Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
Indiana	Upheld	Johnson v. St. Vincent Hospital, 404 N.E.2d 585 (1980).	*Upheld the Indiana Medical Malpractice Act as constitutional. In particular, found that the cap on total damages does not violate the state or federal due process clauses, equal protection clause, or right to a jury trial.*
Kansas	Upheld	Samsel v. Wheeler Transport Services, Inc., 246 Kan. 336 (1990).	Cap on non-economic damages provided in the 1988 law does not violate due process or right to trial. Disapproved on other grounds. Differentiated *Kansas Malpractice Victims* which overturned 1987 law capping non-economic damages.
Louisiana	Upheld caps on total damages, but future medical expenses are excluded from cap	Butler v. Flint Goodrich Hospital of Dillard University, 607 So. 2d 517(1992).	Cap on damages does not violate due process or equal protection clauses because it is not arbitrary, capricious, or unreasonable.
Maryland	Upheld	Murphy v. Edmunds, 325 MD 342, 601 A.2d 102 (1992).	Cap is constitutional because it is rationally related to a legitimate governmental interest and does not restrict access to the courts.
Michigan	Upheld	Zdrojewski v. Murphy, 202 Mich. App. Lexis 1566 (2002).	Cap is constitutional because the legislature has the right to modify common law and statutory rights and remedies. Also, the jury still determines the facts and amount of damages so the right to trial by jury is not violated.
Minnesota	*Upheld* ***Note: Statute repealed.***	*Schweich, et. al. v. Ziegler, 463 N.W.2d 722 (Minn. 1990).*	*Cap does not violate state constitution because it achieves a legitimate legislative purpose of lowering insurance rates and providing predictable damage awards.*
Missouri	Upheld	Adams v. Children's Mercy Hospital, 848 S.W. 2d 535 (1993).	Statute does not violate equal protection, open courts doctrine, or right to jury trial. Statute is related to a legitimate state interest - medical malpractice insurance crisis.
Nebraska	Upheld	Prendergast v. Nelson, 256 N.W.2d 657 (1977).	Upheld the constitutionally of a state medical liability statute, holding that defendant failed to rebut the presumption of the statue's constitutionality.
	Upheld	*Gourley ex. rel Gourley v. Nebraska Methodist Health System Inc., 265 Neb. 918, 633 N.W.2d 43 (Neb. 2003).*	*Cap on total damages does not violate the state constitution's equal protection clause, right to jury trial, open courts doctrine, separation of powers, or principles prohibiting special legislation.*

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
New Hampshire	Struck down $875,000 cap *Struck down $250,000 cap*	Brannigan v. Usitalo, 587 A.2d 1232 (N.H. 1991). *Carson v. Maurer, 425 A.2d 825 (NH 1980).*	Cap violated equal protection. The purpose of the legislation did not outweigh the rights of individuals. *Cap violated state equal protection clause.*
New Mexico	*Upheld*	*Fed. Express Corp. v. United States, 228 F. Supp. 2d 1267 (NM 2002).*	*Cap is not arbitrary and capricious and does not violate equal protection clause in state constitution because it is rationally related to a legitimate legislative goal of ensuring a source of recovery for victims of medical malpractice and curbing runaway costs of healthcare.*
North Dakota	Struck down **Note: N.D. Cent. Code §32.42-02 enacted in 1995 established $500,000 cap on total non-economic damages**	Arneson v. Olson, 270 N.W. 2d (N.D. 1978).	The cap constituted an unconstitutional deprivation of the right to a jury trial under N.D. Const. § 7. Found entire statute unconstitutional.
Ohio	Struck down (see below) ***Note: New law enacted in 2002***	State v. Ohio Academy of Trial Lawyers v. Sheward, 86 Ohio 3d 451, 715 N.E. 2d (1999).	*Court overturned caps as a violation of the due process clause. Court also found the entire bill unconstitutional as a violation of the one subject rule and separation of powers clause.*
Oregon	Struck down	Lakin v. Senco Products, Inc. 329 OR 62, 987 P.2d 463, (1999).	Court overturned cap as a violation of the right to a jury trial which is customary under common law.
South Dakota	*Struck down cap on total damages, revived cap on non-economic damages*	*Knowles ex. rel. Knowles v. United States, 544 N.W. 2d 183 (SD 1996).*	*Cap on total damages held unconstitutional as a violation of the right to a trial by jury because the amount of damages is a factual issues to be decided by a jury. The cap also violated the open courts doctrine by limiting a provider's liability and the due process clause because it created an arbitrary classification of claimants in a malpractice action.*

Constitutional Challenges to State Non-economic Damages Caps Caselaw

October, 2003

STATE	CAPS	CASELAW	RATIONALE
Texas	Struck down	Lucas v. United States, 757 S.W. 2d 687 (1988).	*Court found cap unconstitutional as applied to common law medical malpractice cases. The court held the cap violated the open courts doctrine because such limits are an unreasonable and arbitrary way to assure a rational relationship between actual damages and amounts awarded.*
	Upheld cap in wrongful death ***Note: New law enacted in 2003***	Rose V. Doctors Hospital, 801 S.W. 2d 841 (1990). (Wrongful death case)	*Upheld cap as applied to wrongful death cases. Court held cap does not violate open courts doctrine or state or federal equal protection clauses.*
Virginia	*Upheld*	*Etheridge, et. al. v. Medical Center Hospitals, 237 Va. 87, 376 S.E. 2d 525 (Va. 1989).*	*The cap is constitutional. It does not infringe on a right to a trial by jury because once the jury determines the facts, the court merely applies the law to the facts. Cap also does not violate the procedural due process, substantive due process clauses, separation of powers clause, or the prohibition against special legislation. The court also held the statute does not violate the equal protection clause of the U.S. constitution.*
Washington	Struck down	Sofie v. Fibreboard Corp. 112 N.W. 2d 636,771 P.2d. 711 (1989).	Court held that cap is an unconstitutional infringement of the right to trial by jury.
West Virginia	Upheld previous cap on non-economic damages	Robinson v. Charleston Area Med. Center, 186 W.Va. 720 (1991).	Upheld constitutionality of cap against challenge of equal protection, special legislation, due process and right to a jury trial. The legislation provides an alternative legal remedy. The purpose of the law is to curtail/eliminate a social/economic problem – exorbitant medical malpractice insurance premiums. The cap on non-economic damages applies to the aggregate claims of all plaintiffs.
	Upheld previous cap on non-economic damages ***Note: new law enacted in 2003***	*Verba v. Ghaphery 552 S.E. 2d 406 (W.Va. 2001).*	*Affirmed Robinson and rejected appellant's claim that cap is invalid because of inflationary erosion and that attorney fees and costs should be awarded in cases where non-economic damages exceed the statutory cap.*
Wisconsin	Upheld	Guzman v. St. Francis Hospital, 240 Wis. 2d 559, 623 N.W. 2d 776 (2000).	The cap does not infringe on the right to a jury trial because the right to trial is not affected and the legislature can set amount of recovery. *Cap also does not violate the access to courts doctrine or the separation of powers, equal protection, or substantive due process clauses.*

Constitutional Challenges to State Non-economic Damages Caps Caselaw
October, 2003

Deleted reference to Montana case, Linder v. Smith, 629 P.2d 1187 (Mont. 1981) because the case concerned only Montana's Medical Legal Panel Act, not the cap on non-economic damages.

Deleted reference to Georgia case, Denton v. Con-Way Southern Express, Inc. 402 S.E.2d 269 (1991) because the case concerned the constitutionality of collateral source reform.

MIEC GROUP

NOV 14 20

Medical Insurance Exchange of California
Claremont Liability Insurance Company
Medical Underwriters of California
management company

Memo

Date: November 11, 2003

To: MIEC Board of Governors & Committee members
MUC Board of Directors
Dave Willett; Tim Shannon; Don Steffen; Ron Kozlowski; Tom Hermes; Lauren Kielian; Jim King; Vicki Nicely; Diane Major; Judy Huerta

