because the tort system is designed to prevent future reoccurrences of medical malpractice.

In 1973, the Secretary's Commission on Medical Malpractice recommended that insurers: develop sophisticated loss-prevention programs based on both injury and claims prevention techniques; specifically identify and allocate a portion of the premium dollar for institutional medical malpractice insurance towards loss-prevention; and provide analyses of incidents to institutional health-care providers in order to aid the institutions' injury protection programs.[70] The Commission also found that the unavailability of medical records without resort to litigation created needless expense and increases the incidence of unnecessary malpractice litigation.[71] It further recommended that States enact legislation-enabling patients to obtain access to information contained in their medical records through their legal representatives, public or private, without having to

[70] United States. Department of Health, Education, and Welfare. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice. Washington, DC: GPO, 1973.
[71] Ibid. p. 75

file a suit.[72]

Chaing (18 Yale J. on Reg. 408) argues that the most important aspects of implementing a reporting system are "assuring reporters [of data] that incident reports will not be used against them in litigation and removing non-legal disincentives, such as access and cultural barriers, to reporting." McClean (26 S. Ill. U. L. J. 227) argues "based on scientifically-derived clinical guidelines and mandatory reporting of adverse events for error analysis, risk managed care medicine will severely limit the autonomy of physicians. For medical malpractice attorneys, scientifically-derived clinical guidelines will create a presumptive standard of care, which, because of detailed statistical analysis, will be difficult to rebuke."

Regulation of Investments

The high-risk investment strategies of some insurers and the casualties that occurred when the junk bond and real estate markets declined in the early 1990s have led regulators to reconsider their oversight of insurers' investments. Historically, state laws regulating insurers' investments were relaxed over the years to allow insurers to take advantage of high-yield investments to support new products. The NAIC, in 1990, adopted a model law restricting an insurer to no more than 20 percent of its admitted assets in non-investment grade bonds, with additional restrictions on the proportions of assets in the lower-rated categories. Several states adopted the model law or similar restrictions on junk bonds. This was accompanied by the refinement and strengthening of

[72] Ibid. p. 77

the process for assigning SVO credit designations or categorization of insurers' bonds and preferred stock.

In 1996, the NAIC adopted a comprehensive model law covering all insurer investments. The stated objectives of the model investment law are to: preserve principal; assure reasonable diversification; and require insurers to allocate investments prudently to meet obligations to insured and maintain sufficient financial strength to cover reasonably foreseeable contingencies. In general, the model law sets certain limits on the amounts or relative proportions of different assets that insurers can hold to ensure adequate diversification and limit risk.

Controversy about the investment model law led the NAIC to adopt a second investment model law that utilizes what is known as the "prudent person" approach. Conceptually, this approach allows insurers greater discretion in terms of their allocation of investments if they can demonstrate that they have a sound investment plan and that they adhere to that plan. Regulators are authorized to intervene if an insurer fails to meet this more general requirement.

Insurance companies are required to maintain records and file annual and quarterly financial statements with regulators in accordance with statutory accounting principals (SAP) that differ from Generally Accepted Accounting Principles (GAAP). Statutory accounting seeks to determine an insurer's ability to satisfy its obligations at all times, whereas GAPP measures the earnings of a company on a going-concern basis from period to period. Under SAP, most assets and liabilities are valued conservatively and

certain non-liquid assets, i.e., furniture and fixtures, are not admitted in the calculation of an insurer's surplus.

States typically prioritize the review of their domiciliary companies and any companies that require expedited scrutiny. Most departments utilize some system of financial ratios or other tools to screen and prioritize insurers for analysis. Regulators also utilize NAIC financial information systems including the Insurance Regulatory Information System (IRIS), which includes the Financial Analysis Solvency Tools (FAST) system, and other reports. Various additional sources of information may be tapped including: Securities and Exchange Commission (SEC) filings; claims-paying ability ratings; complaint ratios; market conduct reports; correspondence from competitors and agents; news articles; and other sources of anecdotal information.

Other Measures

Market Assistance Plans or MAPs have been used successfully in several states. A MAP is an organized effort, typically a joint public-private endeavor, to match those having difficulty obtaining insurance with a willing insurer. The MAPs work very well when there are only minor market difficulties. The typical development of a MAP occurs when the insurance department and State Legislators receive complaints about either the availability or affordability of coverage that cannot be met by ordinary measures. Generally, discussion with the insurance industry will lead to an offer to host or participate in the MAP. Insurers are motivated to sell as much insurance as possible given financial, regulatory and market constraints. It is in their interest to cooperate with the

legislature to assist in making sure that the market is adequately served.

Most MAPs are voluntary in nature with participating insurers evaluating the risks presented to them to see if the particular piece of business can be placed. There is generally a high success rate because the insurers may be concerned about further regulatory or legislative actions. They are also motivated by profit potential and sometimes are able to work with those seeking coverage on loss control measures to improve the profit potential for the insurer. MAPs work best where insurers still have capacity to write new business at a rate acceptable to purchasers.

RECOMMENDATIONS FOR FUTURE STUDY

One of the underlying themes in nearly every piece of literature reviewed for this study, as well as the authors' own experiences with developing the report, was the fact that medical malpractice data was inconsistent, incomplete, difficult to obtain and even more difficult to interpret. The authors of this report agree with the conclusions and recommendations contained in the study released in 2003 by the United States General Accounting Office (GAO). In the section titled Matter for Congressional Consideration, the GAO in its report observed, "a lack of necessary data has hindered and continues to hinder the efforts of Congress, state regulators, and others to carefully analyze the problem and the effectiveness of the solutions that have been tried. Because of the potential for future crises, and in order to facilitate the evaluation of legislative remedies put in place by various levels of government, Congress may want to consider taking steps to ensure that additional and better data are collected. Specifically, Congress may want to

consider encouraging the NAIC and state insurance regulators to identify the types of data that are necessary to properly evaluate the medical malpractice market—specifically, the frequency, severity and causes of losses—and begin collecting these data in a form that would allow appropriate analysis. Included in this process would be an analysis of the costs and benefits of collecting such data, as well as the extent to which some segments of this market are not captured by current data-gathering efforts. Such data could serve the interests of state and federal governments and allow both to better understand the causes of recurring crises in the medical malpractice insurance market and formulate the most appropriate and effective solutions.[73]"

The authors of this report did not study the effect of reinsurance pricing on primary medical liability providers, but note that there is some anecdotal evidence that reinsurance prices have increased. Further, evaluation of changes in insurer reserving practices was beyond the scope of the study.

CONCLUSION

The NAIC draft team did not insert them yet.

[73] Medical Malpractice Insurance—Multiple Factors Have Contributed to Increased Premium Rates. July 29, 2003, GAO, Page 46.

Table 1 - Definitions of Major Rating Laws

Prior Approval	Rates must be filed with and approved by the state insurance department before they can be used. Approval can be by means of a deemer provision, which indicates approval if rates are not denied within a specified number of days.
Modified Prior Approval	Rate revisions involving change in expense ratio or rate relativity require prior approval. Rate revisions based on experience only are subject to "file and use" laws.
Flex Rating	Prior approval of rates required only if they exceed a certain percentage above (and sometimes below) the previously filed rates.
File and Use	Rates must be filed with the state insurance department prior to their use. Specific approval is not required, but the department retains the right of subsequent disapproval.
Use and File	Rates must be filed with the state insurance department within a specified period after they have been placed in use.
No File	Rates are not required to be filed with or approved by the state insurance department. However, the company must maintain records of experience and other information used in developing the rates and makes these available to the commissioner upon his request.

Source: National Association of Insurance Commissioners.

Table 2– Definition of Legal Insurance Ownership Types

Stock Insurance Company	An insurance operation owned by stockholders, as contrasted to a mutual insurance company owned by its policyholders. Many major life insurers are mutual companies. Whereas, many leading property/casualty and multi-line insurers are stock insurance companies.
Mutual Insurance Company	An insurer that is owned by its policyholders—no stock is available for purchase on the stock exchanges.
Reciprocal Exchange	An unincorporated association where each insured technically provides insurance to all other insureds with the association. (Thus, each participant in the pool is both an insurer and an insured.) An attorney-in-fact administers the exchange by paying losses experienced by the exchange, investing, underwriting renewal business, receiving premiums, and purchasing reinsurance. Members share profits and losses in proportion to the amount of insurance purchased from the exchange by that member.
Surplus Lines (Aka. Excess-Surplus Lines or Non-Admitted)	A property or liability insurer that provides coverage on a non-admitted basis. State laws generally specify when policyholders can access the non-admitted insurer. This typically occurs in instances where coverage is unavailable from insurers licensed by the state. Examples of surplus lines are coverage for some environmental liability risks, directors' and officers' liabilities, or medical liability insurance.
Risk Retention Groups	A liability insurer that operates as a licensed casualty insurer one state, but is permitted to sell insurance in other states by the terms of the Liability Risk Retention Act. Similar to an assessable mutual. A medical provider must be an owner of the company to secure coverage from it.
Self Insurance (Often known as Retention)	Protecting against loss by setting aside one's own money. This can be done on a mathematical basis by establishing a separate fund into which funds are deposited periodically. Self-insurance can protect against high frequency, low-severity losses. To do this through an insurance company would mean paying a premium that includes loadings for general expenses, cost of putting the policy on the books, acquisition expenses, premium taxes, and contingencies. Often not accepted as valid proof of security by hospitals.
State Insurance Fund (Risk Retention Mechanisms)	Accounts established and administered by a state agency to finance an insurance program that provides an alternative to the other markets or serves as a market of last resort.

Source: Dictionary of Insurance Terms - 2nd Ed. with edits done by the authors.

Table 3 - Direct Written Premium, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
1991	257	6,665,549,348	25,935,990	55,441,013	4,588,622	526,154,768
1992	269	6,827,820,779	25,382,233	53,572,459	4,595,223	489,020,390
1993	266	6,775,072,896	25,470,199	56,426,506	4,617,686	532,449,918
1994	275	7,453,583,318	27,103,939	59,749,168	4,460,913	483,164,615
1995	271	7,276,853,911	26,851,859	57,824,871	4,611,617	408,509,288
1996	278	6,973,356,222	25,084,015	52,870,573	3,355,900	357,993,033
1997	280	6,662,691,234	23,795,326	50,157,760	3,384,353	369,535,567
1998	273	6,860,849,623	25,131,317	53,136,922	4,343,023	369,352,039
1999	272	6,658,823,288	24,480,968	51,735,283	4,491,573	403,190,447
2000	261	6,710,963,108	25,712,502	51,063,856	4,744,257	382,637,505
2001	247	7,675,911,761	31,076,566	64,066,916	4,992,833	475,708,456
2002	254	9,574,579,410	37,695,195	82,315,280	5,880,374	582,364,387

Source: National Association of Insurance Commissioners

Table 4 – 2002 Direct Written Premium, By State

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
CW	—	9,574,579,410	3,018,468	15,483,725	220,785	553,378,553
AK	39	16,122,037	413,386	993,849	48,451	4,411,104
AL	63	131,095,256	2,080,877	10,200,842	203,345	79,921,800
AR	59	59,218,826	1,003,709	3,005,255	123,319	21,552,547
AZ	74	204,489,742	2,763,375	12,084,311	381,781	102,954,827
CA	85	797,560,034	9,383,059	24,030,279	1,375,828	162,656,320
CO	67	117,207,767	1,749,370	7,034,831	220,703	56,520,290
CT	66	158,963,454	2,408,537	6,544,366	332,837	40,513,743
DC	41	38,400,641	936,601	3,423,222	77,137	21,673,080
DE	54	24,359,333	451,099	943,902	88,445	4,492,834
FL	84	829,122,375	9,870,504	24,974,713	1,037,225	169,558,079
GA	87	316,014,110	3,632,346	13,206,022	545,152	114,091,319
HI	45	37,412,921	831,398	2,209,323	103,586	10,363,609
IA	58	72,085,783	1,242,858	3,465,118	248,007	23,618,915
ID	58	27,290,061	470,518	1,154,792	71,207	5,757,509
IL	93	556,513,318	5,984,014	27,463,704	789,956	260,756,810
IN	65	88,244,233	1,357,604	5,609,614	96,498	38,201,527
KS	56	66,257,929	1,183,177	2,825,612	123,197	18,927,451
KY	63	124,214,360	1,971,657	4,092,046	550,000	25,688,878
LA	55	96,036,443	1,746,117	5,930,448	227,839	42,848,037
MA	59	239,205,217	4,054,326	15,267,493	506,395	108,618,293
MD	71	209,741,122	2,954,100	9,787,471	228,717	70,337,845
ME	45	40,149,330	892,207	3,607,411	97,916	23,848,816
MI	77	228,076,718	2,962,035	9,271,266	236,636	50,034,037
MN	62	68,274,668	1,101,204	4,567,107	197,038	35,523,012
MO	71	205,088,919	2,888,576	5,751,013	542,134	30,751,977
MS	58	63,682,554	1,097,975	2,982,240	161,346	20,226,392
MT	50	31,013,560	620,271	1,322,329	83,986	6,996,580

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
NC	74	220,335,540	2,977,507	8,504,447	537,659	58,782,305
ND	40	17,470,320	436,758	1,563,873	29,137	9,726,301
NE	50	26,540,773	530,815	1,267,967	88,653	8,067,869
NH	47	37,018,240	787,622	1,718,955	143,932	9,807,879
NJ	74	415,863,902	5,619,782	25,159,410	332,697	202,205,541
NM	50	39,754,826	795,097	2,070,900	135,782	11,334,916
NV	55	81,083,027	1,474,237	2,794,247	190,598	11,551,776
NY	71	1,083,408,620	15,259,276	69,599,878	1,001,411	553,378,553
OH	86	463,957,147	5,394,851	16,513,593	360,748	92,401,161
OK	58	97,639,172	1,683,434	6,181,310	134,581	40,625,944
OR	64	86,865,176	1,357,268	4,105,857	194,466	23,286,219
PA	91	500,653,458	5,501,686	12,090,825	727,058	62,296,198
RI	48	33,184,328	691,340	2,247,873	62,714	13,929,010
SC	51	38,319,034	751,354	1,926,532	112,516	10,422,709
SD	38	15,382,127	404,793	1,613,746	43,129	9,918,472
TN	77	291,873,998	3,790,571	14,755,870	219,850	119,099,031
TX	93	634,060,733	6,817,857	17,057,174	1,227,553	111,224,733
UT	50	53,412,544	1,068,251	3,789,559	154,386	26,263,560
VA	77	181,492,012	2,357,039	3,998,870	407,481	14,858,688
VT	43	18,776,998	436,674	1,032,273	49,392	4,574,717
WA	76	198,970,549	2,618,034	8,344,035	248,867	65,992,394
WI	57	82,376,013	1,445,193	4,666,988	176,424	31,196,737
WV	59	91,990,983	1,559,169	4,927,226	126,777	29,549,566
WY	38	18,309,179	481,821	1,495,999	37,077	7,989,549

Source: National Association of Insurance Commissioners.