From: Ron Neupauer Ron

Re: Medical Liability Monitor 2003 Rate survey

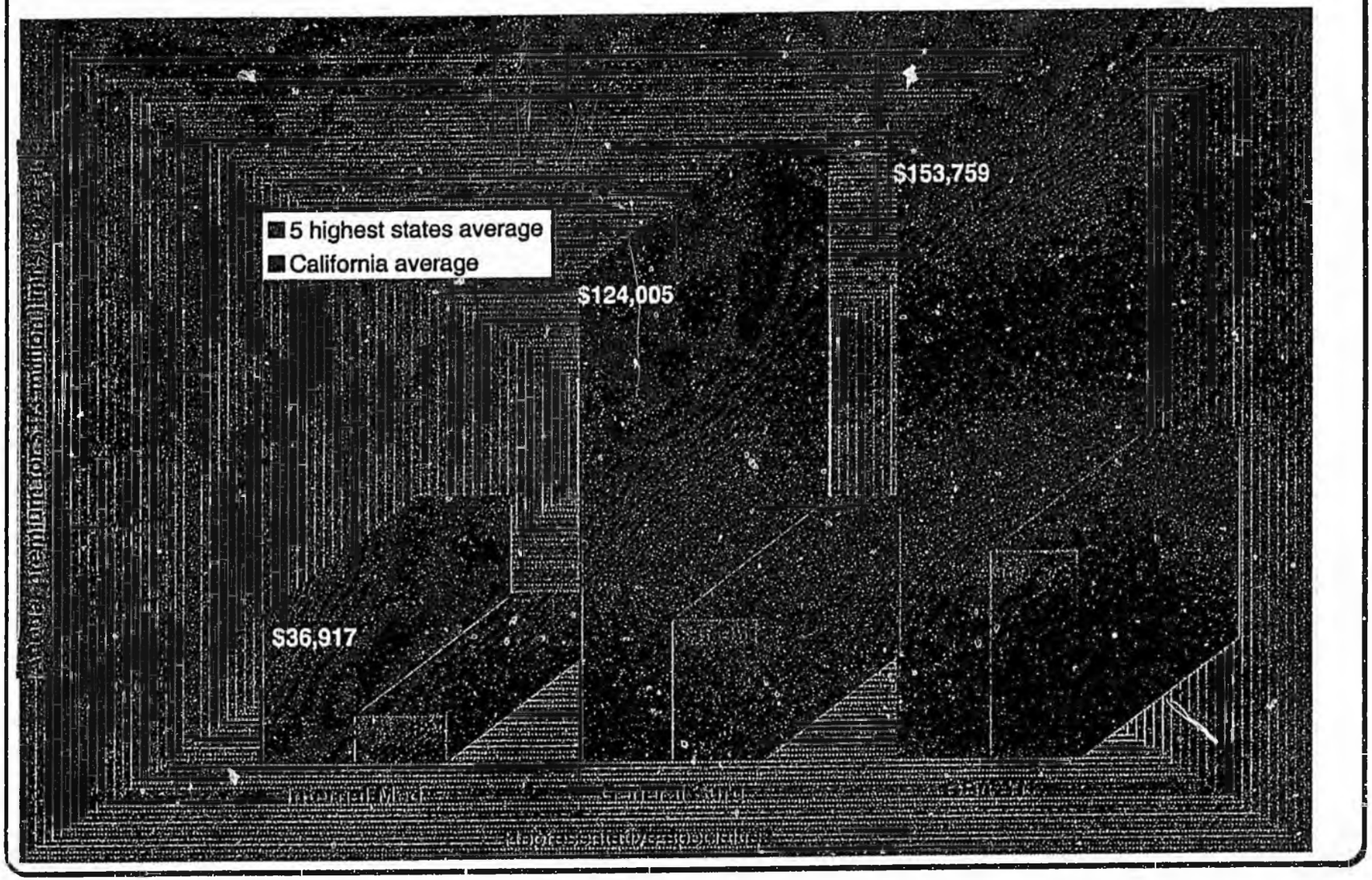
Each year, Medical Liability Monitor asks leading medical liability insurers in each state to supply current malpractice insurance rate information for three representative medical specialties: Internal medicine, general surgery, and ob/gyn. They are asked to give rates for $1/3 million limits, mature claims made coverage, or the nearest equivalent. Some states use mandated Patient Compensation Funds to provide excess coverage. The comparisons factor in the cost of these funds.

Medical Liability Monitor includes comments on trends. Here are some quotes from this year's issue:

- Of the 641 rate changes reported, 196 were increases of between 25 to 69 percent, and 15 were increases of 70% or more.
- Doctor-owned companies in Illinois, Washington, Mississippi, Pennsylvania and Missouri have stopped accepting new business due to capital constraints.
- Doctors are restricting their practice, buying lower limits of coverage and looking to start up alternative means of funding malpractice risk to escape the higher premiums.
- 83% of the survey respondents predict additional large rate increases will be needed in the future.
- California rates are significantly lower than other states with similar population demographics. To illustrate this, we converted the data for each specialty to a series of bar graphs depicting average premium by state, from the most expensive to least. We divided California into Northern and Southern due to the considerable disparity in rates between the territories. Attached is the result for ob/gyn. On the reverse side is a second bar graph showing the difference between average California (entire state) rates and those of the five highest states. The differential in the three representative specialties has grown to 3:1. The only reasonable conclusion that can be drawn by this is that MICRA has kept California rates at levels dramatically lower than they would be absent these tort reforms. No other populous state has anything like MICRA, and we can offer no plausible explanation other than MICRA for this huge rate disparity.

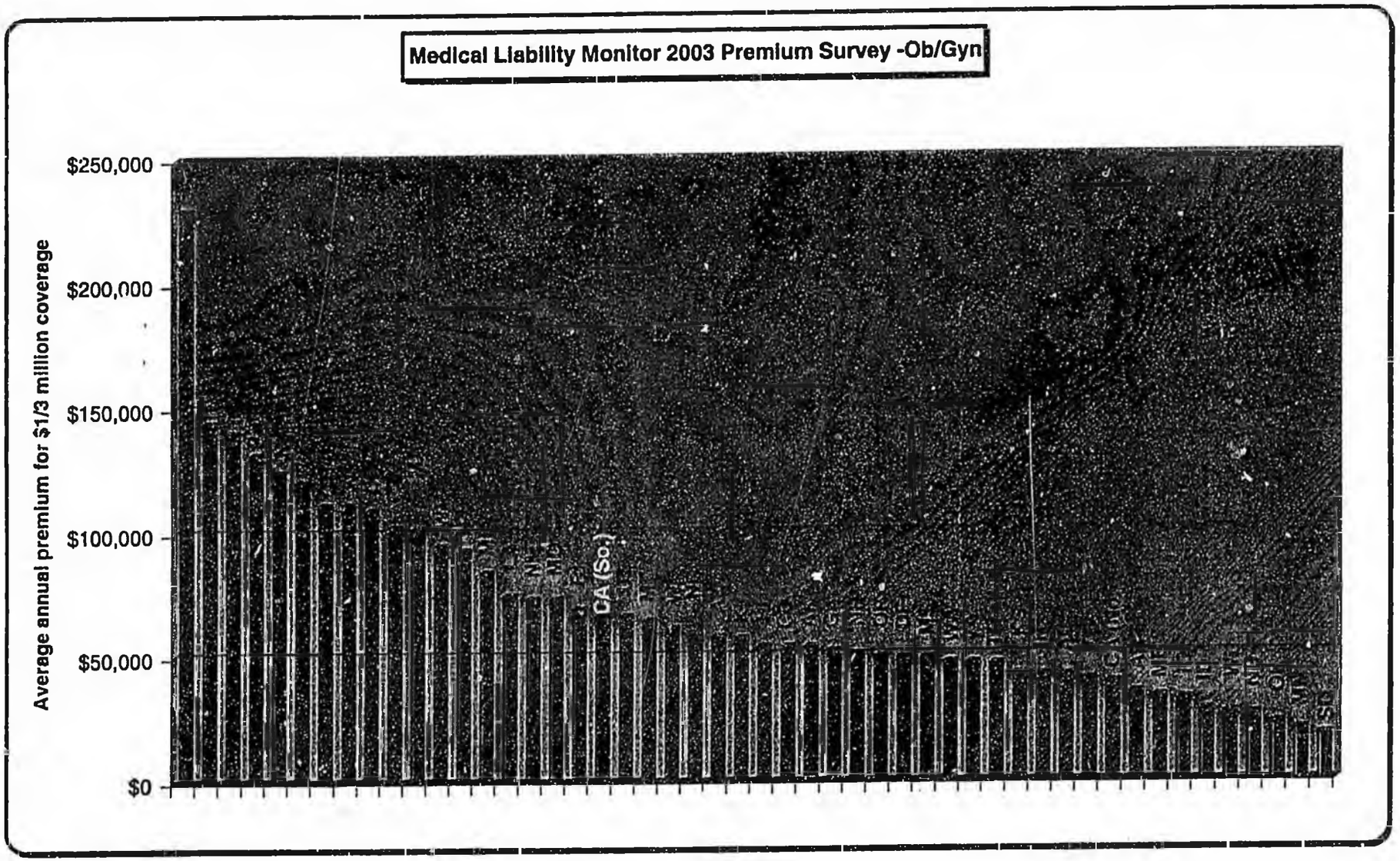
Please let me know if you have questions or comments about this survey.

Physician owned insurers malpractice premium comparison - 2003



summaries Chart 1025

11/11/03


Medical Liability Monitor 2003 Premium Survey -Ob/Gyn
Average annual premium for $1/3 million coverage
$250,000
$200,000
$150,000
$100,000
$50,000
$0
CA (So.)

Date: September 23, 2003

Media Contact: Chuck Moran
Pennsylvania Medical Society
(717) 558-7820

For Immediate Release

New Study Validates Caps on Non-Economic Damages as Critical Lawsuit Abuse Reform

Milliman USA study proves caps work

(Harrisburg, Pa.) - A cap of $250,000 on non-economic damages would reduce combined losses and defense costs for liability insurance policies by about 18 percent says a new report released today.

That's the conclusion by Milliman USA, Inc., after investigating the impact of limits on non-economic damage awards in Pennsylvania.

According to the study, with caps the level of losses to the state's Mcare fund would be projected to decrease by 42 percent.