Table 5 - Direct Losses Incurred, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
1991	257	3,759,089,886	14,626,809	35,190,859	1,963,228	215,044,544
1992	269	5,156,585,627	19,169,463	61,310,250	2,162,016	684,039,543
1993	266	4,365,893,562	16,413,134	42,064,490	2,064,689	397,703,575
1994	275	3,862,705,187	14,046,201	48,120,162	1,528,276	281,395,021
1995	271	3,932,152,619	14,509,788	46,153,127	2,462,594	300,941,799
1996	278	4,153,711,646	14,941,409	39,568,471	1,454,162	291,937,371
1997	280	3,588,222,339	12,815,080	35,781,569	1,684,074	222,867,768
1998	273	4,876,141,150	17,861,323	44,636,842	2,073,421	353,700,780
1999	272	4,969,949,146	18,271,872	42,389,413	2,796,390	319,508,466
2000	261	5,275,317,704	20,211,945	47,605,287	2,839,883	469,528,387
2001	247	7,013,509,025	28,394,773	66,639,109	3,517,091	534,825,400
2002	254	8,168,329,568	32,158,778	83,344,378	3,250,035	817,631,055

Source: National Association of Insurance Commissioners.

Table 6 – 2002 Direct Losses Incurred, By State

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
AK	39	8,778,063	225,079	660,790	14,312	2,085,402
AL	63	31,671,706	502,725	3,190,959	50,581	18,138,926
AR	59	78,703,998	1,333,966	3,727,644	59,366	22,012,748
AZ	74	168,337,412	2,274,830	6,866,072	274,126	51,638,359
CA	85	431,546,245	5,077,015	13,215,074	649,927	70,957,478
CO	67	69,005,399	1,029,931	3,281,436	46,986	20,045,355
CT	66	208,778,732	3,163,214	10,201,740	86,735	70,777,805
DC	41	28,797,229	702,371	2,431,976	8,270	9,668,857
DE	54	20,949,467	387,953	1,283,007	14,507	6,948,976
FL	84	787,527,502	9,375,327	19,718,551	930,172	94,069,722
GA	87	326,179,086	3,749,185	13,046,383	278,061	110,044,795
HI	45	17,088,075	379,735	1,094,973	18,945	5,778,568
IA	58	38,009,711	655,340	2,302,664	30,283	16,305,674
ID	58	25,168,306	433,936	1,070,147	15,270	5,550,183
IL	93	699,114,726	7,517,363	33,496,760	200,901	253,924,426
IN	65	46,759,712	719,380	2,616,165	17,023	16,011,881
KS	56	45,944,818	820,443	1,885,950	43,020	9,366,009
KY	63	87,916,721	1,395,504	3,569,074	152,190	22,533,147
LA	55	23,114,318	420,260	4,027,570	55,470	12,867,122
MA	59	225,295,679	3,818,571	16,704,142	69,886	116,229,237
MD	71	186,340,751	2,624,518	7,358,938	116,619	39,515,840
ME	45	22,628,831	502,863	2,972,450	11,438	18,820,774
MI	77	105,866,705	1,374,892	4,879,837	42,810	35,491,091
MN	62	32,889,494	530,476	3,364,464	11,729	25,974,463
MO	71	203,663,990	2,868,507	6,183,691	258,716	32,121,202
MS	58	82,669,845	1,425,342	4,083,930	74,808	25,886,398
MT	50	36,591,043	731,821	1,668,057	12,092	7,973,987
NC	74	142,117,114	1,920,502	5,040,753	136,083	29,634,587

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
ND	40	10,789,929	269,748	1,476,586	5,081	9,197,441
NE	50	19,204,108	384,082	1,085,535	14,274	5,515,067
NH	47	16,996,065	361,618	921,717	24,311	3,194,903
NJ	74	378,672,136	5,117,191	23,000,634	100,157	162,522,895
NM	50	39,447,124	788,942	1,992,729	62,283	10,032,926
NV	55	116,638,935	2,120,708	6,327,141	129,263	43,888,646
NY	71	1,076,533,281	15,162,441	95,053,992	201,869	792,557,593
OH	86	382,431,886	4,446,882	14,234,553	113,750	100,302,134
OK	58	88,159,715	1,519,995	6,202,019	65,021	44,811,803
OR	64	61,210,060	956,407	3,406,385	44,318	20,373,027
PA	91	512,829,281	5,635,487	12,547,306	374,897	67,563,503
RI	48	26,901,061	560,439	2,211,470	15,666	12,621,173
SC	51	24,213,775	474,780	1,425,034	23,568	7,128,853
SD	38	9,695,167	255,136	986,563	1,934	5,639,567
TN	77	300,778,453	3,906,214	13,035,807	31,695	83,416,976
TX	93	467,042,795	5,021,966	12,904,885	532,992	84,715,898
UT	50	38,121,603	762,432	2,388,834	43,766	15,768,631
VA	77	112,655,221	1,463,055	3,059,641	118,085	15,341,571
VT	43	7,067,240	164,354	577,141	10,361	2,839,071
WA	76	161,978,737	2,131,299	7,614,739	81,263	45,993,898
WI	57	33,066,427	580,113	2,723,829	7,168	13,450,395
WV	59	92,795,829	1,572,811	5,605,903	68,210	34,047,063
WY	38	9,646,062	253,844	1,033,476	7,410	5,887,279

Source: National Association of Insurance Commissioners.

Table 7 - Direct Losses Paid, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
1991	257	3,010,437,474	11,713,764	31,973,813	857,547	260,977,609
1992	269	3,574,163,795	13,286,854	36,884,642	1,462,454	356,848,985
1993	266	3,507,507,255	13,186,117	35,842,549	1,528,061	339,198,087
1994	275	3,878,312,269	14,102,954	35,453,023	1,223,833	290,449,596
1995	271	3,844,305,344	14,185,629	34,662,819	1,819,811	253,013,173
1996	278	4,004,181,852	14,403,532	35,473,376	1,421,175	276,124,446
1997	280	3,904,338,725	13,944,067	34,815,643	1,356,894	287,665,963
1998	273	4,358,813,681	15,966,350	38,757,999	1,232,259	331,181,009
1999	272	4,663,098,255	17,143,744	40,714,718	1,935,654	344,070,347
2000	261	5,059,430,144	19,384,790	47,283,645	2,052,602	344,142,438
2001	247	5,518,217,332	22,340,961	53,169,732	1,521,690	412,028,803
2002	254	5,905,829,834	23,251,299	68,852,863	1,660,748	836,133,767

Source: National Association of Insurance Commissioners.

Table 8 – 2002 Direct Losses Paid, By State

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
		5,905,829,834	1,861,863	11,029,853	0	400,222,158
AK	39	7,771,836	199,278	503,649	0	2,054,427
AL	63	45,299,067	719,033	2,558,756	0	15,579,784
AR	59	45,827,139	776,731	2,410,138	0	16,518,721
AZ	74	148,556,698	2,007,523	6,968,141	105,869	54,142,976
CA	85	373,925,280	4,399,121	12,684,233	541,500	80,305,026
CO	67	55,212,247	824,063	3,551,222	0	25,972,589
CT	66	131,532,643	1,992,919	6,929,560	3,143	40,718,232
DC	41	26,335,674	642,334	2,348,070	0	10,976,650
DE	54	5,036,591	93,270	439,421	0	3,027,681
FL	84	613,735,851	7,306,379	15,793,157	655,979	89,974,454
GA	87	203,779,241	2,342,290	7,553,396	57,500	50,906,795
HI	45	16,004,268	355,650	1,269,553	0	6,790,903
IA	58	39,842,436	686,939	2,887,810	0	19,438,228
ID	58	14,130,403	243,628	1,002,814	0	6,981,905
IL	93	480,328,040	5,164,818	23,771,101	52,501	167,963,222
IN	65	20,275,397	311,929	947,501	0	5,025,000
KS	56	22,426,439	400,472	1,098,401	0	4,878,555
KY	63	54,844,033	870,540	2,798,648	0	19,453,108
LA	55	22,682,809	412,415	1,327,580	0	7,411,416
MA	59	131,756,629	2,233,163	11,025,298	3,500	77,497,468
MD	71	173,462,949	2,443,140	7,480,022	0	39,643,512
ME	45	14,005,668	311,237	1,386,007	0	9,055,942
MI	77	99,461,118	1,291,703	4,354,083	0	26,313,081
MN	62	38,730,671	624,688	2,813,183	0	18,638,037
MO	71	107,567,941	1,515,041	3,612,630	25,000	16,330,158
MS	58	70,109,340	1,208,782	5,907,313	0	43,795,733
MT	50	19,926,589	398,532	1,025,851	0	4,579,506

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
NC	74	135,594,685	1,832,361	6,502,037	0	45,700,674
ND	40	6,949,970	173,749	557,034	0	2,752,732
NE	50	13,592,328	271,847	924,226	0	5,658,100
NH	47	16,842,492	358,351	995,853	0	5,477,114
NJ	74	259,842,946	3,511,391	18,679,588	0	122,307,556
NM	50	34,464,011	689,280	2,273,902	0	14,375,077
NV	55	61,748,840	1,122,706	4,350,619	0	21,113,457
NY	71	793,596,101	11,177,410	50,906,163	28,500	400,222,158
OH	86	216,674,467	2,519,471	8,408,281	225	53,543,524
OK	58	52,036,966	897,189	4,514,674	0	33,972,196
OR	64	39,208,418	612,632	2,484,946	0	14,305,437
PA	91	340,097,902	3,737,340	11,818,522	26,976	86,267,867
RI	48	7,744,931	161,353	555,974	0	3,041,218
SC	51	28,254,317	554,006	2,310,133	0	14,511,985
SD	38	7,168,645	188,649	763,492	0	4,491,264
TN	77	253,658,110	3,294,261	12,430,233	0	68,471,182
TX	93	342,166,935	3,679,214	8,666,776	812,000	48,010,589
UT	50	31,398,899	627,978	2,584,265	0	17,159,151
VA	77	74,984,221	973,821	2,342,216	3,000	15,051,465
VT	43	3,068,218	71,354	343,286	0	2,202,129
WA	76	115,554,395	1,520,453	5,593,393	0	40,157,273
WI	57	29,702,197	521,091	1,728,756	0	9,926,050
WV	59	49,710,574	842,552	3,555,635	0	21,587,639
WY	38	9,202,269	242,165	1,080,362	0	6,168,000

Source: National Association of Insurance Commissioners.

Table 9 - Defense and Cost Containment (DCC) Expenses Incurred, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
1991	257	1,578,795,380	6,143,173	18,387,626	623,338	153,963,639
1992	269	1,731,263,220	6,435,923	18,527,596	702,849	184,021,278
1993	266	1,523,415,577	5,727,126	14,365,785	592,928	96,369,285
1994	275	1,558,932,983	5,668,847	14,266,831	623,706	105,038,406
1995	271	1,831,719,852	6,759,114	16,486,311	713,109	113,123,182
1996	278	1,608,130,260	5,784,641	14,076,320	489,402	94,531,348
1997	280	1,608,051,973	5,743,043	16,018,728	582,005	121,242,277
1998	273	1,701,528,420	6,232,705	15,403,414	617,612	106,436,015
1999	272	1,839,454,493	6,762,700	16,480,217	749,458	126,299,988
2000	261	1,708,456,451	6,545,810	14,267,949	1,054,255	111,361,434
2001	247	1,992,685,767	8,067,554	18,879,000	869,371	156,249,315
2002	254	2,421,160,448	9,532,128	21,741,088	1,308,129	170,224,576

Source: National Association of Insurance Commissioners.

Table 10 – 2002 Defense and Cost Containment (DCC) Expenses Incurred, By State

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
AK	39	4,071,058	104,386	277,087	2,285	1,336,453
AL	63	53,512,843	849,410	5,519,091	9,202	43,784,219
AR	59	20,270,832	343,573	959,917	24,813	5,495,562
AZ	74	60,171,646	813,130	3,262,908	95,110	27,264,495
CA	85	278,413,337	3,275,451	9,343,542	312,897	62,425,291
CO	67	25,869,393	386,110	2,087,647	15,532	17,065,901
CT	66	41,376,576	626,918	2,024,499	45,218	13,284,455
DC	41	12,081,553	294,672	1,359,978	7,454	8,515,470
DE	54	6,779,356	125,544	422,046	9,475	2,677,105
FL	84	205,691,006	2,448,702	5,405,134	257,669	33,291,504
GA	87	71,518,077	822,047	2,665,279	121,734	23,134,788
HI	45	9,866,233	219,250	830,911	4,234	4,803,803
IA	58	10,965,286	189,057	526,995	16,406	3,287,346
ID	58	8,170,173	140,865	394,970	5,366	1,922,142
IL	93	138,553,354	1,489,821	7,949,624	71,733	75,593,535
IN	65	39,272,386	604,191	3,650,208	3,000	29,229,849
KS	56	21,350,042	381,251	857,064	16,226	5,140,295
KY	63	26,819,022	425,699	1,029,316	35,000	6,220,961
LA	55	42,374,076	770,438	3,136,911	26,649	22,574,801
MA	59	53,120,343	900,345	3,943,438	35,109	29,388,176
MD	71	37,155,582	523,318	1,255,062	30,281	7,509,628
ME	45	4,529,597	100,658	480,337	2,000	3,102,185
MI	77	37,336,544	484,890	1,855,962	20,438	11,881,401
MN	62	4,457,629	71,897	621,389	2,388	4,636,843
MO	71	52,691,307	742,131	1,645,468	102,750	8,542,865
MS	58	21,246,593	366,321	912,271	24,967	4,846,081
MT	50	9,291,756	185,835	445,091	4,770	1,933,125
NC	74	52,795,094	713,447	2,935,017	21,550	23,886,091

State	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
ND	40	2,891,612	72,290	255,853	567	1,169,244
NE	50	7,111,293	142,226	355,088	2,238	2,008,574
NH	47	5,204,341	110,731	344,184	5,392	1,961,436
NJ	74	81,187,407	1,097,127	4,851,005	38,750	32,874,724
NM	50	10,329,755	206,595	713,680	24,422	4,846,447
NV	55	29,571,549	537,665	1,277,106	67,473	7,315,845
NY	71	272,570,672	3,839,024	20,950,172	55,172	160,400,139
OH	86	102,474,370	1,191,562	4,318,227	24,668	34,970,755
OK	58	33,897,570	584,441	2,467,400	11,608	16,996,508
OR	64	15,714,648	245,541	955,922	12,063	6,005,167
PA	91	143,400,398	1,575,829	4,159,095	67,827	29,201,813
RI	48	7,693,206	160,275	640,450	3,777	4,078,449
SC	51	3,230,242	63,338	476,979	4,210	2,862,110
SD	38	1,449,735	38,151	168,771	364	860,854
TN	77	63,489,999	824,545	4,103,422	11,077	33,614,040
TX	93	155,133,244	1,668,099	4,752,107	240,321	37,762,860
UT	50	14,903,678	298,074	1,324,472	9,795	9,215,377
VA	77	40,347,371	523,992	1,203,766	48,586	6,428,217
VT	43	2,943,611	68,456	215,564	1,477	1,029,763
WA	76	41,715,383	548,887	2,038,599	24,690	15,028,190
WI	57	9,341,767	163,891	1,604,158	3,840	8,143,210
WV	59	21,569,333	365,582	1,737,258	21,238	12,895,333
WY	38	5,238,570	137,857	670,822	1,940	4,108,633

Source: National Association of Insurance Commissioners.