In calculating its findings, Milliman USA used data from the National Practitioner Data Bank, as well as state insurance departments. The report notes that in Florida more than 75 percent of paid losses are for non-economic damages, while in Texas, 60 percent of paid losses are for non-economic damages.

"Caps on non-economic damages are widely viewed as the most effective reform measures to help control escalating medical malpractice costs," the study's report reads.

The study further concluded that while tort reforms directly affect verdicts, settlements would also be impacted.

"Lawsuit abuse is causing patients to lose access to care," said Edward H. Dench Jr., MD, president of the Pennsylvania Medical Society. "Key reforms are needed if Pennsylvanians are to maintain access to quality health care services."

The Pennsylvania Medical Society has been working to enhance the patient-doctor relationship since 1848. With member physicians throughout the commonwealth, as well as a statewide Patient Advisory Board, the Medical Society addresses concerns of both patients and doctors to improve the delivery of health care services.

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Milliman USA
Consultants and Actuaries

Contact :
Laura Rzasa, Donley Communications
(212) 751-6126, lrzasa@donleycomm.com

MILLIMAN USA ANALYSIS SEES SAVINGS FOR PROFESSIONAL MEDICAL MALPRACTICE COSTS

Examines Large States Using Caps on Non-Economic Damages

NEW YORK, April 8, 2003: A Milliman USA analysis of medical malpractice claims in the 15 largest states from late 1990 to early 2001 shows wide differences in medical malpractice loss costs by state for physicians, and these differences correlate to whether or not the state has enacted caps on non-economic damages. The study demonstrates that the large states with caps on non-economic damages have below-average medical malpractice loss costs for physicians. Conversely, the large states without caps have the highest medical malpractice costs.

"The data indicate that caps on non-economic damages reduce the cost of insuring medical malpractice for physicians in the states in our study that have instituted this element of tort reform," said Richard S. Biondi, Principal and Consulting Actuary at Milliman USA and the author of the Milliman study. "The study implies that caps on non-economic damages would significantly reduce total losses for both physicians and hospitals."

The data is consistent with results others have observed in California, which is well-known for capping non-economic damages at $250,000 since 1975. In that state, the medical malpractice losses per physician are about half (52%) of the countrywide average. Other large states in the study that have instituted caps and subsequently have lower medical malpractice losses per physician are: Colorado (69% of the countrywide average), Indiana (86%) and Maryland (64%).

Conversely, large states without caps have higher than average medical malpractice losses per physician. They include: Florida (136% of countrywide average), Illinois (144%), New Jersey (131%), New York (156%), Pennsylvania (171%), and Washington, D.C. (144%).

In a separate 1997 analysis performed by Mr. Biondi using data for New York, which does not have caps, savings were estimated on physicians' medical malpractice losses if caps were instituted. It was projected that caps of $250,000, $500,000, $750,000, and $1,000,000 would result in a reduction in losses of 29%, 20%, 14% and 11% respectively on policies providing $1 million to $3 million coverage for physicians.

"There are other differences between these states besides the fact that they either have or don't have caps, and there are also differences in the size and application of the caps in the states that have them," said Mr. Biondi. "However, the pattern in this particular study is still very clear in showing that caps on non-economic damages are highly correlated to medical malpractice costs."

The data in the Milliman USA study included physicians' statistics by state from the National Practitioners Data Base Public Use Data File (NPDB), which contains selected variables from medical malpractice payment reports on physicians, dentists and other licensed healthcare professionals. A spreadsheet summarizing the results is attached.

Milliman USA, whose corporate offices are in Seattle, serves the full spectrum of business, financial, government and union organizations. Founded in 1947 as Milliman & Robertson, the company has 29 offices in the United States as well as offices in Bermuda, Hong Kong, Japan, Korea, Brazil, and the UK. Milliman USA employs approximately 1,750 people, including a professional staff of over 750 qualified consultants and actuaries. The firm has consulting practices in property and casualty, employee benefits, healthcare and life insurance. It is a founding member of Milliman Global, an international organization of consulting firms serving insurance, employee benefits and healthcare clients worldwide. For further information, visit www.milliman.com.

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Milliman USA
Consultants and Actuaries

NPDB* Loss Data for 15 Largest States and Nationwide
NPDB* Public Use Data File

*NPDB refers to the National Practioners Data Base

9/1/90-4/30/01

National Claim and Loss Rate per Doctor Reported to the NPDB
(annual losses not trended)

	Doctors (approximate number in 1990)	Annual Loss Per Doctor	Relativity	Status Re Caps (Reference: Aug./Sept. 2002 Medical Liability Monitor)
CA	66,996	2,884	0.52	$250K cap on non-economic damages.
CO	6,724	3,817	0.69	$250K cap on non-economic damages. $1M cap total.
DC	3,068	7,901	1.44	No cap.
FL	26,394	7,508	1.36	No cap for most claims. Caps apply when parties arbitrate.
IL	25,565	7,929	1.44	No cap. Declared unconstitutional.
IN	9,607	4,734	0.86	$1.25M cap on total damages.
KS	4,673	5,846	1.06	No cap. Declared unconstitutional.
MA	20,089	3,802	0.69	$500K cap on non-economic damages with exceptions.
MD	15,061	3,503	0.64	$500K cap on non-economic damages.
MI	18,463	4,347	0.79	$345K cap on non-economic damages.
NJ	18,765	7,232	1.31	No cap.
NY	56,264	8,610	1.56	No cap.
OH	22,401	6,443	1.17	No cap. Declared unconstitutional.
PA	29,784	9,386	1.71	No cap.
TX	29,004	6,083	1.11	No cap.
All Others	181,034	4,363	0.79	
Total	537,389	5,502		

Milliman USA Study includes physicians' statistics from the NPDB Public Use Data File, which contains selected variables from medical malpractice payment reports on physicians, dentist and other licensed healthcare professionals.

Author of Milliman USA Study: Richard S. Biondi, Principal and Consulting Actuary, New York office
Contact: Laura Rzasa, Donley Communications, (212) 751-6126, lrzasa@donleycomm.com

Lou

From: "Daniel Blaney-Koen" <Daniel_Blaney-Koen@ama-assn.org>
To: <asma@alaska.net>; <Jclark@csms.org>; "Sara Thran" <Sara_Thran@ama-assn.org>; <koos@isms.org>; <nelson@isms.org>; <white@kyma.org>; <WTA@kyma.org>; <cmcmullen@mag.org>; <JScott@medone.org>; <lmariner@medone.org>; <Shanbacker@msdc.org>; <Sgreenhoe@msms.org>; <PDWeber@msnj.org>; <RSeligson@ncmedsoc.org>; <DOwens@osma.org>; <tjc@wsma.org>; <swacker@wyomed.org>
Cc: "Jim Rodgers" <Jim_Rodgers@ama-assn.org>; "Kathy Kuntzman" <Kathy_Kuntzman@ama-assn.org>; "Mindy Schneiderman" <Mindy_Schneiderman@ama-assn.org>; "Teresa Marchiori" <Teresa_Marchiori@ama-assn.org>
Sent: Wednesday, April 02, 2003 2:46 PM
Attach: Patients losing access survey March 2003dft.doc
Subject: Revised national survey release -- DRAFT attached

I apologize for the late notice, but due to further consideration of releasing financial averages for liability premiums and the concern of ACOG that the financial information previously included might confuse media and others, those sections have been removed from the national release.

If your society is issuing a release tomorrow, we would strongly advise to not include or make any mention of those national averages at this time. If your society is releasing state-specific financial data, that remains up to you, and the AMA will continue to refer reporters to your society when asked about a specific state's experience. We will not be discussing national averages at this time.

The AMA will only make select charts and graphs available to reporters and those will be forwarded to you as soon as they are ready.

A revised DRAFT release is attached. A final release will be sent tomorrow.

Please let me know if you have any questions.

Daniel

Daniel Blaney-Koen

American Medical Association
Field Communications Manager
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American Medical Association
Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE **April 3, 2003**

AMA SURVEY SHOWS PATIENTS LOSING ACCESS TO CARE

America's medical liability crisis causing physicians to limit their practices

CHICAGO—America's out-of-control legal system and skyrocketing medical liability insurance premiums have caused nearly two-thirds of high-risk specialists to make changes to their practice, including stopping providing certain services and referring complex cases, according to a new American Medical Association survey. The survey analysis looked at the differences between high and low-risk specialties as well as crisis versus non-crisis states.

More than 30 state and national medical specialty societies took part in conducting the survey, which included responses from more than 4,800 physicians nationwide. The high-risk specialties include emergency medicine, general surgery, neurosurgery, obstetrics/gynecology, orthopedic surgery and thoracic surgery.

The crisis states identified in an AMA analysis released last month are Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia.

"What will it take for our elected leaders to realize that patients—and the communities in which they live—are losing access to the physicians who save lives?" asked AMA President Yank D. Coble Jr., MD. "These new data deliver hard numbers to a shocking reality—America's broken medical liability system is having disastrous effects on patients and their physicians."

Top line survey findings include:

- 64.8 percent of America's high-risk specialists have made changes to their practice, including no longer providing emergency and trauma care, performing high-risk surgical procedures, delivering babies, and more.
- 92.4 percent of high-risk specialists said that liability pressures were important in their decision to stop providing certain services.
- 41.5 percent of high-risk specialists began referring complex cases; 34 percent of physicians surveyed in AMA crisis states began referring complex cases compared to 24 percent in non-crisis states.

The U.S. House of Representatives passed legislation last month—the HEALTH Act of 2003—that Dr. Coble said would go a long way toward helping America's patients and physicians.

"Before you can heal the patient, first you have to stop the hemorrhaging," said Dr. Coble. "We strongly urge the Senate to pass common-sense medical liability reform legislation that will preserve patients'

access to care. The AMA will continue to work with patients, physicians and lawmakers at the grassroots and national levels to pass medical liability reforms until this crisis ceases to exist."

For more information, please contact:

Daniel Blaney-Koen
Field Communications Manager
(312) 464-4415

Note: The AMA encourages reporters and others interested in state and specialty-specific information to contact those societies directly.

Lou

From: "Sara Thran" <Sara_Thran@ama-assn.org>
To: <asma@alaska.net>; <Jclark@csms.org>; <koos@isms.org>; <nelson@isms.org>; <white@kyma.org>; <WTA@kyma.org>; <cmcmullen@mag.org>; <JScott@medone.org>; <lmariner@medone.org>; <Shanbacker@msdc.org>; <Sgreenhoe@msms.org>; <PDWeber@msnj.org>; <RSeligson@ncmedsoc.org>; <DOwens@osma.org>; <tjc@wsma.org>; <swacker@wyomed.org>
Cc: "Daniel Blaney-Koen" <Daniel_Blaney-Koen@ama-assn.org>; "Kathy Kuntzman" <Kathy_Kuntzman@ama-assn.org>; "Mindy Schneiderman" <Mindy_Schneiderman@ama-assn.org>; "Teresa Marchiori" <Teresa_Marchiori@ama-assn.org>
Sent: Thursday, April 03, 2003 10:47 AM
Attach: PLI newsletter final.pdf
Subject: Re: National PLI survey results

Attached are the overall survey results, which Daniel will share with any media people who request them.

National Physician Survey on Professional Medical Liability

April 2003

Prepared by: AMA's Division of Market Research and Analysis

Key Survey Findings

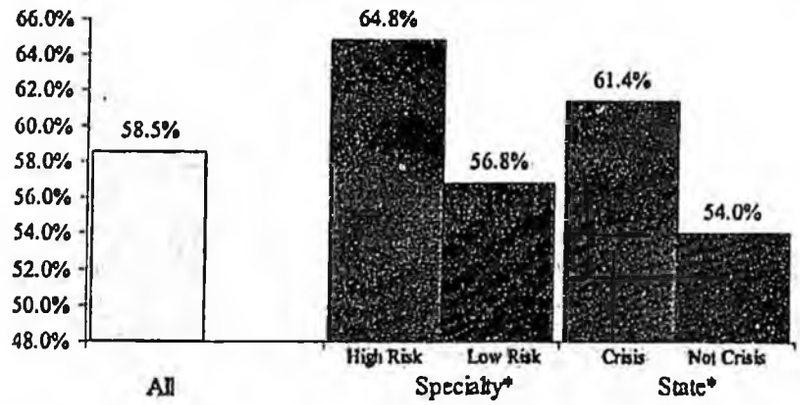
Respondents were asked if they had made each of a number of practice changes in the last two years. Overall, 58% of physicians indicated that they had made at least one of the changes listed. The practice changes that were most often reported were: began referring complex cases (30%) and stopped providing certain services (19%). Practice changes were generally made more often among the physicians in high risk specialties and those in crisis states.

For each practice change made, respondents were asked how important professional liability pressures were in their decision to make the change. The tables below each bar chart present the percentage of respondents making a practice change who indicated that professional liability pressures were important in their decision.

Methodology

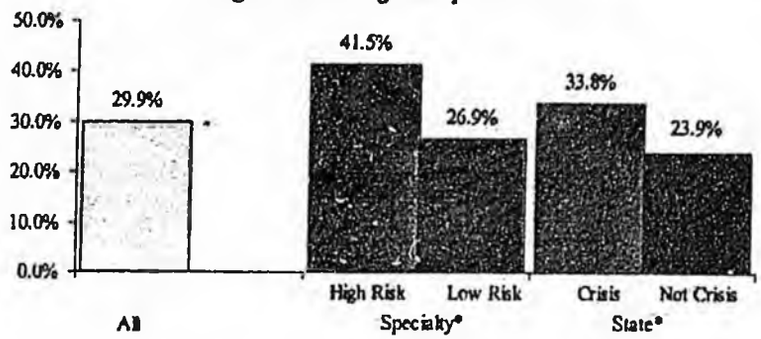
In [illegible] 2003, the American Medical Association began a national survey to [illegible] physicians in 20 [illegible] specialty societies and 7 state medical associations. The survey was conducted online and asked about professional medical liability insurance coverage and practice changes made in the last two years. This report presents results for [illegible] physicians who responded between [illegible] 2003.

Made Any Practice Change



*Significant at p = 0.05

Began Referring Complex Cases

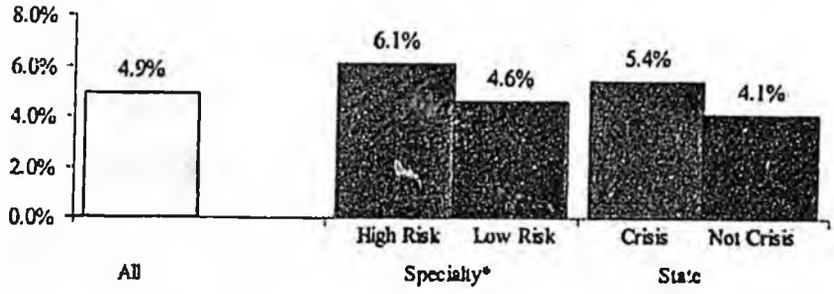


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
91.4%	94.3%	90.3%	92.9%	88.3%

*Significant at p = 0.05

Closed Practice

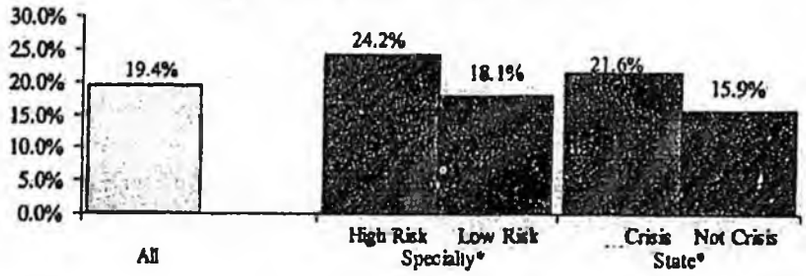


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
62.5%	83.0%	55.2%	69.7%	46.5%

*Significant at p = 0.05

Stopped Providing Certain Services

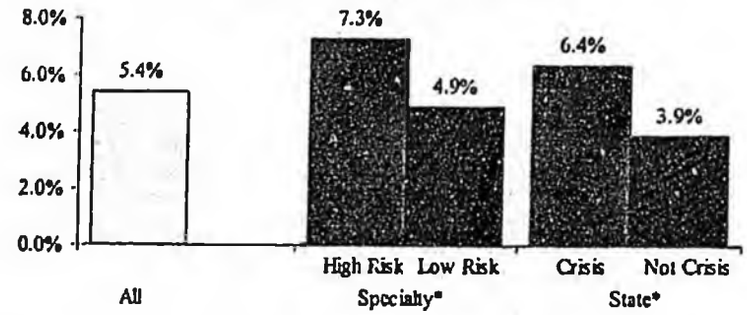


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
81.6%	92.4%	77.7%	83.9%	76.9%

*Significant at p = 0.05

Stopped Providing Patient Care

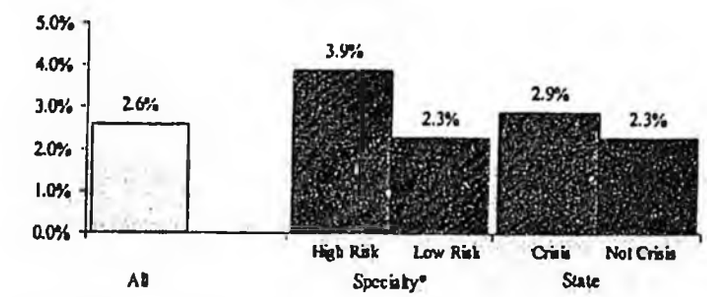


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
74.1%	83.8%	70.2%	78.7%	62.5%

*Significant at p = 0.05

Retired



Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty		State*	
	High Risk	Low Risk	Crisis	Not Crisis
73.6%	74.6%	73.2%	80.4%	60.6%

*Significant at p = 0.05

Lou

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Cc: "Daniel Blaney-Koen" <Daniel_Blaney-Koen@ama-assn.org>; "Jim Rodgers" <Jim_Rodgers@ama-assn.org>; "Kathy Kuntzman" <Kathy_Kuntzman@ama-assn.org>; "Mindy Schneiderman" <Mindy_Schneiderman@ama-assn.org>; "Teresa Marchiori" <Teresa_Marchiori@ama-assn.org>
Sent: Wednesday, March 26, 2003 1:21 PM
Attach: PLI newsletter.doc
Subject: National PLI survey results

Attached is a preliminary summary of the national survey results. Some of the specialty society staff asked for this during our conference call. We still plan to get you the draft AMA press release in a few days.