Table 11 –Medical Liability Insurance Median Insurer Expenses, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Premium Earned	General Expenses	Pct. of Premium	Taxes, Licenses & Fees	Pct. of Premium	Commission and Brokerage Expense	Pct. of Premium
1992	269	4,260,283	247,475	5.81%	61,548	1.44%	96,810	2.27%
1993	266	4,683,625	262,691	5.61%	74,699	1.59%	114,538	2.45%
1994	275	3,642,914	244,601	6.71%	60,088	1.65%	81,331	2.23%
1995	271	4,507,534	354,134	7.86%	63,744	1.41%	132,800	2.95%
1996	278	4,195,373	252,250	6.01%	61,916	1.48%	92,874	2.21%
1997	280	3,361,496	205,120	6.10%	42,593	1.27%	86,307	2.57%
1998	273	4,302,148	248,328	5.77%	65,117	1.51%	135,753	3.16%
1999	272	4,346,863	225,145	5.18%	49,132	1.13%	114,462	2.63%
2000	261	4,301,093	265,880	6.18%	57,459	1.34%	125,888	2.93%
2001	247	4,940,901	204,178	4.13%	85,328	1.73%	154,403	3.13%
2002	254	5,338,000	246,000	4.61%	75,000	1.41%	208,000	3.90%

Source: National Association of Insurance Commissioners

Table 12 – Medical Liability Median Insurer Profitability, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Loss Ratio	Expense Ratio	Combined Ratio	Underwriting Profit	Pct. of Premium	Pretax Profit	Pct. of Premium	Total Profit (Loss)	Pct. of Premium
1992	383	89.27%	25.90%	116.69%	-93,604	(10.11%)	-88,475	(9.56%)	214,136	23.13%
1993	367	77.65%	22.98%	98.92%	-3,735	(0.38%)	-4,980	(0.51%)	197,952	20.08%
1994	373	80.18%	27.27%	113.43%	-23,064	(3.04%)	-14,567	(1.92%)	110,465	14.56%
1995	370	82.74%	27.92%	114.05%	-66,695	(8.03%)	-61,383	(7.39%)	118,045	14.20%
1996	377	82.31%	24.40%	106.43%	-12,612	(1.37%)	-18,345	(1.99%)	165,109	17.93%
1997	374	90.71%	25.42%	116.59%	-105,362	(11.25%)	-104,802	(11.19%)	42,593	4.55%
1998	376	83.50%	30.06%	114.25%	-40,836	(5.21%)	-39,181	(5.00%)	153,412	19.58%
1999	347	93.57%	29.46%	124.02%	-204,088	(13.91%)	-220,286	(15.01%)	35,634	2.43%
2000	350	98.88%	28.01%	131.16%	-252,821	(21.59%)	-258,567	(22.08%)	10,447	0.89%
2001	314	103.45%	25.48%	130.76%	-435,783	(25.86%)	-462,194	(27.43%)	-26,411	(1.57%)
2002	309	103.58%	25.61%	122.18%	-604,000	(32.47%)	-540,000	(29.03%)	-46,000	(2.47%)

Source: National Association of Insurance Commissioners

Table 13 – 2002 Medical Liability Profitability Results, By State

State	Premium Earned (000's)	Losses Incurred*	Loss Adjustment Expense*	General Expenses*	Selling Expenses*	Taxes, Licenses & Fees*	Dividends To Policyholders*	Under-writing Profit*	Investment Gain*	Federal Tax*	Return on Net Worth*
AL	123,351	38.2	43.1	7.5	5.2	2.7	0.2	3.1	24.4	7.7	13.6
AK	13,226	93.8	56.5	7.5	8.2	2.2	11.2	-79.3	18.4	-22.8	-17.6
AZ	135,597	95.2	38.5	7.5	8.2	0.9	7.5	-57.8	22.8	-14.1	-5.7
AR	39,727	189.6	52.3	7.5	10.8	2.6	1.5	-164.1	25.6	-50.6	-35.1
CA	644,598	63.5	31.0	7.5	9.8	2.5	3.5	-17.8	15.2	-2.1	4.0
CO	97,668	46.1	37.8	7.5	6.4	1.2	9.5	-8.4	18.8	2.1	8.9
CT	120,543	153.9	22.9	7.5	8.8	2.3	3.5	-99.0	38.5	-24.3	-7.6
DE	17,215	109.2	27.6	7.5	14.8	1.9	0.1	-61.2	19.9	-16.1	-8.9
DC	30,893	93.0	21.8	7.5	8.2	2.8	0.9	-34.1	28.9	-4.2	3.8
FL	604,014	120.8	37.6	7.5	10.4	2.0	0.2	-78.5	18.4	-22.5	-17.4
GA	200,600	133.7	34.0	7.5	8.6	3.3	1.5	-88.6	23.0	-24.8	-15.5
HI	30,092	67.1	96.4	7.5	7.5	5.5	1.0	-85.0	19.0	-24.6	-18.7
ID	21,840	96.2	39.4	7.5	9.2	2.0	7.7	-62.0	18.8	-16.6	-10.8
IL	399,142	124.1	38.7	7.5	9.9	0.7	0.2	-81.1	27.2	-21.0	-10.1
IN	58,693	40.7	49.9	7.5	9.0	1.2	0.2	-8.5	21.0	2.7	9.3
IA	58,831	76.5	21.9	7.5	8.1	1.7	3.3	-19.0	13.6	-3.0	2.6
KS	45,804	70.0	33.9	7.5	9.9	1.7	0.1	-23.1	14.6	-4.2	1.3
KY	81,826	80.5	41.1	7.5	9.5	3.1	0.3	-41.9	25.9	-7.7	0.5
LA	82,000	40.9	44.7	7.5	9.2	1.9	0.1	-4.3	24.6	5.1	11.3
ME	27,055	101.8	24.3	7.5	8.4	2.2	0.6	-44.8	18.3	-10.7	-4.4
MD	155,433	90.1	24.8	7.5	9.7	2.2	12.7	-47.0	22.1	-10.5	-3.0
MA	182,898	113.0	26.2	7.5	9.7	2.7	7.3	-66.3	43.5	-11.5	0.9
MI	177,045	61.2	33.8	7.5	10.1	1.6	6.1	-20.2	23.2	-0.8	6.1
MN	56,147	102.3	18.8	7.5	8.9	2.1	10.5	-50.1	12.2	-14.3	-13.5
MS	44,522	215.6	79.6	7.5	9.1	2.9	0.3	-214.9	28.8	-67.5	-44.6
MO	119,300	85.9	30.6	7.5	11.5	2.0	1.7	-39.1	20.2	-8.2	-1.4
MT	17,348	118.5	23.8	7.5	9.8	2.1	0.2	-61.9	20.6	-16.1	-9.1
NE	22,359	38.7	28.1	7.5	10.5	1.7	0.8	12.7	19.3	9.7	16.5
NV	57,293	147.5	38.1	7.5	11.7	3.4	0.2	-108.4	23.3	-31.7	-21.4
NH	19,296	90.8	20.8	7.5	12.2	5.8	0.3	-37.4	21.1	-7.4	-0.1
NJ	290,103	82.6	26.1	7.5	10.5	1.4	0.1	-28.2	27.7	-2.4	5.0
NM	29,940	196.9	46.4	7.5	7.6	2.4	0.2	-160.9	24.0	-49.9	-37.6
NY	888,290	105.2	28.2	7.5	5.2	2.7	7.0	-55.7	39.9	-8.7	1.9
NC	158,764	112.0	34.5	7.5	9.5	2.0	0.2	-65.8	16.7	-18.5	-14.3
ND	12,887	77.3	28.5	7.5	11.8	2.2	5.0	-32.2	16.8	-6.8	-1.0
OH	300,057	106.0	35.0	7.5	12.6	1.6	0.1	-62.9	19.2	-16.8	-10.6
OK	63,526	90.2	43.5	7.5	8.4	2.4	0.2	-52.1	24.5	-11.6	-3.4
OR	56,534	143.5	31.3	7.5	8.3	0.8	0.9	-92.3	16.9	-27.7	-24.3
PA	335,491	141.4	40.1	7.5	8.6	2.0	0.1	-99.6	25.4	-28.0	-16.9
RI	21,681	127.8	40.5	7.5	11.2	2.3	0.2	-89.6	36.0	-21.7	-6.7
SC	23,587	96.7	41.8	7.5	11.0	2.3	0.2	-59.4	17.9	-16.0	-10.5
SD	10,543	40.2	22.0	7.5	14.2	2.5	1.3	12.5	14.1	8.2	16.6
TN	250,361	98.9	32.4	7.5	5.9	1.3	5.7	-51.6	20.8	-12.4	-5.5
TX	422,003	102.0	34.6	7.5	9.4	1.9	0.2	-55.6	19.2	-14.3	-8.1
UT	37,152	103.6	32.3	7.5	7.9	0.8	0.2	-52.2	23.8	-11.9	-3.9
VT	6,891	133.2	43.1	7.5	13.2	2.5	0.9	-100.3	21.4	-29.3	-19.9
VA	141,345	89.8	44.1	7.5	9.3	2.2	0.2	-53.1	17.2	-13.9	-8.8
WA	134,009	84.1	29.4	7.5	7.1	2.1	0.3	-30.4	16.2	-6.3	-0.9
WV	76,937	91.4	51.8	7.5	11.3	4.3	0.1	-66.3	20.0	-17.8	-11.1
WI	64,060	31.6	25.9	7.5	9.9	1.9	55.6	-32.5	25.0	-4.6	2.9
WY	10,594	93.5	20.6	7.5	11.5	1.8	0.2	-35.1	14.6	-8.4	-3.6

* As a percent of net premiums earned.

Source: National Association of Insurance Commissioners.

Table 14 - 2002 Medical Liability Combined Ratios, By State

State	Direct Loss Incurred	Loss Adjustment Expense	Direct Premium Written	Combined Ratio	Losses Incurred To Premium	Loss Adjustment Expense to Premium
AK	8,764,207	4,053,823	16,122,037	79.51%	54.36%	25.14%
AL	35,261,548	53,889,393	130,730,124	68.19%	26.97%	41.22%
AR	82,809,117	20,845,838	59,218,377	175.04%	139.84%	35.20%
AZ	169,831,479	58,770,841	204,482,771	111.80%	83.05%	28.74%
CA	433,980,863	279,433,208	797,541,264	89.45%	54.41%	35.04%
CO	69,935,465	26,712,235	117,206,510	82.46%	59.67%	22.79%
CT	209,284,110	42,347,315	158,914,049	158.34%	131.70%	26.65%
DC	32,337,315	14,142,424	38,394,747	121.06%	84.22%	36.83%
DE	19,898,940	5,530,189	24,233,473	104.93%	82.11%	22.82%
FL	792,301,816	206,708,992	825,199,361	121.06%	96.01%	25.05%
GA	325,580,234	71,930,417	315,957,472	125.81%	103.05%	22.77%
HI	16,513,637	10,090,714	37,412,671	71.11%	44.14%	26.97%
IA	37,260,117	10,814,555	72,085,105	66.69%	51.69%	15.00%
ID	24,934,222	8,199,716	27,287,203	121.43%	91.38%	30.05%
IL	765,171,330	145,423,794	556,039,958	163.76%	137.61%	26.15%
IN	51,968,432	42,062,446	88,224,429	106.58%	58.90%	47.68%
KS	45,778,831	21,339,955	66,253,237	101.31%	69.10%	32.21%
KY	85,702,382	27,335,077	124,163,358	91.04%	69.02%	22.02%
LA	24,411,602	40,167,454	95,960,952	67.30%	25.44%	41.86%
MA	242,449,063	53,314,711	239,173,347	123.66%	101.37%	22.29%
MD	189,342,913	37,145,077	209,685,185	108.01%	90.30%	17.71%
ME	22,363,918	4,464,630	40,149,330	66.82%	55.70%	11.12%
MI	107,350,456	36,538,338	227,537,271	63.24%	47.18%	16.06%
MN	32,942,421	4,315,807	68,273,039	54.57%	48.25%	6.32%
MO	206,411,788	55,467,791	205,019,484	127.73%	100.68%	27.05%
MS	88,765,589	24,042,831	63,497,737	177.66%	139.79%	37.86%
MT	36,477,518	9,270,234	30,996,208	147.59%	117.68%	29.91%
NC	140,556,627	54,871,311	220,333,824	88.70%	63.79%	24.90%
ND	11,387,673	3,127,663	17,458,468	83.14%	65.23%	17.91%
NE	18,881,996	7,119,699	26,540,646	97.97%	71.14%	26.83%
NH	17,853,696	5,962,161	36,493,181	65.26%	48.92%	16.34%
NJ	377,640,469	81,332,170	415,860,504	110.37%	90.81%	19.56%
NM	38,055,900	10,357,746	39,743,240	121.82%	95.75%	26.06%
NV	119,424,770	30,284,394	81,012,956	184.80%	147.41%	37.38%
NY	1,068,101,936	257,082,310	1,079,010,048	122.81%	98.99%	23.83%
OH	379,326,283	108,528,926	460,549,633	105.93%	82.36%	23.57%
OK	88,997,402	33,847,104	97,621,674	125.84%	91.17%	34.67%
OR	64,066,119	16,468,846	86,864,695	92.71%	73.75%	18.96%
PA	510,739,436	144,285,296	499,022,656	131.26%	102.35%	28.91%
RI	27,093,730	7,228,928	33,089,645	103.73%	81.88%	21.85%
SC	25,190,924	3,355,593	38,274,802	74.58%	65.82%	8.77%
SD	9,669,251	1,441,409	15,377,269	72.25%	62.88%	9.37%
TN	309,332,583	66,076,132	291,863,920	128.62%	105.99%	22.64%
TX	469,282,412	161,27[illegible]495	633,658,064	99.50%	74.06%	25.44%
UT	37,543,372	14,740,830	53,412,544	97.89%	70.29%	27.60%
VA	142,078,285	44,444,409	181,476,921	102.78%	78.29%	24.49%
VT	18,448,046	2,905,618	18,751,148	113.88%	98.38%	15.50%
WA	164,442,772	43,362,823	198,969,784	104.44%	82.65%	21.79%
WI	34,084,567	10,417,291	82,375,534	54.02%	41.38%	12.65%
WV	93,857,290	21,952,298	91,978,370	125.91%	102.04%	23.87%
WY	9,139,229	5,133,248	18,305,948	77.97%	49.92%	28.04%
CW	8,333,024,081	2,449,911,505	9,557,804,173	112.82%	87.19%	25.63%

Source: National Association of Insurance Commissioners.