National Physician Survey on Professional Medical Liability

March 2003

The findings from the survey confirm what many suspect, that professional medical liability premiums have increased rapidly. This has resulted in many physicians making changes in their practices that may affect patient access to care.

Key Survey Findings

Respondents were asked their annual premium for basic professional medical liability coverage for 2001, 2002, and 2003. The dollar and percent change from year to year were calculated for each respondent who answered the premium questions for both years.

Respondents were asked to report additional expenses for supplemental insurance, catastrophic insurance, surcharges for state patient compensation funds or other professional medical liability insurance coverage for 2001 and 2002. Professional liability insurance premiums have increased substantially between 2001 and 2003. Additional expenses increased between 2001 and 2002.

Premiums, changes in premiums, and additional expenses were significantly higher for physicians in high risk specialities and crisis states.

Respondents were asked if they had made each of a number of practice changes in the last two years. Overall, 58% of physicians indicated that they had made at least one of the changes listed. The practice changes that were most often reported were: began referring complex cases (30%) and stopped providing certain services (19%). Practice changes were generally made more often among the physicians in high risk specialties and those in crisis states.

For each practice change made, respondents were asked how important professional liability pressures were in their decision to make the change. The tables below each bar chart present the percentage of respondents making a practice change who indicated that professional liability pressures were important in their decision.

Table 1. Statistics on Premium Variables

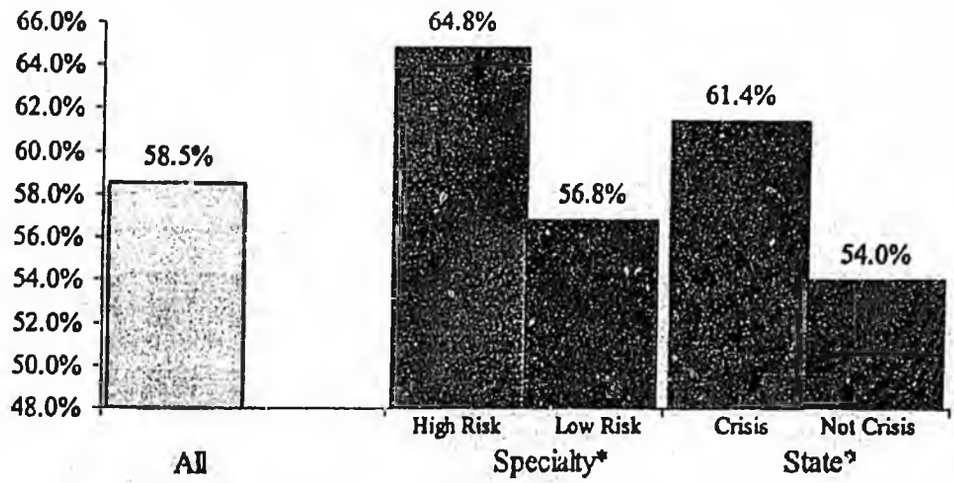
	Mean	Median	25th Percentile	75th Percentile
2001 PLI Premium	16,300	10,000	6,000	20,000
2002 PLI Premium	20,900	12,000	7,000	25,000
2003 PLI Premium	26,900	15,000	8,000	33,000
$ Increase in PLI Premium 2001 to 2002	5,300	2,000	400	6,000
$ Increase in PLI Premium 2002 to 2003	6,800	2,100	0	7,400
% Increase in PLI Premium 2001 to 2002	42.0	22.2	4.2	50
% Increase in PLI Premium 2002 to 2003	38.5	24.0	0	50
2001 Additional Expense	5,200	2,000	1,000	4,400
2002 Additional Expense	6,700	3,000	1,000	6,000

Table 2. Means of Premium Variables

	Specialty		State	
	High Risk	Low Risk	Crisis	Not Crisis
2001 PLI Premium	35,000*	10,700	17,400*	14,400
2002 PLI Premium	45,400*	13,700	23,400*	16,500
2003 PLI Premium	57,100*	17,100	30,500*	20,600
$ Increase in PLI Premium 2001 to 2002	11,900*	3,200	6,700*	2,800
$ Increase in PLI Premium 2002 to 2003	14,900*	4,200	8,400*	4,400
% Increase in PLI Premium 2001 to 2002	41.3	42.2	49.6*	28.5
% Increase in PLI Premium 2002 to 2003	41.6	37.5	44.1*	29.3
2001 Additional Expense	12,500*	3,000	5,600	4,500
2002 Additional Expense	13,600*	4,900	7,900*	4,800

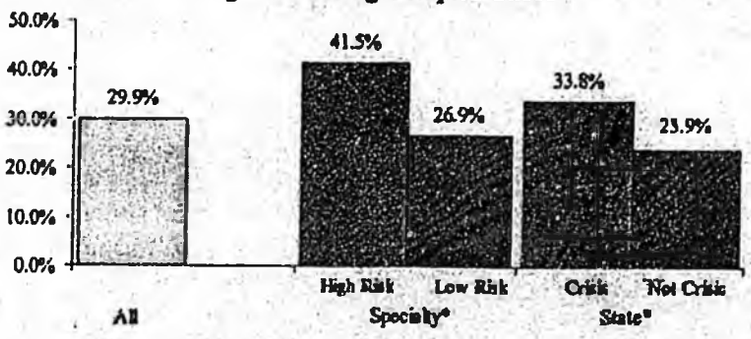
*Significant at p = 0.05

Made Any Practice Change



*Significant at p = 0.05

Began Referring Complex Cases

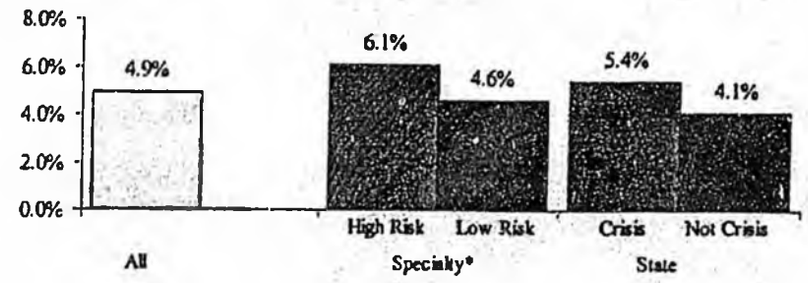


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
91.4%	94.3%	90.3%	92.9%	88.3%

*Significant at p = 0.05

Closed Practice

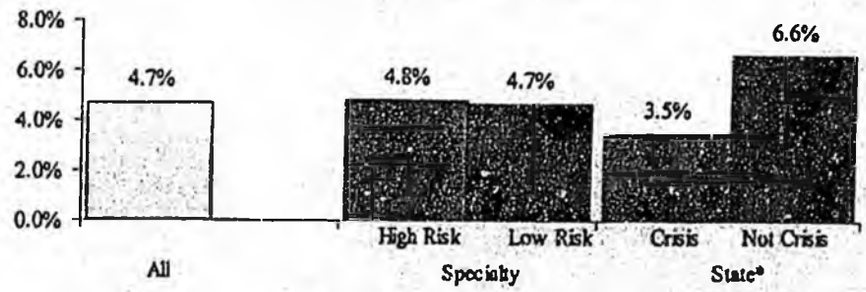


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
62.5%	83.0%	55.2%	69.7%	46.5%

*Significant at p = 0.05

Moved to Different State

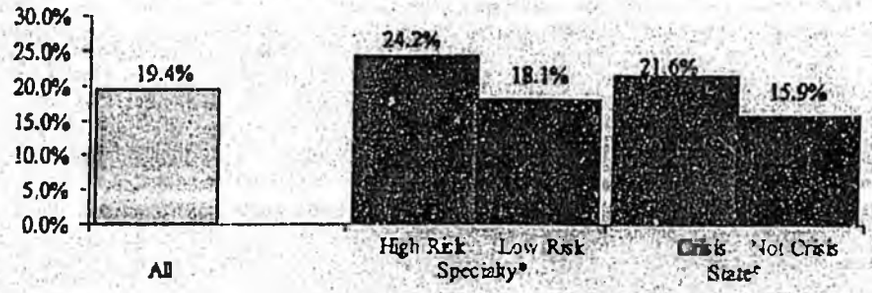


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State	
	High Risk	Low Risk	Crisis	Not Crisis
39.8%	56.4%	35.4%	36.6%	42.5%

*Significant at p = 0.05

Stopped Providing Certain Services

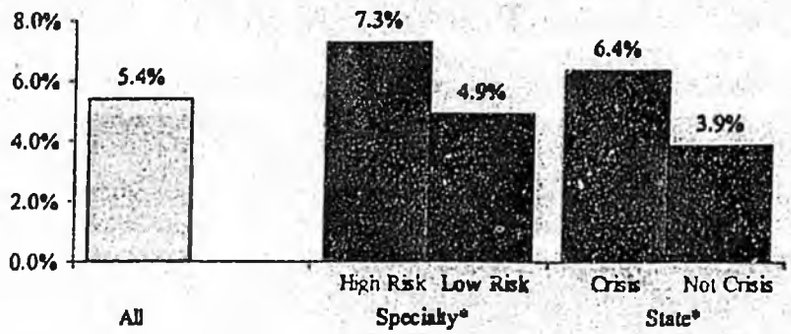


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
81.6%	92.4%	77.7%	83.9%	76.9%