Table 15 - 2002 Medical Liability Underwriting Profit and Return on Net Worth, By State

State	Combined Ratio	Investment Gain To Earned Premium	Operating Ratio	Return on Net Worth
AK	79.51%	16.01%	63.49%	1.48%
AL	68.19%	21.63%	46.57%	3.77%
AR	175.04%	18.60%	156.44%	(6.80%)
AZ	111.80%	16.18%	95.61%	(2.07%)
CA	89.45%	10.48%	78.97%	0.69%
CO	82.46%	15.73%	66.73%	1.11%
CT	158.34%	25.43%	132.91%	(1.79%)
DC	121.06%	22.21%	98.85%	(1.21%)
DE	104.93%	13.02%	91.91%	(1.56%)
FL	121.06%	13.79%	107.28%	(3.10%)
GA	125.81%	17.70%	108.11%	(3.58%)
HI	71.11%	15.08%	56.03%	2.86%
IA	66.69%	9.41%	57.28%	4.01%
ID	121.43%	14.55%	106.87%	(2.52%)
IL	163.76%	21.34%	142.43%	(4.89%)
IN	106.58%	15.14%	91.44%	(1.28%)
KS	101.31%	10.28%	91.03%	(1.05%)
KY	91.04%	17.47%	73.57%	0.51%
LA	67.30%	18.80%	48.50%	3.69%
MA	123.66%	33.66%	90.00%	(0.10%)
MD	108.01%	14.36%	93.65%	(1.85%)
ME	66.82%	11.81%	55.01%	3.48%
MI	63.24%	17.14%	46.10%	3.52%
MN	54.57%	8.21%	46.36%	4.85%
MO	127.73%	12.41%	115.33%	(4.79%)
MS	177.66%	22.41%	155.25%	(5.86%)
MT	147.59%	12.03%	135.56%	(6.66%)
NC	80.70%	11.80%	76.90%	0.68%
ND	83.14%	10.21%	72.94%	1.49%
NE	97.97%	13.92%	84.05%	0.62%
NH	65.26%	9.72%	55.54%	2.63%
NJ	110.37%	20.47%	89.90%	(1.20%)
NM	121.82%	17.03%	104.78%	(2.63%)
NV	184.80%	16.33%	168.47%	(6.69%)
NY	122.81%	31.85%	90.97%	(0.19%)
OH	105.93%	14.48%	91.45%	(2.21%)
OK	125.84%	15.74%	110.10%	(2.54%)
OR	92.71%	14.71%	78.01%	(1.28%)
PA	131.26%	17.63%	113.63%	(2.95%)
RI	103.73%	23.84%	79.89%	0.34%
SC	74.58%	11.89%	62.70%	1.11%
SD	72.25%	6.78%	65.47%	2.84%
TN	128.62%	17.55%	111.08%	(2.01%)
TX	99.50%	12.16%	87.35%	(0.56%)
UT	97.89%	16.50%	81.39%	0.55%
VA	102.78%	13.87%	88.91%	(1.15%)
VT	113.88%	9.23%	104.65%	(3.88%)
WA	104.44%	11.19%	93.25%	(1.62%)
WI	54.02%	17.36%	36.66%	1.46%
WV	125.91%	14.59%	111.32%	(1.31%)
WY	77.97%	7.96%	70.00%	(0.08%)

Source: National Association of Insurance Commissioners.

Table 16 - Analysis of Total Invested Asset Valuation, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

Year	Number of Insurers	Total	Mean	Standard Deviation	Median	Maximum
1991	120	24,494,697,087	204,122,476	403,434,287	63,271,649	3,466,594,255
1992	130	26,880,912,522	206,776,250	402,722,110	65,890,296	3,574,874,240
1993	125	26,929,358,937	215,434,871	422,179,073	61,286,757	3,697,185,665
1994	126	30,818,377,700	244,590,299	463,973,555	65,992,100	3,701,295,861
1995	127	31,608,940,803	248,889,298	485,915,755	62,353,979	3,888,181,449
1996	129	32,320,614,955	250,547,403	488,202,042	61,980,383	3,853,146,654
1997	127	32,217,471,831	253,680,881	511,483,439	54,054,253	4,072,242,532
1998	115	32,809,721,529	285,301,926	534,344,856	79,420,644	3,888,316,542
1999	116	32,250,255,261	278,019,442	533,435,098	65,360,939	4,091,048,990
2000	106	27,801,184,057	262,275,321	493,371,610	67,786,176	3,989,543,546
2001	100	26,636,826,620	266,368,266	534,794,772	62,635,457	4,327,580,462
2002	115	26,626,881,655	231,538,101	496,442,889	44,777,217	4,203,373,647

Source: National Association of Insurance Commissioners.

Table 17 –Median Insurer Invested Asset Value by Type of Asset, Countrywide
Insurers with 50% of More of Their Business in Medical Liability Insurance

Year	Total Invested Assets	Bonds	Cash & Short-Term Investments	Common & Preferred Stock	Other Invested Assets
1991	63,271,649	48,370,502	6,109,895	609,821	0
1992	65,890,296	51,054,708	5,715,585	353,476	0
1993	61,266,757	54,364,800	5,482,865	1,032,473	0
1994	65,992,100	54,462,212	4,684,198	1,064,996	0
1995	62,353,979	48,622,546	4,531,922	817,352	0
1996	61,980,383	42,725,736	4,359,789	1,451,954	0
1997	54,054,253	38,747,206	4,613,931	1,636,210	0
1998	79,420,644	57,759,201	4,601,308	5,504,295	0
1999	65,360,939	54,068,225	3,706,911	4,180,907	0
2000	67,786,176	54,327,139	3,402,538	3,928,709	28,862
2001	62,635,457	50,577,881	5,630,883	2,349,735	0
2002	44,777,217	35,705,869	6,799,217	1,416,863	0

Source: National Association of Insurance Commissioners.

Table 18 –Invested Assets as a Percent of Total, Countrywide

Insurers with 50% of More of Their Business in Medical Liability Insurance

Year	Total Invested Assets	Bonds	Cash and Short-Term Investments	Common & Preferred Stock	Other Invested Assets
1991	63,271,649	83.26%	10.38%	0.43%	0.00%
1992	65,890,296	83.49%	9.89%	0.58%	0.00%
1993	61,286,757	82.42%	9.04%	2.09%	0.00%
1994	65,992,100	81.47%	8.54%	3.30%	0.00%
1995	62,353,979	80.61%	8.21%	3.38%	0.00%
1996	61,980,383	81.38%	7.95%	5.02%	0.00%
1997	54,054,253	80.15%	7.77%	5.00%	0.00%
1998	79,420,644	81.85%	6.18%	7.71%	0.00%
1999	65,360,939	81.46%	6.06%	5.64%	0.00%
2000	67,786,176	80.18%	7.14%	5.39%	0.02%
2001	62,635,457	79.75%	9.29%	4.13%	0.00%
2002	44,777,217	74.81%	13.29%	3.05%	0.00%

Source: National Association of Insurance Commissioners.

Table 19 - Analyses of Total Capital Gains (Losses)

Insurers with >50% of Business in Medical Liability Insurance

Year	Number of Insurers	Sum	Median	Mean	Std Dev	Minimum	Maximum
1991	98	295,630,667	749,693	3,016,639	6,122,614	212	44,753,918
1992	109	483,441,654	777,215	4,435,245	13,373,603	14	130,607,250
1993	104	564,664,401	1,258,664	5,429,465	12,954,221	135	101,712,447
1994	84	144,086,864	171,136	1,715,320	5,385,191	190	42,799,576
1995	111	510,195,186	747,564	4,596,353	11,172,709	1,500	88,201,970
1996	112	461,783,182	362,740	4,123,064	11,520,486	94	87,510,082
1997	107	713,401,516	829,660	6,667,304	20,449,728	1,065	156,970,930
1998	110	659,457,488	864,150	5,995,068	15,578,301	331	132,254,220
1999	89	660,808,320	986,655	7,424,813	17,484,159	147	128,919,597
2000	74	287,792,134	368,006	3,889,083	14,845,542	70	111,205,911
2001	85	320,574,470	752,238	3,771,464	12,089,014	293	105,209,115
2002	94	-435,995,555	-222,474	-4,638,251	22,564,124	-168,646,379	47,013,226

Source: National Association of Insurance Commissioners.

Table 20 - Total Investment Income Analyses, Countrywide
Insurers with >50% of Business in Medical Liability Insurance

Year	Sum	Median	Mean	Standard Deviation
1991	1,347,691,563	3,426,802	11,230,763	22,680,762
1992	1,423,044,170	3,706,093	10,946,494	21,328,337
1993	1,321,163,500	3,260,011	10,569,308	21,183,474
1994	1,484,392,871	3,316,313	11,780,896	22,236,704
1995	1,624,970,897	3,288,262	12,795,046	25,200,194
1996	1,686,003,512	3,211,232	13,069,795	25,376,231
1997	1,635,365,011	2,736,183	12,876,890	25,135,766
1998	1,622,862,126	3,685,234	14,111,845	26,150,269
1999	1,585,505,068	3,372,125	13,668,147	24,931,462
2000	1,478,866,495	4,512,703	13,951,571	24,431,705
2001	1,390,263,184	3,446,759	13,902,632	25,780,373
2002	1,240,418,990	2,132,924	10,786,252	21,262,188

Source: National Association of Insurance Commissioners.

Table 21 – Median Insurer Investment Income By Investment Type, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

Year	Bonds	Cash and Short-Term Investments	Common Stocks	Mortgages and Real Estate	Other Investment Income	Preferred Stocks
1991	73,564	67,868	0	0	0	0
1992	93,154	40,392	0	0	0	0
1993	101,840	25,726	0	0	0	0
1994	107,960	34,367	0	0	0	0
1995	102,729	47,296	0	0	0	0
1996	119,234	42,206	0	0	0	0
1997	131,280	44,201	0	0	0	0
1998	158,568	61,226	0	0	0	0
1999	183,351	51,713	0	0	0	0
2000	176,929	89,665	0	0	0	0
2001	119,374	61,516	0	0	0	0
2002	19,445	85,588	0	0	0	0

Source: National Association of Insurance Commissioners.

Table 22 – Total Investment Income By Investment Type, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

Year	Bonds	Cash and Short-Term Investments	Common Stocks	Mortgages and Real Estate	Other Investment Income	Preferred Stocks	All
1991	1,187,775,100	87,974,998	24,012,688	14,018,031	3,213,316	30,697,430	1,347,691,563
1992	1,258,679,059	70,789,183	34,457,897	15,873,686	8,398,702	34,845,643	1,423,044,170
1993	1,170,202,446	61,212,542	27,933,430	17,875,723	8,014,428	35,924,931	1,321,163,500
1994	1,308,551,241	78,204,872	40,131,574	16,725,851	3,819,515	36,959,818	1,484,392,871
1995	1,382,894,229	126,289,116	50,229,244	17,250,737	5,356,698	42,950,873	1,624,970,897
1996	1,451,427,500	88,500,423	55,941,274	17,037,988	36,466,737	36,629,590	1,686,003,512
1997	1,436,247,653	81,897,349	48,961,074	16,725,094	12,983,718	38,550,123	1,635,365,011
1998	1,410,382,527	100,433,295	41,881,420	15,944,300	15,056,703	39,163,881	1,622,862,126
1999	1,383,039,370	80,705,260	56,951,101	15,012,278	12,836,594	36,960,465	1,585,505,068
2000	1,302,340,754	84,826,154	28,699,420	17,392,676	8,138,881	37,468,610	1,478,866,495
2001	1,243,598,329	69,687,107	19,291,114	16,368,904	10,902,604	30,415,126	1,390,263,184
2002	1,133,718,847	38,362,527	23,260,624	14,095,573	4,258,388	26,723,031	1,240,418,990

Source: National Association of Insurance Commissioners.

Table 23 – Percent of Investment Income By Investment Type, Countrywide

Insurers with >50% of Business in Medical Liability Insurance

Year	Bonds	Cash and Short-Term Investments	Common Stocks	Mortgages and Real Estate	Other Investment Income	Preferred Stocks
1991	88.13	6.53	1.78	1.04	0.24	2.28
1992	88.45	4.97	2.42	1.12	0.59	2.45
1993	88.57	4.63	2.11	1.35	0.61	2.72
1994	88.15	5.27	2.70	1.13	0.26	2.49
1995	85.10	7.77	3.09	1.06	0.33	2.64
1996	86.09	5.25	3.32	1.01	2.16	2.17
1997	87.82	5.01	2.99	1.02	0.79	2.36
1998	86.91	6.19	2.58	0.98	0.93	2.41
1999	87.23	5.09	3.59	0.95	0.81	2.33
2000	88.06	5.74	1.94	1.18	0.55	2.53
2001	89.45	5.01	1.39	1.18	0.78	2.19
2002	91.40	3.09	1.88	1.14	0.34	2.15

Source: National Asscciation of Insurance Commissioners.

Table 24 - Policyholder Surplus, Countrywide

(In 2002 $USD)

Year	Number of Insurers	Total	Mean	Standard Deviation	Median	Minimum	Maximum
1991	257	6,590,434,518,496	25,643,714,080	68,542,958,597	3,662,190,818	-85,903,126,127	534,993,035,315
1992	269	6,781,787,508,430	25,211,105,979	64,599,076,700	4,161,544,647	-106,639,066,303	439,970,278,342
1993	266	7,582,610,394,690	28,506,054,115	73,318,492,703	4,435,310,166	-87,018,524,674	519,890,790,953
1994	275	8,618,140,861,949	31,453,068,839	80,667,933,269	4,855,128,182	-9,700,046,125	593,738,393,063
1995	271	9,835,307,042,275	36,427,063,120	96,333,020,463	5,514,915,716	-2,845,279,958	645,926,277,665
1996	278	11,309,522,892,499	40,681,737,023	109,993,458,473	6,622,037,772	-5,591,755,334	764,468,079,784
1997	280	14,043,718,344,425	50,156,136,944	153,634,380,290	7,487,138,579	-4,090,985,784	1,296,748,589,633
1998	273	16,134,536,487,275	59,100,866,254	180,327,720,399	8,776,901,260	-5,597,195,712	1,505,980,769,638
1999	272	14,693,627,255,010	54,020,688,438	161,770,910,659	9,350,825,423	-7,818,357,905	1,234,888,922,436
2000	261	12,659,434,323,161	48,503,579,782	149,578,042,285	8,320,452,416	-22,297,335,253	1,144,362,536,974
2001	247	11,876,985,623,826	48,084,962,040	144,653,586,743	7,863,731,807	-30,151,756,712	1,135,337,144,788
2002	254	12,401,730,219,976	48,825,709,527	148,692,937,955	7,693,268,246	-37,705,821,717	1,058,721,694,753

Source: National Association of Insurance Commissioners.

Table 25 – Policyholder Surplus to Total Assets, Countrywide

Year	Number of Insurers	Mean	Standard Deviation	Median	Minimum	Maximum	Number of Insurers with Ratio <= 5%
1991	257	33.09%	23.28%	26.21%	(53.28%)	100.01%	5
1992	269	32.63%	25.33%	27.28%	(140.47%)	100.25%	7
1993	266	32.85%	24.45%	27.95%	(136.22%)	100.01%	8
1994	275	36.22%	23.25%	29.17%	(19.41%)	100.00%	5
1995	271	38.69%	23.42%	31.60%	(11.22%)	101.73%	3
1996	278	39.54%	26.60%	33.35%	(181.67%)	99.97%	5
1997	280	43.59%	24.17%	35.74%	(17.97%)	99.96%	3
1998	273	43.53%	22.99%	36.45%	(27.38%)	99.99%	2
1999	272	45.56%	25.01%	37.69%	(48.43%)	100.04%	4
2000	261	44.40%	30.60%	35.92%	(211.48%)	100.00%	4
2001	247	40.83%	26.94%	31.24%	(44.90%)	112.82%	6
2002	254	40.90%	27.02%	31.08%	(40.76%)	100.00%	4

Source: National Association of Insurance Commissioners.

Table 26 - Market Concentration Ratios, Countrywide

Year	Number of Insurers	Mkt. Share of 4 Largest Insurers	Mkt. Share Of 8 Largest Insurers	Mkt. Share Of 20 Largest Insurers	Herfindahl-Hirschman Index
1991	266	20.61%	31.41%	52.90%	217.55
1992	271	19.23%	30.66%	51.22%	202.28
1993	274	21.11%	32.86%	52.71%	221.65
1994	279	20.02%	32.17%	54.59%	213.89
1995	279	19.85%	31.74%	54.61%	207.67
1996	281	17.95%	29.88%	54.14%	195.19
1997	284	18.15%	30.39%	52.97%	194.39
1998	277	18.03%	31.15%	54.41%	200.68
1999	278	18.63%	31.34%	53.24%	200.73
2000	268	18.34%	29.46%	51.00%	189.69
2001	254	20.38%	30.99%	54.55%	212.06
2002	261	21.68%	33.03%	56.00%	227.13

Source: National Association of Insurance Commissioners.

Table 27 - 2002 Total, Mean & Median Insurer Direct Premium Written, By State

State	Direct Premium Written	Number Of Insurers	Mean Premium Written	Median Premium Written
AK	16,122,037	39	413,386	48,451
AL	130,730,124	67	1,951,196	153,826
AR	59,218,377	60	986,973	122,900
AZ	204,482,771	76	2,690,563	304,963
CA	797,541,264	88	9,062,969	1,265,103
CO	117,206,510	68	1,723,625	213,706
CT	158,914,049	69	2,303,102	303,112
DC	38,394,747	44	872,608	63,491
DE	24,233,473	56	432,741	84,063
FL	825,199,361	89	9,271,903	940,215
GA	315,957,472	91	3,472,060	413,897
HI	37,412,671	47	796,014	84,281
IA	72,085,105	59	1,221,781	247,980
ID	27,287,203	60	454,787	58,963
IL	556,039,958	102	5,451,372	405,876
IN	88,224,429	68	1,297,418	84,054
KS	66,253,237	59	1,122,936	107,435
KY	124,163,358	65	1,910,206	481,385
LA	95,960,952	57	1,683,525	227,127
MA	239,173,347	61	3,920,875	429,355
MD	209,685,185	77	2,723,184	187,221
ME	40,149,330	45	892,207	97,916
MI	227,537,271	82	2,774,845	179,251
MN	68,273,039	64	1,066,766	183,355
MO	205,019,484	75	2,733,593	490,000
MS	63,497,737	61	1,040,947	121,424
MT	30,996,208	52	590,081	66,672
NC	220,333,824	75	2,937,784	527,662
ND	17,458,468	43	406,011	25,118
NE	26,540,646	51	520,405	71,936
NH	36,493,181	49	744,759	118,408
NJ	415,860,504	75	5,544,807	375,417
NM	39,743,240	52	764,293	126,837
NV	81,012,956	58	1,396,775	149,782
NY	1,079,010,048	73	14,780,960	912,327
OH	460,549,633	92	5,005,974	287,973
OK	97,621,674	60	1,627,028	117,790
OR	86,864,695	66	1,316,132	187,380
PA	499,022,656	95	5,252,870	582,040
RI	33,089,645	50	661,793	50,175
SC	38,274,802	55	695,905	98,123
SD	15,377,269	41	375,055	39,998
TN	291,863,920	79	3,694,480	198,864
TX	633,658,064	99	6,400,587	785,312
UT	53,412,544	50	1,068,251	154,386
VA	181,476,921	79	2,297,176	383,944
VT	18,751,148	46	407,634	41,220
WA	198,969,784	77	2,584,023	231,899
WI	82,375,534	59	1,396,195	150,000
WV	91,978,370	62	1,483,522	109,161
WY	18,305,948	40	457,649	32,854

Source: National Association of Insurance Commissioners.

Table 28 - 2002 Market Concentration Ratios, By State

Year	Number of Insurers	Mkt. Share of 4 Largest Insurers	Mkt. Share Of 8 Largest Insurers	Mkt. Share Of 20 Largest Insurers	Herfindahl-Hirschman Index
AK	39	70.64%	86.86%	98.38%	1700.47
AL	67	80.85%	87.92%	95.94%	3934.65
AR	60	61.89%	79.58%	95.25%	1663.24
AZ	76	67.11%	77.51%	91.99%	2684.63
CA	88	51.72%	66.40%	87.38%	880.24
CO	68	69.14%	80.27%	93.29%	2526.91
CT	69	60.53%	75.18%	92.93%	1253.97
DC	44	79.23%	88.96%	98.68%	3423.68
DE	56	56.58%	77.47%	94.05%	991.46
FL	89	48.25%	70.53%	91.83%	880.63
GA	91	59.61%	74.00%	89.07%	1617.38
HI	47	77.35%	88.06%	97.45%	1756.61
IA	59	62.09%	77.26%	92.74%	1489.52
ID	60	62.45%	81.79%	94.38%	1193.30
IL	102	63.31%	75.08%	90.26%	2352.08
IN	68	80.08%	89.85%	97.10%	2741.34
KS	59	51.84%	74.07%	95.60%	1179.00
KY	65	47.29%	66.37%	89.69%	832.28
LA	57	66.96%	79.66%	94.82%	2244.54
MA	61	77.54%	86.02%	95.66%	2532.94
MD	77	66.27%	83.35%	94.08%	1666.04
ME	45	83.05%	89.01%	97.86%	3774.34
MI	82	67.96%	81.42%	94.00%	1392.33
MN	64	72.28%	80.74%	93.25%	2890.99
MO	75	42.76%	65.75%	88.22%	691.74
MS	61	60.98%	76.81%	95.31%	1430.81
MT	52	57.21%	80.00%	95.89%	1092.01
NC	75	62.82%	75.76%	91.27%	1222.70
ND	43	81.88%	91.97%	99.05%	3379.70
NE	51	57.61%	77.62%	95.11%	1318.38
NH	49	59.78%	80.99%	96.59%	1241.59
NJ	75	78.57%	88.84%	96.36%	2807.09
NM	52	69.74%	84.34%	95.06%	1530.53
NV	58	47.95%	74.00%	95.96%	824.55
NY	73	83.29%	90.51%	97.03%	3054.65
OH	92	63.56%	77.49%	92.08%	1211.13
OK	60	81.37%	90.67%	97.02%	2457.78
OR	66	70.72%	82.95%	93.86%	1563.79
PA	95	41.73%	63.82%	87.39%	639.06
RI	50	77.58%	86.84%	97.87%	2378.59
SC	55	69.12%	83.64%	96.03%	1463.31
SD	41	83.44%	91.67%	98.63%	4338.19
TN	79	72.45%	83.76%	96.01%	2072.47
TX*	99	46.57%	63.59%	85.01%	774.31
UT	50	71.93%	83.65%	96.16%	2666.53
VA	79	30.75%	55.06%	87.49%	498.91
VT	46	73.03%	89.96%	98.29%	1506.08
WA	77	59.73%	78.15%	93.04%	1450.56
WI	59	73.45%	83.87%	96.04%	1972.92
WV	62	72.58%	89.48%	97.02%	1833.95
WY	40	86.43%	93.56%	99.16%	2734.29

Source: National Association of Insurance Commissioners.

*Texas' largest medical liability insurer, the Texas Medical Liability Trust, is a statutorily created entity not reporting to the NAIC. If it is included into the calculations for Texas, the index increases to 1290.

Table 29 - Capital and Surplus Requirements, By State

[TO BE ADDED]

Table 30 - Entries and Exits, Countrywide

Year	Number of Insurers	Entries	Pct of Insurers*	Exits	Pct of Insurers*	Net Change	Pct of Insurers*
1992	274	20	7.69%	21	8.08%	-1	(0.38%)
1993	268	24	8.76%	17	6.20%	7	2.55%
1994	278	14	5.22%	13	4.85%	1	0.37%
1995	275	18	6.47%	2	0.72%	16	5.76%
1996	281	10	3.64%	10	3.64%	0	0.00%
1997	284	10	3.56%	10	3.56%	0	0.00%
1998	277	8	2.82%	10	3.52%	-2	(0.70%)
1999	275	11	3.97%	11	3.97%	0	0.00%
2000	263	12	4.36%	11	4.00%	1	0.36%
2001	252	10	3.80%	18	6.84%	-8	(3.04%)
2002	258	15	5.95%	17	6.75%	-2	(0.79%)

Source: National Association of Insurance Commissioners.

Table 31 - Median Insurer Entries and Exits, By State

Year	Number of Insurers	Entries	Pct of Insurers*	Exits	Pct of Insurers*	Net Change	Pct of Insurers*
1992	51	3	5.88%	2	3.92%	1	1.96%
1993	53	4	7.84%	3	5.88%	1	1.96%
1994	53	4	7.55%	4	7.55%	0	0.00%
1995	58	4	7.55%	2	3.77%	2	3.77%
1996	56	5	8.62%	4	6.90%	1	1.72%
1997	61	4	7.14%	3	5.36%	1	1.79%
1998	64	5	8.20%	4	6.56%	1	1.64%
1999	65	5	7.81%	6	9.38%	-1	(1.56%)
2000	61	6	9.23%	5	7.69%	1	1.54%
2001	62	5	8.20%	7	11.48%	-2	(3.28%)
2002	58	8	12.90%	7	11.29%	1	1.61%

Source: National Association of Insurance Commissioners.

Table 32 - 2002 Aggregate Premium By Company Type, By State

State	Total	Stock	Mutual	Surplus & Excess	Reciprocal	Risk Retention Groups	Residual Mk. Mechanisms/ State Funds	Other
AK	24,283,241	2,572,505	5,175,545	11,479,638	4,885,193	170,360	.	.
AL	153,648,074	29,830,966	88,298,826	16,489,502	17,340,261	1,688,519	.	.
AR	59,919,570	13,089,344	27,284,143	10,403,304	8,446,491	696,288	.	.
AZ	208,860,476	40,804,567	104,504,248	42,416,332	12,870,730	7,310,413	.	954,186
CA	800,628,603	260,628,511	199,574,631	136,894,411	178,836,528	20,173,303	.	4,521,219
CO	122,077,329	73,386,332	1,875,144	31,669,210	12,491,044	2,655,599	.	.
CT	163,449,319	46,225,362	42,265,180	28,893,402	10,524,149	33,359,408	.	2,181,818
DC	51,799,075	16,370,276	32,192	12,660,087	22,393,381	343,139	.	.
DE	26,456,426	20,293,872	865,650	3,685,978	847,825	763,101	.	.
FL	825,659,394	165,207,868	59,266,007	308,199,781	259,403,764	31,513,391	.	2,068,583
GA	322,113,305	72,378,637	128,591,388	88,008,319	15,315,248	5,188,156	.	12,631,557
HI	54,664,762	9,922,510	214,699	24,100,983	19,287,945	843,625	.	295,000
IA	94,542,725	58,921,552	4,190,737	26,827,511	2,007,019	2,595,906	.	.
ID	52,336,057	19,124,103	2,479,460	20,459,457	9,766,422	506,615	.	.
IL	562,660,857	152,456,615	4,826,038	122,091,019	271,418,524	11,007,054	.	861,607
IN	110,038,243	44,870,324	39,031,368	22,169,418	2,783,850	1,183,283	.	.
KS	85,220,699	33,335,608	22,294,344	19,470,647	8,232,047	746,299	.	1,141,754
KY	146,919,211	75,982,577	11,697,235	44,623,695	9,798,339	4,817,365	.	.
LA	110,443,020	28,263,114	43,245,808	36,717,826	967,535	1,248,737	.	.
MA	259,123,377	33,341,992	128,715,954	85,219,037	373,874	11,100,611	.	371,909
MD	227,510,540	69,167,768	71,258,290	35,253,225	7,656,357	43,375,331	.	799,569
ME	56,899,771	22,445,680	24,298,985	7,855,209	1,151,965	1,147,932	.	.
MI	247,842,638	140,092,678	1,314,131	81,221,103	15,349,195	9,765,067	.	100,464
MN	85,574,095	61,444,053	2,095,357	19,188,646	172,721	2,256,265	.	417,053
MO	204,395,602	78,578,449	25,729,706	33,247,270	60,747,185	3,436,419	.	2,656,573
MS	90,783,089	34,762,909	1,814,118	30,400,530	23,144,339	661,193	.	.
MT	50,350,396	25,496,310	226,138	18,951,428	5,422,598	243,492	.	10,430
NC	240,251,516	59,982,413	93,067,626	71,585,251	11,149,195	3,919,376	.	547,655
ND	35,622,802	23,929,659	204,311	10,835,754	544,052	109,026	.	.
NE	48,501,428	28,074,960	357,908	14,925,903	1,304,681	867,771	.	2,970,205
NH	43,462,049	10,641,738	13,685,494	17,818,007	425,607	891,203	.	.
NJ	442,871,124	300,064,340	2,526,484	126,394,018	920,875	5,660,036	.	7,305,371
NM	53,023,274	29,079,582	3,889,958	9,790,679	8,425,973	1,837,082	.	.
NV	99,487,744	50,120,881	10,507,153	26,941,061	9,782,579	2,136,070	.	.
NY	1,096,262,561	161,548,836	559,718,883	65,616,616	202,034,053	96,415,242	.	10,928,931
OH	484,411,830	271,852,346	90,771,019	79,935,711	34,000,257	7,567,189	.	285,308
OK	129,993,894	99,131,444	1,541,542	27,165,692	140,118	2,015,098	.	.
OR	109,305,884	38,622,212	24,947,070	32,100,431	11,449,997	2,186,174	.	.
PA	529,394,851	235,177,858	4,624,898	140,465,348	26,742,708	82,925,883	36,449,584	3,008,572
RI	44,693,360	19,751,063	15,603,504	7,601,217	127,782	1,609,794	.	.
SC	71,118,338	38,961,927	2,405,077	27,834,449	1,392,344	524,541	.	.
SD	36,769,475	23,312,569	691,079	11,987,511	654,543	123,773	.	.
TN	319,435,[illegible]2	61,874,864	124,503,686	92,979,845	37,619,045	2,438,026	.	19,976
TX	623,469,877	186,388,300	11,385,748	263,185,680	89,287,067	23,458,682	49,704,396	60,004
UT	75,643,008	42,794,517	1,500,756	27,324,688	3,492,204	530,843	.	.
VA	192,091,584	73,875,257	29,720,530	47,660,377	22,966,228	17,869,192	.	.
VT	36,658,782	15,905,342	5,270,314	13,314,240	590,765	305,394	.	1,272,727
WA	219,663,643	69,862,354	1,361,656	54,867,422	85,339,357	8,232,854	.	.
WI	105,789,801	77,148,165	1,813,395	22,060,851	414,543	2,243,191	2,047,168	62,488
WV	103,966,758	71,383,838	920,108	29,097,294	1,280,379	1,285,139	.	.
WY	38,257,260	19,423,132	106,538	13,494,815	5,092,611	140,164	.	.
CW	10,378,346,179	3,637,902,079	2,042,290,059	2,553,579,828	1,536,811,492	464,088,614	88,201,148	55,472,959

Source: National Association of Insurance Commissioners.