*Significant at p = 0.05

Stopped Providing Patient Care

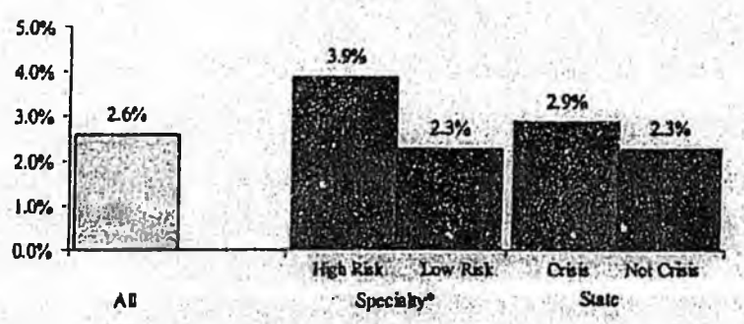


Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty*		State*	
	High Risk	Low Risk	Crisis	Not Crisis
74.1%	83.8%	70.2%	78.7%	62.5%

*Significant at p = 0.05

Retired



Respondents Indicating that Professional Liability Pressures were Important in the Decision

All	Specialty		State*	
	High Risk	Low Risk	Crisis	Not Crisis
73.6%	74.6%	73.2%	80.4%	60.6%

*Significant at p = 0.05

A New Crisis for the Med Mal Market?

Medical malpractice insurance loss costs are surging, insurers are quitting the business and doctors are threatening to leave their practices. Is med mal on the verge of a major new crisis?

By James D. Hurley

James D. Hurley is a principal of Tillinghast – Towers Perrin in Atlanta. He specializes in [illegible]ssional liability. Mr. [illegible] has a B.S. from [illegible] College of Insurance in New York. He is an associate of the Casualty Actuarial Society and a member of the American Academy of Actuaries.

Following two major crises in the medical malpractice market in the 1970s and 1980s (see *Box*, page 5), U.S. insurers writing med mal policies in the 1990s enjoyed profitable financial results, thanks largely to improved underwriting and relatively high levels of investment income. Health care providers purchasing this coverage shared in this profitability as insurers lowered premiums.

Unfortunately, the malpractice market has again taken a turn for the worse. Underwriting experience has deteriorated significantly over the last three years. The industry combined ratio jumped more than 20 points to 153% in 2001. If investment income is included, the operating ratio rose more than 30 points to 138% in 2001. This means that for every dollar of premium earned in 2001, insurers lost 38 cents — the worst result since separate tracking began in 1976.

In addition, the much publicized St. Paul decision to cease writing medical malpractice policies and the forced retirements of PHICO, MIIX and Frontier, among others, removed approximately 15% of premium-writing capacity from the marketplace.

To avoid jeopardizing their surplus base and financial health, the remaining insurers are raising premium rates in response to higher loss and reinsurance costs and lower prospective investment returns. Displaced insureds have limited options in purchasing coverage, and all insureds face higher prices.

Given all these circumstances, many in the industry believe insurers *and* health care providers are headed for (or are already in) another major crisis.

Why Was Med Mal So Profitable? Why was med mal so profitable in the 1990s? And what led to the recent downturn? Following are the factors that produced favorable results for insurers in the early and mid-1990s:

- **Loss Trend Was Relatively Low.** The annual change in the cost of claims (frequency and severity) in the 1990s was lower than expected, varying from state to state and by provider type. This echoed historically low medical inflation and may have benefited from the impact of tort reforms.

- **Rates Were Flat.** Rate increases were uncommon, with declines in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.

- **Favorable Reserve Development Helped.** Lower than expected loss cost trend allowed reductions in loss reserves that had originally anticipated historically higher trend levels. As experience emerged, loss reserves for prior years were reduced, contributing to very profitable calendar year results. This evidence appeared gradually over years as claims settled. Thus, the loss reserve reductions for prior coverage years helped to lower published calendar year loss ratios during the mid-to-late 1990s. But favorable development in these prior loss reserves has now ceased. (See *Exhibit 1.*)

■ **Investment Yields Were Healthy.** During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Although med mal insurers had only a modest holding of equities, capital gains on stocks also helped improve overall financial results.

■ **Reinsurers Helped.** Similar to what had happened in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.

Why Results Have Turned. Although these factors contributed to the profitability of med mal in the 1990s, they also paved the way for the reversals that began at the end of the decade.

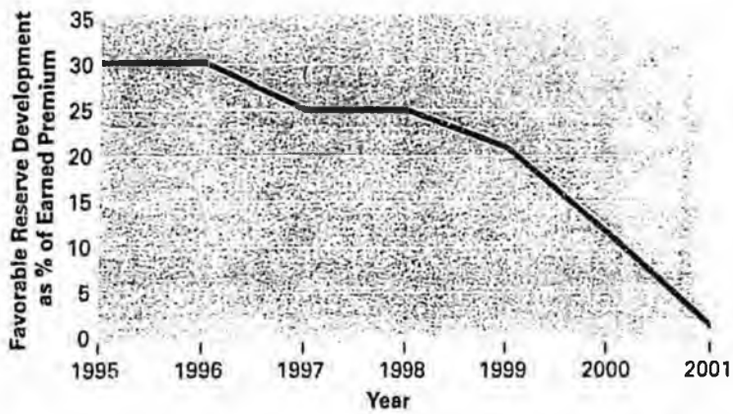
■ **Insurers Expanded Into New Markets.** Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (with limited information to develop rates). They also became more competitive in existing markets, offering more aggressive premium discounts.

■ **Loss Trend Began to Worsen.** Loss cost trends, particularly claim severity, started to pick up toward the latter part of the 1990s. The number of large claims (sometimes very large) increased, but even basic limits costs (eliminating the distortions of very large claims) began to deteriorate. This is contributing to significant upward rate indications in many states.

■ **Loss Reserves Became Suspect.** Aggregate loss reserve levels were reconciled to the lower loss cost trends. While insurers did not reduce reserves in 2001, there appears to be little or no strengthening in the aggregate, although results vary on a company-by-company basis. This means that future results will be worse on a calendar year basis than on a coverage year basis, as loss reserves ultimately have to catch up with the higher levels of loss trend.

■ **Investment Results Have Worsened.** Bond yields have declined, and equity values are down from 1990s highs. In addition to lowering interest earnings on existing assets, the lower yields also affect the expectation for investment earnings used to offset needed prospective premium levels. Rates established using an interest rate assumption of 6% rather than 7% are 2% to 4% higher (assuming no changes in other rate components) due to the multiplier effect of investment income. Moving to even lower yields compounds the impact.

Exhibit 1
Favorable Loss Reserve Development Has Ceased



Note: Based on 30 Specialty Companies, Primarily Physician Owned or Operated.

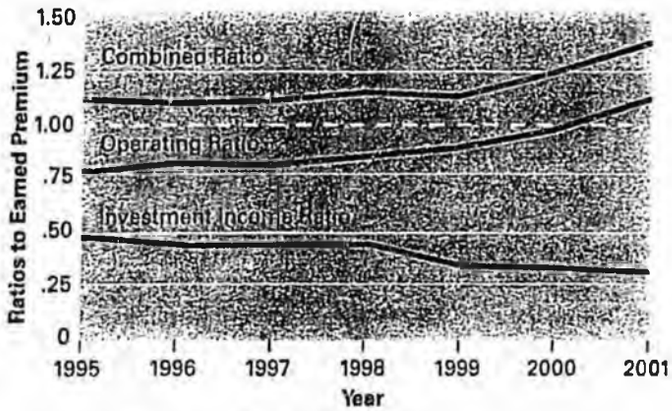
■ **The Reinsurance Market Has Hardened.** Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of exposure, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after 9/11, caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

Are Insurers at Fault? Some allege that insurers caused the current downturn through too rapid and reckless expansion. Given the positive results of the early 1990s, some carriers expanded into new markets and offered more aggressive discounts. But before assigning blame, consider the nature of the business then.

To obtain a clearer financial picture of medical malpractice insurance, we shall focus on the results of 30 specialty companies that are primarily physician owned or operated and that write only a minor amount of non–medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the U.S.

These companies, which achieved more favorable financial results than that of the total industry, showed a slight operating profit (4% of premiums) in 2000. This deteriorated to a 10% operating loss in 2001. (See *Exhibit 2*, page 4.)

Exhibit 2
Results Deteriorated Over the Last Three Years



Combined Ratio = Calendar Year Losses + Expenses ÷ Premium
Operating Ratio = Net Income After Taxes ÷ Premium
Investment Income Ratio = Pre-Tax Investment Income ÷ Premium

Note: Based on 30 Specialty Companies, Primarily Physician Owned or Operated.

There are two key drivers of these financial results:

- **Insurance Underwriting.** One calculates the combined ratio by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124% and 138% in 2000 and 2001, respectively. The preceding five years were fairly stable, from 110% to 115%. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively flat.