Table 33 - 2002 Percent of Market Share By Company Type, By State

State	Total Direct Written Premium	Stock %	Mutual %	Surplus Lines %	Reciprocal %	Risk Retention Group %	Residual Market Mechanism %	Other %
AK	24,283,241	10.59%	21.31%	47.27%	20.12%	0.70%	-	-
AL	153,646,074	19.42%	57.47%	10.73%	11.29%	1.10%	.	.
AR	59,919,570	21.84%	45.53%	17.36%	14.10%	1.16%	.	.
AZ	208,860,476	19.54%	50.04%	20.31%	6.16%	3.50%	.	0.46%
CA	800,628,603	32.55%	24.93%	17.10%	22.34%	2.52%	.	0.56%
CO	122,077,329	60.11%	1.54%	25.94%	10.23%	2.18%	.	.
CT	163,449,319	28.28%	25.86%	17.68%	6.44%	20.41%	.	1.33%
DC	51,799,075	31.60%	0.06%	24.44%	43.23%	0.66%	.	.
DE	26,456,426	76.71%	3.27%	13.93%	3.20%	2.88%	.	.
FL	825,659,394	20.01%	7.18%	37.33%	31.42%	3.82%	.	0.25%
GA	322,113,505	22.47%	39.92%	27.32%	4.75%	1.61%	.	3.92%
HI	54,664,762	18.15%	0.39%	44.09%	35.28%	1.54%	.	0.54%
IA	94,542,725	62.32%	4.43%	28.38%	2.12%	2.75%	.	.
ID	52,536,057	36.54%	4.74%	39.09%	18.66%	0.97%	.	.
IL	562,660,857	27.10%	0.86%	21.70%	48.24%	1.96%	.	0.15%
IN	110,038,243	40.78%	35.47%	20.15%	2.53%	1.08%	.	.
KS	85,220,699	39.12%	26.16%	22.85%	9.66%	0.88%	.	1.34%
KY	146,919,211	51.72%	7.96%	30.37%	6.67%	3.28%	.	.
LA	110,443,020	25.59%	39.16%	33.25%	0.86%	1.13%	.	.
MA	259,123,377	12.87%	49.67%	32.89%	0.14%	4.28%	.	0.14%
MD	227,510,540	30.40%	31.32%	15.50%	3.37%	19.07%	.	0.35%
ME	56,899,771	39.45%	42.70%	13.81%	2.02%	2.02%	.	.
MI	247,842,638	56.52%	0.53%	32.77%	6.19%	3.94%	.	0.04%
MN	85,574,095	71.80%	2.45%	22.42%	0.20%	2.64%	.	0.49%
MO	204,395,602	38.44%	12.59%	16.27%	29.72%	1.68%	.	1.30%
MS	90,783,089	38.29%	2.00%	33.49%	25.49%	0.73%	.	.
MT	50,350,396	50.64%	0.45%	37.64%	10.77%	0.48%	.	0.02%
NC	240,251,516	24.97%	38.74%	29.80%	4.64%	1.63%	.	0.23%
ND	35,622,802	67.18%	0.57%	30.42%	1.53%	0.31%	.	.
NE	48,501,428	57.88%	0.74%	30.77%	2.69%	1.79%	.	6.12%
NH	43,462,049	24.49%	31.49%	41.00%	0.98%	2.05%	.	.
NJ	442,871,124	67.75%	0.[illegible]%	28.54%	0.21%	1.28%	.	1.65%
NM	53,023,274	54.84%	[illegible]	18.46%	15.89%	3.46%	.	.
NV	99,487,744	50.38%	10.56%	27.08%	9.83%	2.15%	.	.
NY	1,096,262,561	14.74%	51.06%	5.99%	18.43%	8.79%	.	1.00%
OH	484,411,830	56.12%	18.74%	16.50%	7.02%	1.56%	.	0.06%
OK	129,993,894	76.26%	1.19%	20.90%	0.11%	1.55%	.	.
OR	109,305,884	35.33%	22.82%	29.37%	10.48%	2.00%	.	.
PA	529,394,851	44.42%	0.87%	26.53%	5.05%	15.66%	6.89%	0.57%
RI	44,693,360	44.19%	34.91%	17.01%	0.29%	3.60%	.	.
SC	71,118,338	54.78%	3.38%	39.14%	1.96%	0.74%	.	.
SD	36,769,475	63.40%	1.88%	32.60%	1.78%	0.34%	.	.
TN	319,435,442	19.37%	38.98%	29.11%	11.78%	0.76%	.	0.01%
TX	623,469,877	29.90%	1.83%	42.21%	14.32%	3.76%	7.97%	0.01%
UT	75,643,008	56.57%	1.98%	36.12%	4.62%	0.70%	.	.
VA	192,091,584	38.46%	15.47%	24.81%	11.96%	9.30%	.	.
VT	36,658,782	43.39%	14.38%	36.32%	1.61%	0.83%	.	3.47%
WA	219,663,643	31.80%	0.62%	24.98%	38.85%	3.75%	.	.
WI	105,789,801	72.93%	1.71%	20.85%	0.39%	2.12%	1.94%	0.06%
WV	103,966,758	68.66%	0.89%	27.99%	1.23%	1.24%	.	.
WY	38,257,260	50.77%	0.28%	35.27%	13.31%	0.37%	.	.
CW	10,378,346,179	35.05%	19.68%	24.60%	14.81%	4.47%	0.85%	0.53%

Source: National Association of Insurance Commissioners.

Table 34 - Analysis of Risk-Based Capital Action Levels, Countrywide

Year	No Action Taken	Company Action Level	Regulatory Action Level	Authorized Control Level	Mandatory Control Level
1994	253	7	3	.	6
1995	251	4	4	1	6
1996	255	7	3	1	6
1997	264	6	1	1	5
1998	252	4	2	1	5
1999	236	4	.	2	5
2000	225	7	1	1	5
2001	230	3	4	1	9
2002	237	3	4	2	8

Source: National Association of Insurance Commissioners.

Table 35 - Non-Economic Damage Caps, By State

STATE	CITATION	DESCPRIPTION	JUDCIAL DECISON
AL	§ 6-5-544	In 1987, Alabama enacted a statewide medical malpractice cap. The statute, which has never been repealed, provides that a medical malpractice plaintiff's recovery for non-economic losses, including punitive damages, cannot exceed $400,000.	The Alabama Supreme Court declared this statute to be unconstitutional in Moore v. Mobile Infirmity Ass'n, 592 So. 2d 156 (Ala. 1991).
AK	§ 09.17.010	Damages awarded by a court, arising out of a single injury or death cannot exceed $400,000 or the injured person's life expectancy in years multiplied by $8,000,whichever is greater. The upper-tier cap for severe disfigurement or physical impairment, the greater of $1,000,000 or the plaintiff's life expectancy, in years, multiplied by $25,000 The amended statute also clarifies that multiple injuries arising out of one incident invoke only one cap, and that consortium claims do not open up a second cap.	
AZ	None	Arizona does not place a cap on the amount of damages recoverable in a medical malpractice action. Article 2, § 31 of the Arizona constitution prohibits the enactment of any law limiting the damages one may recover for personal injury or death.	
AR	None	No medical malpractice caps.	
CA	Civ § 3333.2	The amount of damages for non-economic losses cannot exceed $250,000.	The cap on non-economic damages was held to be constitutional in Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985). See also Yates v. Pollock, 194 Cal. App. 3d 195, 239 Cal. Rptr. 383 (1987) and Atkins v. Strayhorn, 223 Cal. App. 3d 1380, 273 Cal. Rptr. 231 (1990)
CO	§ 13-64-302	Damages for medical malpractice against a hospital or physician may not exceed $1,000,000 per patient, including any derivative claim by any other claimant. Of that $1,000,000, not more than $250,000 may be attributable to non-economic loss or injury. However, if the court finds that the future economic damages exceed this cap, it may award damages in excess of the limit.	This damage cap was held to be constitutional in Scholz v. Metropolitan Pathologists, P.C., 851 P.2d 901 (Colo. 1993).
CT	None	No medical malpractice caps.	
DE	None	No medical malpractice caps.	
DC	None	No medical malpractice caps.	
FL	§§ 766.207, 766.209	There is no cap unless voluntary binding arbitration is used to make a determination of damages. If a defendant refuses to accept the claimant's offer to arbitrate, the claimant, if successful at trial, is entitled to pre-judgment interest and up to 25 percent of the award in attorneys' fees. If a claimant refuses to accept a defendant's offer to arbitrate, his recovery will be limited to economic damages (but only 80 percent of lost wages) plus no more than $350,000 in non-economic damages. If the claimant does accept, his recovery will be limited to economic damage (but only 80 percent of lost wages) plus no more than $250,000 in non-economic damages, plus attorneys' fees of fifteen percent.	This damage cap was held to be constitutional in University of Miami v. Echarte, 618 So. 2d 189 (Fla.), cert. denied, 510 U.S. 915 (1993).
GA	§ 51-12-5.1	Georgia does not place a cap on the amount of compensatory damages that may be awarded. However, punitive damages are capped at $250,000, unless the claimant can successfully demonstrate that the defendant had an intent to harm	
HI	§§ 663-8.5, 663-8.7, 671-15	Non-economic damages that are recoverable in tort actions include damages for pain and suffering, mental anguish, loss of enjoyment of life, loss of consortium, and all other non-pecuniary losses or claims. The amount of damages recoverable for pain and suffering cannot exceed $375,000.	

ID	§ 6-1603	Non-economic damages for personal injury or wrongful death cannot exceed $400,000. The $400,000 cap has been adjusted on July 1 of each year since 1988 by the rate of increase in average wages in Idaho. The limitation on non-economic damage awards is inapplicable to causes of action arising out of willful or reckless conduct and to causes of action arising out of acts constituting a felony under state or federal law.	
IL	735 Ill. Comp. Stat. Ann. § 5/2-1115.1	In 1995, the Illinois legislature passed a $500,000 limit on non-economic damages in medical malpractice cases.	The medical malpractice cap was declared unconstitutional in Best v. Taylor Machine Works, 179 Ill. 2d 367, 689 N.E.2d 1057 (1997
IN	§ 34-18-14-3	A health care provider is not liable for an amount in excess of $250,000 for an occurrence of malpractice. Damages for all providers cannot exceed $1,250,000 per occurrence of malpractice.	The cap was held to be constitutional in Johnson v. St. Vincent Hospital, 273 Ind. 374, 394-401, 404 N.E.2d 585, 598-602 (1980).
IA	None	No medical malpractice caps.	
KS	None	In 1986, Kansas enacted a statewide medical malpractice cap.	The medical malpractice cap was declared unconstitutional in Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 757 P.2d 251 (1988).
KY	None	No medical malpractice caps.	
LA	§§ 40:1299:42, 40:1299:44	The Louisiana Medical Malpractice Act established a Patient's Compensation Fund. State health care providers are automatically entitled to be covered by the fund. Private health care providers may join the fund if they file proof that they are covered by a policy of malpractice liability insurance in an amount of at least $100,000 per claim and pay the surcharge assessed by the Louisiana Insurance Rating Commission. The liability of each qualified health care provider is limited to $100,000 plus interest per patient per incident. Judgments, settlements, or binding arbitration orders in excess of $100,000 per provider are paid out of the fund. The claimant's total recovery is limited to $500,000 plus future medical costs.	The Louisiana Supreme Court has held that the limit on damages of $500,000 plus future medical costs is constitutional. Butler v. Flint Goodrich Hospital of Dillard University, 607 So. 2d 517 (La. 1992), cert. denied, 508 U.S. 909 (1993).
ME	None	No medical malpractice caps.	
MD	Cts. & Jud. Proc. § 11-108	The limit on recoverable non-economic damages for any personal injury cause of action for medical malpractice cannot exceed $500,000. Beginning October 1, 1995, and every October 1 thereafter, the limit on non-economic damages is increased by $15,000.	
MA	§ 231: 60H	In any action for malpractice, the court may not award the plaintiff more than $500,000 for pain and suffering, loss of companionship, embarrassment and other items of general damages.	
MI	§§ 600.1483, 600.6304	The total amount of damages for non-economic loss recoverable by all plaintiffs cannot exceed $280,000. Exceptions allow the court, in some circumstances, to maximize damages to no more than $500,000. The court will reduce a jury award in excess of this amount.	
MN	None	No medical malpractice caps.	
MS	§ 85-5-7	The limit for non-economic damages cannot exceed $500,000 if the claim was filed after passage of House Bill No. 2, but before 07/01/2011. Any claim filed on or after 07/01/2011, but before 07/01/2017, the amount of non-economic damages cannot exceed $750,000. For claims on or after 07/01/2017, the amount of non-economic damages cannot exceed $1,000,000.	
MO	§ 538.210 See also Missouri HB 273	In 1986, the Missouri General Assembly enacted a $350,000 per occurrence limit for non-economic damages. This limit is subject to annual adjustments by the Director of the Division of Insurance to reflect increases in the consumer price index. In 2003, the Director of Insurance set the limit for non-economic damages at $557,000.	The medical malpractice cap was declared constitutional in Adams v. Children's Mercy Hospital, 832 S.W.2d 898 (Mo.), cert. denied, 506 U.S. 991 (1992).
MT	§ 25-9-411	In a malpractice claim or claim against one or more health care providers based on a single incident of malpractice, an award for past and future damages for non-economic loss cannot exceed $250,000.	

NE	§ 44-2825	A health care provider is not liable to any patient or his or her representative for an amount in excess of $200,000. The total amount recoverable under the Nebraska Hospital-Medical Liability Act from any and all health care providers cannot exceed $1.25 million, for any occurrence after 12/31/92. No specific cap for non-economic damages.	
NV	§ 41A.031	The non-economic damages awarded for medical malpractice or dental malpractice cannot exceed $350,000. This amount can vary with an exemption for certain conditions. Exemptions to the stated limit must not exceed the amount of money remaining under a professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to that plaintiff. This limitation does not apply to damages for medical malpractice unless the defendant was covered by professional liability insurance at the time of the occurrence and on the date the insurer receives notice of the claim.	
NH	§§ 507-C:7, 508:4-d	In 1986, New Hampshire enacted a medical malpractice cap that limited total damages to $875,000.	On two occasions, the New Hampshire Supreme Court declared the medical malpractice cap unconstitutional in Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980) and Brannigan v. Usitalso, 134 N.H. 50, 587 A.2d 1232 (1991).
NJ	New Jersey Medical Malpractice Bills A3080 A2931 S2035	A $250,000 cap would limit non-economic damages, unless the plaintiff is "hemiplegic, paraplegic, or quadriplegic, the plaintiff has permanently impaired cognitive capacity rendering him incapable of independent daily living, or there has been a permanent loss of or damage to a reproductive organ resulting in the inability to procreate." In those cases the cap would be $500,000.	
NM	§ 41-5-6	Except for punitive damages and medical care and related benefits, the amount recoverable from any injury or death as a result of malpractice cannot exceed $600,000 per occurrence.	
NY	None	No medical malpractice cap.	
NC	None	No medical malpractice cap.	
ND	§ 32-42-02	For claims arising after April 1, 1995, there is a $500,000 cap on non-economic damages in medical malpractice cases. This applies regardless of the number of defendants, the number of theories, or the number of family members who sue.	
OH	Ohio Senate Bill 281 Effective 04/11/03	The cap on non-economic damages is limited to the greater of $250,000 or an amount equal to 3 times the plaintiff's economic loss up to a maximum of $500,000. Non-economic losses for permanent and substantial physical deformity are limited to the greater of $1 million or an amount equal to $15,000 times the number years remaining in the plaintiff's expected life.	
OK	None	No medical malpractice cap.	
OR	§ 18.560	In 1987, the Oregon legislature established a $500,000 cap on damages for non-economic loss in bodily injury and death cases.	The Oregon Supreme Court ruled it to be unconstitutional under most circumstances. It held that the damage cap violates the right to a jury trial provided by the state constitution whenever the cap is applied to a claim. Lakin v. Senco Products, Inc., 329 Or. 62, 987 P.2 463, 1999 WL 498088 (July 15, 1999).
PA	Act 13 - HB 1802 Approved by Gov. 03/20/02	The liability limit of the Medical Liability Catastrophe Loss Fund for each healthcare provider that conducts more than 50% of its healthcare business in Pennsylvania and for each hospital cannot exceed $700,000 per occurrence and $2.1 million per aggregate. For each participating healthcare provider, the limit of liability cannot exceed $500,000 per occurrence and $1.5 million per aggregate.	
RI	None	No medical malpractice cap.	
SC	None	No medical malpractice cap.	