- **Investment Income.** Pre-tax investment income derives from policyholder-supplied funds invested until losses are paid as well as from the company surplus. The ability to offset some of the losses is measured by a percentage of earned premiums. This statistic declined over the measurement period from the mid-40% to the mid-30% level and, in 2001, to 31%.

This "offset" will continue to decline because (i) most invested assets are bonds and are affected by the lower yields of late, a change not fully felt in current investment income; and (ii) the premium base is growing due to increased rates, growth in exposure, or both. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

Exhibit 3 shows surplus declines as a percentage change from one year to the next. Surplus increased through 1999 and began its decline in 2000 with a more substantial loss in 2001. This decline reduces the capacity to write business prospectively and to absorb adverse loss development on business written in prior years.

Another Crisis? During the med mal crises of the 1970s and 1980s, loss trend deterioration and the unprofitability of medical malpractice insurance led to reduced capacity, large rate increases and efforts at tort reform. Are conditions today similar enough to the previous crises to produce similar problems for insurers and providers? Despite 2001 being the most unprofitable year for medical malpractice since separate tracking began, the answer, at least for insurers, is probably "no."

Although loss cost trends are increasing, these trends, at least so far, are not as dramatic as they were in the two earlier crises. Nevertheless, insurers are experiencing an increased incidence of unpredictable multimillion-dollar claims. According to one large database, the percentage of $1 million paid claims has doubled to slightly more than 7% of paid claims over the last six years, although the degree and magnitude vary by state.

Other factors militate against a similar crisis for insurers:

- **Tort Reform Is on the Agenda.** States enacted tort reform legislation after the previous crises as a compromise between an individual's right to seek recompense and affordable health care. The best known is MICRA, California's tort reform package. With MICRA, California has achieved a more stable marketplace and lower premium increases over the years than have other states. According to a compilation of NAIC data, California's premiums grew 167% over the past 25 years, compared to 505% for the other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. Poorly crafted reforms may actually increase losses.

- **The Economy Is Stronger.** Current economic conditions differ from those that prevailed during the previous crises. Today's low inflation and low interest rates contrast sharply

History of Med Mal Crises

The medical malpractice line went through two crises, one in the 1970s and the other in the 1980s. The earlier crisis was mainly a crisis of availability as insurers left the marketplace and provider-owned companies were formed, offering coverage at much higher rates. In the 1980s, the crisis was one of affordability. Insurers found it necessary to increase rates dramatically in response to surging claim frequency and severity.

A question raised then — and now — is whether a decline in the quality of medical practice invited the increase in claim levels. Given advances in technology and medicine and improved access to health care, this seems unlikely.

However, these advances were accompanied by major changes in the health care delivery process (e.g., managed care, increased specialization and associated greater dependence on multiple providers in securing medical care). In fact, with expectations set so high by modern medicine, more and more patients may have become claimants when the best possible outcome was not realized.

with the high inflation–high interest rate climates during earlier difficult markets.

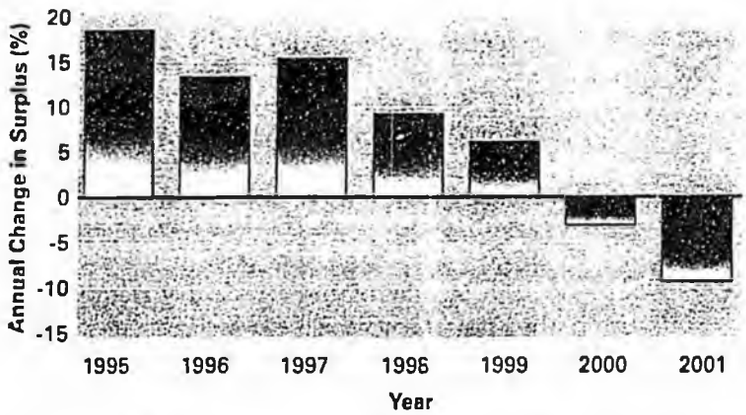
However, the decline in interest rates requires a rate increase, even if loss costs aren't a problem. Prior rates were built anticipating higher prospective investment income as an offset and is now unlikely to be achieved. Although affecting rates, equity market declines are similar to prior troubled periods and put added pressure on capacity as companies evaluate how best to deploy more limited available capital.

- **The Presence of Specialty Companies.** Although the reduction in capacity to write med mal coverage is dramatic (after voluntary and forced withdrawals), a significant portion of the business is now written by specialty companies committed to provide coverage. New commercial and specialty company capacity as well as captive/self-insured programs are coming online. Nevertheless, some displaced insureds will have difficulty finding coverage and those that do will pay higher rates.

- **Insurers Are in Better Shape.** Despite declining surplus, the active insurers, particularly the specialty companies, are better able (than were companies in the 1970s or 1980s) to handle the pressures of increasing rates and units of exposure. For most, their current financial circumstances will allow them time to realize the benefits of passing through needed increases.

A Crisis for Health Care Providers. Unfortunately, health care providers are in a more difficult position. Their financial proposition has become less tenable. With insurers seeking substantial rate increases, health care providers are caught in a financial squeeze because much more of their revenue is derived from private health or government medical plans (than in the 1970s and 1980s).

Exhibit 3
Surplus Declined in 2000 and 2001



Note: Based on 30 Specialty Companies, Primarily Physician Owned or Operated.

These programs limit or prevent health care providers from passing on costs to patients by increasing their fees. Without revenue and rate relief, providers may find the economics don't work, which could lead many to abandon their practices, threatening the public's access to quality health care.

Lou

From: "Mike Maves EVP/CEO" <Mike_Maves_EVP#s#CEO@ama-assn.org>
To: <asma@alaska.net>
Sent: Tuesday, January 21, 2003 6:38 AM
Attach: Medliabilityq&a01-20-03fin.doc
Subject: CEO to CEO: Correction

The Q & A document sent yesterday was inadvertently marked "draft." However, it is a final version; attached is a document without the "draft" notation. The body text in both documents is exactly the same.

America's Medical Liability Crisis
Sample Q&A

Q: What are the AMA's current concerns regarding medical liability (malpractice)?

A: The American Medical Association wants to ensure that patients have access to health care when they need it. Excessive jury awards in recent years have caused liability insurance premiums to skyrocket. As a result, a growing number of physicians can no longer find or afford liability insurance. Without insurance, physicians in some parts of the country are being forced to restrict their practices – avoiding high-risk, but necessary, medical procedures such as delivering babies. Others are simply retiring early or relocating to states where reforms are in place and premiums are more affordable. The bottom line: patients in crisis states around the country are seeing their physicians disappear and are finding it more difficult to get the care they need. This has got to stop.

Q: How are patients being affected?

A: Patients living in crisis states are watching helplessly as their doctors retire early, leave the state or stop offering certain procedures, such as delivering babies or complex surgical procedures. Patients are watching helplessly as maternity wards, trauma centers and rural health clinics are forced to close. Access to patient care in the crisis states is heading for a grave meltdown, and there are increasing problem signs of the same happening in states not yet in crisis.

Q: What does the AMA think should be done to address the current crisis?

A: The AMA strongly supports a national law that is based on the reforms California has had in place since 1975. California's law (also known as MICRA) puts a reasonable limit – $250,000 – on non-economic damages. Non-economic damages – also referred to as "pain and suffering" – have been a magnet for trial lawyers and a big factor driving the current crisis. The California model caps non-economic damages at $250,000, while still allowing patients full and complete access to the courts. Under California law, patients still have the ability to recover 100 percent of their economic damages, including complete compensation for medical expenses, rehabilitation costs, childcare costs, all current and future wage earnings that are lost, and other economic loss. We need a law that is fair for all, and California's law provides that balance.

Q: Does the AMA support President Bush's recent medical malpractice reform proposal?

A: The AMA strongly supports the President's call to bring common sense back to the legal system. The current medical liability system is broken and in need of repair. Medical liability premiums have reached $200,000 a year or more in some high-risk specialties and 12 states are in crisis. Thirty more states are on the brink of crisis. If responsible action is not taken, more physicians are going to be forced from their practices and patients living in crisis areas will find it increasingly difficult to get the full-range of services they need. In addition to protecting patient access to care, instituting a $250,000 cap on non-economic damages could save our country as much as $100 billion each year in health care costs, according to a recent study by HHS.

Q: Why do doctors want to limit the amount of money a patient receives if that patient is harmed by a doctor's negligence?

A: That is not our view at all. The American Medical Association proposes no limits on what patients can recover for their medical expenses, rehabilitation costs, childcare expenses, all current and future wage earnings that are lost, including employer-based benefits, and any other economic-type losses. We do support, however, a reasonable cap on non-economic damages – which are unpredictable, subjective damages that have spurred the "lottery" mentality over-running our judicial system.

Q: By limiting non-economic damages, isn't the AMA saying that patients' pain and suffering isn't worth anything?

A: Absolutely not. When a patient is harmed by a physician's negligence – he or she should be fully compensated. But we need a system that works for everyone and not just the select few who receive "jackpot-sized" awards. The current system encourages trial lawyers to search for "lottery" cases to line their pockets. The states that are currently in crisis are those states that either have no cap on non-economic damages, or a cap that is so high it is ineffective. We need to decide: Do we want trial lawyers having access to every dollar they can squeeze from an out-of-control tort system or do we want patients having access to their physicians when they need them?