SD	§ 21-3-11	In any medical malpractice action in South Dakota, the total general damages cannot exceed $500,000.	This statute formerly provided for a cap of $1,000,000 on all damages, whether economic or non-economic. The cap on all damages, however, was found to violate the state constitution. Knowles v. U.S., 544 N.W.2d 183 (S.D. 1996). The Knowles decision automatically revived the form of the statute, as it existed prior to being amended in 1985, at which time it provided for a $500,000 cap on general damages.
TN	None	No medical malpractice cap.	
TX	Tex. Rev. Civ. Stat. Ann. art. 4590i, §§ 11.02, 11.04	Texas law limits damages in a medical malpractice action for wrongful death to $500,000 (in 1977 dollars). This amount is adjusted annually for inflation, and is now approximately $1,300,000.	The statute was intended to apply to all medical malpractice cases, but has been held to be unconstitutional except with respect to wrongful death. Rose v. Doctors Hospital, 801 S.W.2d 841 (Tex. 1990).
UT	§ 78-14-7.1	In a medical malpractice action, non-economic damages cannot exceed $250,000. When indexed for inflation, the limit is $400,000.	
VT	None	No medical malpractice cap.	
VA	§ 8.01-581.15	Virginia imposes a $1,500,000 damage cap on recoveries for bodily injury or death in medical malpractice cases occurring after August 1999. Each year the cap is increased by $50,000 annually.	
WA	§ 4.56.250	In 1986, Washington enacted a statewide medical malpractice cap.	The Supreme Court of Washington held that the statutory cap on non-economic damages is an unconstitutional infringement of the right to trial by jury. Sofie v. Fireboard Corp., 112 Wash. 2d 636, 771 P.2d 711 (1989).
WV	§ 55-7B-8	In 1986, West Virginia enacted a statewide medical malpractice cap. In West Virginia the jury is instructed that the maximum it may award against a health care provider for non-economic loss is $1,000,000.	The medical malpractice cap was declared to be constitutional in Robinson v. Charleston Area Medical Center, 186 W. Va. 720, 414 S.E.2d 877 (1991).
WI	§ 893.55	Except in death cases, for any medical malpractice occurrence on or after May 25, 1995, the total limit on non-economic damages from all health care providers is $350,000. This limit is adjusted annually for inflation.	
WY	None	No medical malpractice cap.	

Source: National Association of Insurance Commissioners.

Table 36 - States That Have Enacted Patient Compensation Funds
Medical Liability Insurance

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HARD COPY SENT VIA REGULAR MAIL

January 22, 2004

Commissioner Jose Montemayor
Chair, Market Conditions Working Group
c/o Eric Nordman, CPCU, CIE
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Comments on December 3, 2003 draft of "Medical Malpractice Insurance: A Study of Market Conditions"

Dear Commissioner Montemayor:

On behalf of the American Medical Association (AMA) I am writing to provide the following comments regarding the National Association of Insurance Commissioners' Market Conditions Working Group draft report "Medical Malpractice Insurance: A Study of Market Conditions" (December 3, 2003).

The AMA applauds the Working Group for its time and effort in studying the medical liability insurance market and in preparing this report. As the national organization for insurance regulators the NAIC plays an extremely important role in this issue and it is likely this report will be an integral part of any policy discussions on medical liability reform at the state and federal level.

While this draft of the report is a good effort to deal with a complicated subject rife with conflicting opinion, as the working group continues to develop its report and study the issue, the AMA would like to offer the following suggestions to refine the report. First, medical liability reform has been the subject of an enormous amount of literature and studies written from various perspectives and motivated by widely differing agendas. As one would expect, the quality of information available on medical liability reform can vary dramatically. As the working group continues to develop its report, the AMA would encourage the group to base the report's text and recommendations on peer-reviewed economic studies firmly grounded in empirical data. Opinion-based position papers and law review articles certainly have their role in the reform debate. The AMA suggests, however, that since the basis of the report is NAIC's own economic analysis of the medical liability market, reference to position papers and law review articles to support economic theories in the "tort reform" section is misleading, particularly since it appears to give them equal weight as peer reviewed economic studies. The AMA also believes the reader would benefit from the clarification of various legal theories throughout the report and a review of the organization of the report. For example, it may benefit the reader's understanding of the various tort reforms discussed if the literature supporting these reforms is separated from the literature opposing these reforms. Finally, the AMA urges the working group to accurately state AMA's strong policy on medical liability reform in the report.

Following are the AMA's specific comments based on these concerns.

The Public Hearing on Medical Malpractice
(pg. 19) At the public hearing on medical liability reform, the AMA provided a handout to attendees titled "Medical Liability Reform Now." Like the slides used by Dr. Anderson and Jay Angoff, the AMA requests that the NAIC make this handout available on request. An electronic version of the document is attached for your convenience.

Market Analyses from Other Studies
(pg. 22) In summarizing the American Medical Association's Health Care Financial Trends Report, the factors that have driven the trend in claims severity are misstated. The Trends Report found that the "overall upward trend in premiums is attributable to the trends in claims severity and the factors that drive those trends include increases in jury awards, settlements, and the frequency of million dollar verdicts." To ensure accuracy, the AMA respectfully requests that the NAIC clarify the report based on the above.

Review of Medical Malpractice Insurance Market, 1992-2002
The major concern with this section of the report is the product market definition for medical malpractice insurance. The report provides the following implicit definition of the market: "For purposes of this report, medical liability will encompass insurance purchased by health care providers, hospitals, nursing homes and other institutions that provide health services."

There is a caveat later in the section (see page 48), "The data contains many insurers, often captive insurers that do not actively write insurance in the market. Captive insurers may write insurance for a specific group of hospitals, nursing homes or medical specialties and hence do not directly compete for market share. The data also includes insurers that may write insurance exclusively in certain markets, such as hospitals or certain medical specialties." This should be stated earlier to warn the reader that the discussion on concentration that follows uses this aggregate market definition.

While it would be difficult to apply a purely economic rule for defining the product markets, medical liability insurance for physicians and for hospitals are distinct products. If NAIC has data on direct written premiums by product line, it should be presented. Otherwise, the Herfindahl-Hirschman Indexes (HHIs) for two states that are derived from the sum of direct written premiums over these and other medical liability insurance products could be nearly equal, but the value of one may be driven by the existence of one or two large hospital insurers and the other by a few large physician insurers.

Following are specific concerns and questions regarding the data provided in this section:

In the discussion of mean insurer direct premiums and median insurer direct premium written, it is noted that "... differences between the mean and median values are important to examine in the context of market concentration. Markets tend to be more competitive when the mean and median are similar in relative terms." A comparison of the mean and median insurer written premiums does not provide information about the tails of the distribution. Is there a theoretical or empirical basis for using this difference as a measure of market concentration? How does this difference measure relate to the HHI?

The changes in the number of insurers accounts for mergers, new entries, and exits for various reasons. While the Department of Justice criteria for evaluating mergers based on the HHI (and increases in the HHI post-merger) can be used as a benchmark in evaluating market concentration in medical liability insurance markets, the repeated mention of merger guidelines, proposed horizontal merger, and post-merger markets may leave the reader with the notion that changes in

the number of insurers was a result of merger activity. Given the report provides no data on the number or size of mergers, the merger activity terminology should be used more sparingly.

Are the numbers of insurers in the tables on market concentration and premiums (e.g., Table 26 and Table 27) the count of insurers with direct written premiums, or do they include insurers who are licensed, but not providing coverage? Likewise, do the mean premium written and median premium written figures include only insurers with direct written premiums? In the introduction to this section and in the discussion of losses (see footnotes 36 and 37) there are slightly different definitions of "insurer."

In the discussion of the HHI, number of insurers and the size of state population, in Table 26 and Table 27, it is stated that "there is an approximately inverse correlation between the numbers of insurers writing premium in a market with the concentration of business they write." and "It also appears, from the data, that states with smaller populations have a more concentrated market than states with larger populations." What are the correlations between these variables?

The discussion in the section "Entry and Exit Conditions" confuses the cost of doing business with barriers that new insurers face in entering a market that established firms either did not face upon entry, or do not currently face.

- For example"...there must be at least a dollar of surplus for every dollar of premium volume a new insurer intends to write. This raises the financial requirement considerably for a new insurer intending to acquire a significant market share in a large state." But an incumbent insurer also needs a surplus to expand.

- There is reference to "non-monetary barriers" which are actually monetary cost, not barriers to entry: "In addition, there are non-monetary barriers to entering the medical malpractice market." The list that follows leads the reader to believe that these are barriers to entry that incumbent insurers impose on new entrants. In most cases these "non-monetary barriers" are costs of doing business. They generally do not differ between incumbents and new insurers (e.g., regulatory constraint). If they do differ and result in a short-term differential cost advantage, it is not a barrier to entry (e.g., lack of specialty market experience and lack of locally knowledgeable staff).

Survey of Market Interventions

Tort Reform

The AMA believes the current medical liability crisis which is threatening access to health care in 19 states is driven by increases in jury awards, which jumped 176 percent from 1994 to 2001, with the median jury award now topping $1 million. These sharp increases have in turn increased premiums for medical liability insurance. To stabilize the market, the legal system must be reformed and the only proven reform is California's Medical Injury and Compensation Reform Act or MICRA, which has proven effective for almost thirty years in stabilizing the medical liability market in California. The cornerstone of MICRA and a key element for any medical liability reform package is a reasonable cap on non-economic damages. Following are our specific comments on the various elements of tort reform discussed in the report.

(pg. 61) The report cites the AMA's Health Care Financial Trends Report on medical professional liability insurance as stating that the AMA offers three policy options on tort reforms. In fact, the Trends Report "highlights" these as policy options. We believe this reference minimizes the AMA's strong policy on medical liability reform as adopted by the AMA's House of Delegates.

It is the policy of the AMA that effective medical liability reform must be based on the California Medical Injury and Compensation Reform Act (MICRA) model, including a $250,000 cap on non-economic damages, offset of collateral sources of plaintiff compensation, decreasing incremental or sliding scale attorney contingency fees, periodic payment of future damages, and limiting the time period for suspending a minor's statute of limitations to no more than six years after birth. (H-435.967) For the working group's convenience, a copy of the AMA's policy is attached. **The AMA respectfully requests that our policy is accurately stated in the report.**

(pg. 61) The AMA cautions the NAIC against citing Hunter and Doroshow's article *Premium Deceit* because this article relies on flawed analysis to support their conclusions. For example, to gauge the average premium paid by physicians in California versus other states, the authors used flawed methodology by including premiums paid by all types of health care providers, not just physicians, in the numerator, and overstating the number of physicians who purchase medical liability insurance by including retired physicians, physicians who teach, physicians who conduct research, and physicians in the military – all of whom do not purchase medical liability insurance – in the denominator. Using NAIC's own data, it's clear that since 1976 medical liability premiums in California have grown slower (182%) than the rest of the nation (569%).

(pg. 63) While the NAIC draft report summarized the conclusions of the 1986 GAO Report, *Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms*, finding that some states found their reforms had been effective while other states did not, the NAIC report does not specify which states fell into the two categories – a critical point to understanding effective reforms. The GAO report stated that reforms enacted in California and Indiana had helped to moderate upward trends in the cost of insurance and the average amount paid per claim, while those in Arkansas, Florida, New York and North Carolina had little effect. This distinction is critical since California and Indiana were the only states of the six that enacted **effective** caps on damages as part of their package of medical liability reforms. To enhance the accuracy of the report, the AMA encourages the NAIC to provide this detail in their report.

Damage Limitations, Caps

A reasonable cap on non-economic damages is the single most important element of any liability reform package. At least 20 states have laws that limit awards for non-economic damages in medical liability causes of action. Another six states cap total damages. The amount and structure of the cap varies dramatically among the states. For example, some states place a hard cap on non-economic damages, while others have a cap that is subject to exceptions for certain types of injuries or increases annually for inflation. **The AMA encourages the NAIC to include these distinctions in this section of the report because as the structure of the cap varies among the states, so does its effectiveness. We believe the available empirical evidence shows that only a $250,000 hard cap on non-economic damages – like California's that is neither subject to exceptions or inflationary increases – is effective in controlling medical liability premiums.**

The effectiveness of a reasonable cap on non-economic damages is further confirmed by studies published in peer-reviewed journals and research conducted by various governmental agencies, which show that caps are effective in reducing claims payments, stabilizing medical liability premiums, reducing overall health care costs, and ensuring patients have access to health care. These sources of information offer the best evidence that caps work because they consider, and rule out, other competing explanations. While some of these studies are mentioned in the report, the report does not include references to some of the leading peer reviewed studies on the effectiveness of caps on damages. For example, the report does not include a reference to Kessler

and McClellan's 1997 study, which found that direct reforms (which include caps on non-economic damages) reduced the likelihood that a physician will be sued by 2.1% and within three years reduced premiums by 8.4% compared to states without direct reforms. *Kessler, Daniel P. and Mark. B. McClellan. "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care." Law and Contemporary Problems 60 (Winter 1997): 81-106.* While the NAIC report cites one study by Sloan, it does not reference another Sloan study which after examining a large set of closed claims, found that caps on non-economic damages reduced insurer payouts by 31% and reduced payouts-plus-expenses by 23%. *Sloan, Frank A., Paul M. Mergenhagen, and Randall R. Bovbjerg. "Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: a Microanalysis." Journal of Health Politics, Policy and Law 14 (Winter 1989): 663-66?* Finally, looking at the impact of MICRA style reforms specifically, LECG, Inc. concluded that caps on non-economic damages had reduced the average size of large malpractice claims, though average claim size had increased. In addition, the data examined suggested that MICRA had not inhibited the filing of claims (claim frequency was substantially unchanged). *LECG, Inc, "California's MICRA Reforms: How Would a Higher Cap on Non-Economic Damages Affect the Cost and Access to Health Care?" Fall 1998.* The AMA recommends that the NAIC include these leading studies in the report. The AMA also strongly encourages the working group to include a recommendation in the final report supporting a reasonable cap on non-economic damages as the single most important element of a medical liability reform package.

To strengthen this section of the report, the AMA offers the following specific comments on the "Damage Limitations, Caps" section:

(pg. 9, 65, 74, 80) Throughout the report references are made regarding damages awarded to compensate individuals for medical error. Damages are awarded in a medical liability cause of action based on a finding of medical *negligence* not medical *error*. A defendant is liable for negligence in a medical liability cause of action when conduct falling below the applicable standard of care is found to have caused the plaintiff's injury.

(pg. 65) The NAIC report inaccurately states that punitive damages are included in some cases as part of an award for non-economic damages. Punitive damages are awarded separately from non-economic damages and are based on a different legal standard. Unlike non-economic damages, punitive damages are generally awarded where the defendant is found to have *intentionally* inflicted harm on the patient or acted with gross negligence. The purpose of awarding punitive damages is to punish the defendant. By contrast, non-economic damages are awarded to compensate the plaintiff.

(pg. 65) The AMA offers the following suggestions to Table 35. We believe these changes are necessary to ensure the chart has the most recent information and to accurately distinguish between the various state laws limiting non-economic damages.

> Florida – In 2003 the Florida legislature enacted a new cap on non-economic damages. The cap provision in the chart should be replaced with the following information:
> For physicians $500,000 cap on non-economic damages per claimant with any one physician not responsible for more than $500,000. For nonpractitioners, $750,000 cap on non-economic damages. The cap increases to $1 million in non-economic damages for physicians if (1) the negligence resulted in death or a permanent vegetative state, or (2) if the court finds that a manifest injustice would occur unless the non-economic

damages cap was increased because the non-economic harm sustained by the patient was particularly severe and the defendant's negligence caused a *catastrophic injury* to the patient.

Idaho –In 2003 the legislature enacted a new cap on non-economic damages. The cap provision in the chart should be replaced with the following information:
$250,000 cap on non-economic damages per claimant in personal injury and wrongful death actions. (Idaho had a previous $400,000 cap that was adjusted annually since 1988).
The cap will be adjusted annually beginning July 1, 2004 based on the average annual wage.
The limit does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions.

Previous cap upheld as constitutional in *Kirkland v. Blaine County Medical Center,* 134 Idaho 464, 4 P.3d 115 (Idaho, 2000).

Indiana – Any amount awarded over $250,000 will be paid through the patient compensation fund. For consistency, the drafters may consider including the same explanation of the patient compensation fund as provided in Louisiana's description.

Kansas – Subsequent to the *Kansas Malpractice Victims* case, Kansas' legislature enacted a $250,000 cap on non-economic damages recoverable by each party from all of the defendants. This statute was upheld as constitutional in *Samsel v. Wheeler Transport Services, Inc.*, 246 Kan. 336 (1990).

Kentucky – Constitution prohibits caps on damages

Maryland – The judge may award up to 150% of the limit.

Massachusetts – The cap does not apply if there is proof of substantial disfigurement, permanent loss or impairment, or other special circumstances that warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained.

Michigan – The cap is adjusted annually for inflation. The cap was also upheld in *Zdrojewski v. Murphy*, 202 Mich. App. Lexis 1565 (2002).

Missouri - In *Scott v. SSM Healthcare*, the court held Missouri's cap can be applied separately for each act of malpractice. Therefore, if there are two separate and distinct "occurrences" of malpractice that contribute to a single injury the court can apply a separate cap for each occurrence even if they are applied to a single defendant. *Scott v. SSM Healthcare*, 70 SW 3d 530 (Ct. App. 2002).

Nebraska - In 2003, the Nebraska legislature increased the total cap to $1.75 million. The cap applies to health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability

insurance and pay surcharge into excess coverage fund). Qualified providers shall not be liable for more than $200,000 in total damages with any excess damages paid from the excess coverage fund.

Nevada - the $350,000 cap applies to each defendant.

New Jersey – Since this chart focuses on state laws on non-economic damages, we suggest deleting the reference to these bills from the chart because they have not yet been enacted.

New Mexico – For consistency should specify that qualified health care providers are not liable for more than $200,000 with any award in excess paid for through the patient compensation fund.

Ohio – The explanation of Ohio's law should be clarified. The cap on non-economic damages is limited to the greater of $250,000 or an amount equal to three times the plaintiff's economic loss up to a maximum of $350,000 for each plaintiff or $500,000 if there are multiple plaintiffs. Non-economic losses for permanent and substantial physical deformity or a permanent physical functional injury is limited to $500,000 per plaintiff or $1 million for multiple plaintiffs.

Pennsylvania – The limits described in the chart are not a cap on non-economic damages. Rather this is the maximum amount Pennsylvania's MCARE fund, a patient compensation fund, will be liable for in damages. Therefore, this should be deleted from the chart.

Texas – Legislature enacted a new cap in 2003. Under the new cap, judgments against physicians and health care providers are limited to $250,000 in noneconomic damages; a separate cap of $250,000 in noneconomic damages applies to a judgment against a single health care institution; a judgment made on any subsequent health care institution is also limited to $250,000 in noneconomic damages with not more than a total $500,000 judgment against all health care institutions.

Utah – This cap provision is misstated in the chart. For causes of action arising on or after July 1, 2001 but before July 1, 2002, non-economic damages are limited to $250,000. For causes of action arising on or after July 1, 2002, the cap increases to $400,000. Thereafter, the cap will be adjusted annually for inflation.

West Virginia – Legislature enacted new cap in 2003. The new law provides a $250,000 cap on noneconomic damages per occurrence. The cap increases to $500,000 for cases involving (1) wrongful death, (2) permanent and substantial physical deformity, loss of use of limb or loss of a bodily organ system, or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. Cap is adjusted annually for inflation, but the $250,000 cap shall not exceed $375,000 and the $500,000 cap shall not exceed $750,000.

Wyoming – Constitution prohibits caps on damages.

(pg. 65) In the second paragraph, the NAIC report describes the differences in application among states with a total cap on damages. The AMA working group should include a similar sentence describing the differences among states with a cap on non-economic damages because these variations can have a dramatic impact on the cap's effectiveness. For example, California has a hard cap with no exceptions and no adjustments for inflation or other factors. By contrast, some states have exceptions for certain injuries, apply the cap to each defendant, or increase the cap annually based on inflation or another factor, all of which weaken the cap's effectiveness.

(pg. 68) While the GAO report states that due to data limitations it is not possible to quantify the impact of a cap on non-economic damages on insurers' losses, the report goes on to state that "[m]ultiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Such losses are by far the largest component of insurer costs, and in the long run, premium rates are set at a level designed to cover anticipated costs." The AMA believes this information should be included in the report.

(pg 68) The AMA believes the reference to Ross (30 Ind. L. Rev. 594) should be deleted. While everyone is entitled to their opinion, Ross' opinion as cited in the report has been invalidated by several state supreme courts which have upheld state laws that place limits on damages, finding that these laws did not violate the equal protection clause of the state or federal constitution. Courts have also upheld state laws placing caps on damages based on the due process clause, right to a trial by jury, open court doctrine, and intrusion on the rulemaking power of the legislative branch. In addition, Ross' statement that caps on damages are "unlikely to effectuate their intended purpose of lowering malpractice insurance premiums and health care costs" is based purely on opinion without any supporting data. Including this reference among references to peer reviewed economic literature is highly misleading.

Collateral Source Rules

(pg. 69-70) The AMA believes collateral source reform is an integral part of a medical liability reform package because it eliminates double recoveries. However, the description of the collateral source rule in the report is a bit confusing because the term "collateral source rule" is also used to describe collateral source reform. The collateral source rule is a common law evidentiary rule which prohibits information concerning payments made to the plaintiff from collateral sources, such as health insurance or disability insurance, from being submitted as evidence. Over thirty states have enacted collateral source reform laws to eviscerate this rule, allowing such information to be submitted to the judge or jury for consideration in awarding damages. In many states the law simply allows the information on payments made by collateral sources to be admitted as evidence. Other states also allow the plaintiff to submit evidence of payments made on his or her behalf to secure such benefits, such as health insurance deductibles or co-payments. Finally, some states require the judge or jury to decrease the award based on payments received from collateral sources. California's MICRA law simply allows information on payments made by collateral sources to be admitted as evidence for consideration by the jury.

In addition, the discussion of subrogation is confusing. Most insurers, including health insurers, include a subrogation clause in their contract which allows the insurer to place a lien on any judgment or damage award received by the plaintiff where a third party caused harm. A well crafted collateral source reform law would prohibit a health or disability insurer from invoking this subrogation clause to take money from the plaintiff's award, thereby eliminating the possible "double reduction" of a plaintiff's award that would occur if the judge or jury reduced a

plaintiff's judgment based on payments made from collateral sources and did not limit subrogation. In this scenario, the collateral benefit provider could place a lien on the already reduced award to recover their payments from the plaintiff, resulting in a double reduction. Not limiting subrogation primarily benefits health plans and other health care insurers at the expense of injured patients, physicians, hospitals, other health care professionals, and medical liability insurers.

The AMA would encourage the working group to incorporate this distinction into the report to facilitate understanding of a complicated issue and to take this into consideration when drafting the group's recommendations. In addition, the AMA encourages the working group to include a recommendation in the final report supporting collateral source reform

Periodic Payment of Future Damages
The AMA believes that periodic payment of future damages is a key element of any medical liability reform package because it ensures the plaintiff has money available when he or she needs it and allows an insurer to more accurately estimate future losses. The AMA encourages the working group to include a recommendation in the final report supporting periodic payment of future damages.

Contingency Fee Limitation
Many people realize that in addition to paying up to 50% of his/her award in contingency fees, all court costs, expert witness fees, deposition costs, and other expenses must also be paid out of the plaintiff's judgment. Thus, a large percentage of any award is never actually received by the plaintiff. The AMA believes that placing limits on contingency fees is crucial to any liability reform package, because it allows patients to receive a greater portion of any recovery. The AMA encourages the working group to include a recommendation in the final report supporting limits on attorney contingency fees.

To strengthen this section of the report, the AMA makes the following recommendations:

(pg. 77) The AMA encourages the NAIC to make the distinction between attorney contingency fees and other costs associated with a trial. A successful plaintiff is typically financially responsible for court costs, expert witness fees, deposition costs, etc. in addition to attorney fees. These costs can eat up a substantial part of a plaintiff's recovery.

(pg. 79) The AMA believes the references to Public Citizen's paper *Medical Misdiagnosis* in the NAIC report is misleading because many claims asserted in *Medical Misdiagnosis* have no supporting data and in fact are contrary to findings based on independent peer reviewed data. The AMA, therefore, respectfully requests references to Public Citizen's *Medical Misdiagnosis* be deleted from the report.

(pg. 79) The reference to McMullen's quote on mediation would be more useful for the reader if it were placed in the section on Alternative Dispute Resolution mechanisms.

(pg. 79-80) The AMA believes the reference to Reames (62 Chi. Kent L. Rev. 271) should be deleted because it is based purely on the author's opinion and misrepresents California law. California's Supreme Court repudiated this type of argument made by Reames in *Roa v. Lodi Medical Group, Inc.*, 37 Cal. 3d 920 (1985). In *Roa* the court upheld the statute placing a limit on attorney contingency fees as constitutional because it is rationally related to the legitimate state purpose of reducing medical malpractice premiums. Furthermore, Reames statement that "[w]ithout a qualified attorney, a malpractice victim's right to petition for redress is a nullity" is

inaccurate. Limiting attorney contingency fees does not prohibit an individual from his/her day in court. Since fee limitations are structured progressively, typical contingent fee amounts do not begin to see limitations until the plaintiff's award reaches a significant threshold. Based on the foregoing, the AMA respectfully requests that the reference to Reames article be deleted from the report.

Legislative Strategy Regarding Bad Faith
The report fails to provide any details on how the NAIC is considering changes to laws regarding bad faith. It is difficult, therefore, to comment on this section. Yet, the AMA cautions that changes to bad faith laws may fail to address the systemic problem identified by the GAO as causing the medical liability crisis – an increase in jury awards driven by our out-of-control litigation system.

Alternative Dispute Resolution and Mediation
While ADR mechanisms may streamline the litigation process, if not structured properly they could also prolong the process by creating one more hurdle for the parties involved. This could in turn increase everyone's expenses and waste valuable time. The effectiveness of ADR is also dependent on the existence of other tort reform measures that address the root of the problem – high jury awards. Prior to making any recommendations on ADR, the AMA encourages the working group to review state efforts to use ADR mechanisms to resolve medical liability cases.

Special Courts
The use of special courts has proven effective in other areas of the law, such as workers compensation. The AMA has developed suggestions for a fault-based administrative system for resolving medical liability disputes and encourages the development of a state based demonstration project to implement this system. (see AMA report attached) Readers may find reference to the AMA's suggestions helpful.

Patient Compensation Fund
Patient compensation funds for all types of injuries have been enacted in nine states, including Indiana, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, and Wisconsin. Most of these funds were implemented during the medical liability crises in the 1970s or early 1980s and have experienced varying degrees of success in stabilizing the medical liability insurance markets in their states. In all states with a patient compensation fund, except New York, the fund is financed exclusively by surcharges on health care providers. Therefore, without a meaningful cap in place, the fund may not reduce the overall cost of medical liability insurance. Rather it will simply shift costs from the traditional insurer to the patient compensation fund. The AMA believes that evidence demonstrates that a patient compensation fund will be successful in stabilizing a medical liability market only if it is coupled with an effective damage cap. The AMA encourages the working group to compare funds in various states, including Indiana, Louisiana, and Pennsylvania before deciding whether patient compensation funds should be recommended as a viable tort reform measure.

Alternative Treatment of Trauma Centers and High Risk Specialties
Since the late 80s, Florida and Virginia have had an alternative mechanism to compensate patients who have suffered a serious birth related neurological injury in place, however, neither of these mechanisms have been effective in stabilizing the medical liability market. More recently Nevada and Oklahoma enacted reforms aimed at specialties. In 2002, Nevada's legislature enacted a separate $50,000 cap on civil damages for care related to a trauma injury. In 2003 Oklahoma's legislature enacted a $300,000 cap on non-economic damages in cases involving pregnancy, labor and delivery, or care provided immediately post-partum. Despite passage of

these reforms, medical liability carriers are continuing to flee both of these states. Furthermore, one must question whether addressing the symptom in some specialties will only exacerbate the problem in other specialties. The AMA encourages the NAIC to carefully review these state experiences before making any recommendation as to the effectiveness of this approach.

Patient Safety Measures and Data Reporting Issues
The AMA applauds the NAIC for including a section on patient safety measures. As discussed in the report, the AMA is committed to promoting a meaningful long-term approach to ensuring greater patient safety in the delivery of health care in our nation. (H-335.965). The AMA encourages the NAIC to include a recommendation supporting a confidential non-punitive error reporting mechanism using the federal Aviation Safety Risk Analysis Program as a guide.

Finally while it is not specifically addressed in the report, the AMA would again like to encourage the NAIC to support a recommendation that reforms should be aimed at the state and federal level. While the AMA has always been and will continue to be a strong supporter of states' rights, the current crisis is a national problem in at least 45 states, including 19 states identified by the AMA as in crisis and an additional 26 states showing clear danger signs of joining them. It is clear this is a national problem that requires a national solution. That said, the AMA will not support any federal effort that would undermine effective tort reform enacted in the states.

On behalf of the AMA, thank you for your consideration of our comments on the latest draft of the report. We look forward to discussing them with you at the next working group meeting. In the meantime, please do not hesitate to contact me directly at (312) 464-5033 if you have any questions or would like additional information on any concerns raised in the letter.

Sincerely,

Kimberly Horvath, JD

cc: Eric Nordman, CPCU, CIE
David Cermak

Enclosure