Q: Does the AMA want to limit patients' access to the courts?

A: Quite the contrary. The AMA believes patients should have full access to the courts, but let's make sure that the cases filed by trial lawyers have merit. Currently, 70-80 percent of all cases filed against doctors are dismissed without action. That's a ridiculous amount of cases that should have never been brought in the first place. We need to work to eliminate these types of frivolous lawsuits because they are driving insurance rates sky high and driving many physicians out of practice. As a physician, if I focused my energies on an intervention that failed 70-80 percent of the time, I would start looking for a new approach. I think the trial bar needs to do the same. Because the current tort system is not working and it's adversely affecting patient care in this country.

Q: What about those who say the current crisis is the fault of insurers, who are trying to make up for years of losses in the stock market by price-gouging physicians with high insurance premiums?

A: This is just one more smokescreen the trial bar is using to deflect attention from the facts. Insurance companies typically place about 80 percent of their investments in the bond market – not the stock market. And that bond market has provided them a stable return of about 5 percent per year since 1997. Clearly, we need common sense liability reforms. These reforms have stabilized the market in California and can do so for the rest of the country.

Q: Doctors make a lot of money – why are they complaining about an increase in their insurance premiums?

A: Physicians earn good incomes, but that doesn't make them immune from economic realities. And the reality is – a growing number of physicians cannot keep their practices open if liability rates continue to skyrocket. Keep in mind, we are not talking about the modest increases that most of us pay for goods and services from year to year. We are talking about increases of 100 percent or more in certain areas of the country. The median jury award has risen to $1 million, and doctors who practice in "crisis" states pay double or triple what doctors in non-crisis states pay in professional liability insurance.

Q: What about those who suggest the California insurance market is stable because of Proposition 103, not its 1975 law?

A: The truth is, Proposition 103 has had very little to do with medical liability insurance. Since 1975, California's medical liability reforms have been responsible for protecting California's patients and keeping the insurance market stable. Prop. 103 was passed in 1988 to address mainly auto insurance issues. Prop. 103 does not prohibit insurers from raising rates. It says that if an insurer wants to raise rates by more than 15 percent, there must be public hearings. That's only happened once, and the request was recalled by the insurer after the public objected. Anyone who tells you Prop. 103 is the reason for California's successful medical liability reforms is not dealing with the facts.

Q: The Institute of Medicine says that doctor mistakes kill 98,000 people a year. Shouldn't we get rid of those bad doctors?

A: The American Medical Association believes one error that harms a patient is one error too many. Unfortunately, medicine is not an exact science and we know that – despite our best efforts – mistakes do occur. The AMA agrees that bad or incompetent physicians should be removed. That's why we support strong licensing boards. But let's be clear about one very important fact – the current liability system does nothing to identify negligence. In fact, a recent Harvard study shows no correlation between medical liability award payments and physician negligence. So while we need to work to make medicine safer, let's not pretend that the current liability system is the way to go about it.

Q: Why aren't doctors doing more to improve patient safety?

A: Doctors work everyday to improve patient safety. The AMA founded the National Patient Safety Foundation to do just that. Safety starts with understanding why these errors occur in the first place. To do that, however, we need to create an environment where errors can be identified and studied openly so we can implement safeguards to prevent them. The Aviation Safety Reporting System model is one the medical community should emulate. It's a system that focuses on finding out as quickly as possible why an error has occurred and what can be done to prevent that error from occurring in the future. So while we need to work to make medicine safer, let's not pretend that the current liability system is the way to go about it. In fact, a recent Harvard study shows no correlation between medical liability award payments and physician negligence

Q: ***How do you respond to the charge that 5 percent of the nation's doctors are responsible for more than 50 percent of the nation's malpractice?***

A: That is a provocative charge based on flawed assumptions by the trial bar. If only 5 percent of the doctors are responsible for most of the malpractice in this country – then why do the vast majority of physicians get sued – many of them, two or three times. The current medical liability system doesn't identify negligence and it doesn't weed out bad doctors – it just increases the cost of medical care and decreases patient access to care. In short, there is no correlation between getting sued and malpractice, but there is clear evidence that the legal system in the crisis states is causing grave reductions in patient access to health care.

Q: Are doctors violating the Hippocratic Oath when they go on strike?

A: Physicians are NOT going on strike. Some physicians have made the difficult decision not to perform elective surgery, but even then, they are taking steps to ensure that their patients have access to emergency care and services. Physicians who have chosen to take a leave of absence are doing so only as a last resort. Many are using to this time to weigh their options, looking for ways to keep their practices open so they can continue caring for their patients and not be forced to limit services, retire early or relocate. Whether physicians leave their practices amid the media glare like they did in West Virginia and Nevada – or are leaving quietly in other communities in crisis – the end result is the same: Patients are seeing their physicians disappear and having their access to health care restricted.

Q: How much lobbying money is the AMA spending on this?

A: The AMA has made medical liability reform its top legislative priority, and we will direct all necessary resources to winning this battle for America's physicians and patients. We believe the current crisis is one lawmakers cannot afford to ignore. Like physicians, lawmakers have a responsibility to protect patient access to health care. If they choose to ignore this responsibility, the crisis will only continue to worsen.

Q: What is the AMA asking patients to do?

A: The AMA is encouraging every physician and every patient to contact their state and federal representatives and tell them, "Enough is enough—pass medical liability reforms that protect patient access to health care. And pass it now!"

A Surgical Fix for Medical Malpractice

Reforms Work Best as a Package, Study Shows

By Jeffrey Speicher

Almost everyone agrees: The medical malpractice system in the United States serves no one well. Although a few multimillion dollar settlements draw public attention, most individuals who suffer real injury at the hands of their physician or hospital accept less than the full value of their claim—and endure long delays before receiving compensation. Those most harmed—people left with lifelong medical needs or permanent loss of income—are most likely to be underpaid.

Physicians, who in the 1950s faced a 1-in-7 chance of being sued over the course of a career, now see the odds reduced to 1-in-7 *per year.* As a result malpractice insurance premiums have skyrocketed, causing many practitioners to abandon their specialties or adopt costly defensive-medicine procedures. Many insurers, buffeted since the early '70s by recurrent cycles of higher claims frequency and larger jury awards, have withdrawn from the market, which has reduced availability of coverage and further driven up costs. And as for attorneys . . . . well, even some thoughtful legal scholars believe the system is out of whack.

According to Randall Bovbjerg of Washington's Urban Institute, author of numerous studies on medical malpractice, many of the system's problems arise from a basic difference between doctors and lawyers: Physicians think about healing injuries, attorneys about resolving disputes. Says Bovbjerg, "Doctors see medical malpractice as a way to make injured patients whole—financially as well as physically. Lawyers come into the process after a conflict arises, and their focus is on justice for their client."

Jeffrey Speicher is manager of member communications for the Academy and an editor for Contingencies.

This difference in worldview intertwines medical malpractice with the legal system. Malpractice must balance the need to compensate deserving claimants, deter future violations by making doctors more careful, and obtain justice for both patients and medical providers. All this from what Bovbjerg defines as "mainly an insurance system run by experts."

A group of those insurance experts, members of the American Academy of Actuaries, recently suggested an approach to make the system less costly. According to the Academy report, "Medical Malpractice Tort Reform: Lessons from the States," the mixed results of reform attempts by the states point the way to effective federal action.

"Congress should adopt a comprehensive approach to tort reform by adopting a package of measures," says Jim Hurley, an actuary with Tillinghast/Towers Perrin and leader of the Academy group. "Our report provides a synthesis of measures that have been effective at the state level."

A Package Deal

The California Medical Injury Compensation Reform Act (MICRA) of 1975 shows the success of the package approach. Before MICRA's adoption, the state's percentage of total U.S. loss payments was significantly higher that its proportion of the nation's physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Costs continue to fall, even as California's share of physicians remains stable. Writes the Academy group: "The relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package." [See Figure 1.]

At the head of the Academy's list for lawmakers is a nationwide cap on jury awards for noneconomic damages such as pain and suffering. As evidence, Hurley points to Ohio where malpractice costs fell after a 1975 cap on damages, only to rise dramatically after court challenges led to a 1985

American Academy of Actuaries Bi-Monthly

FIGURE 1

Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

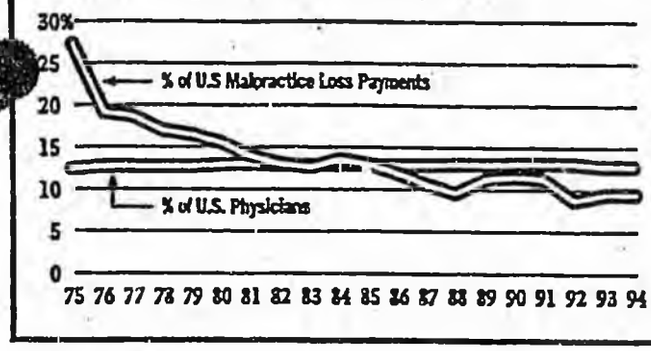
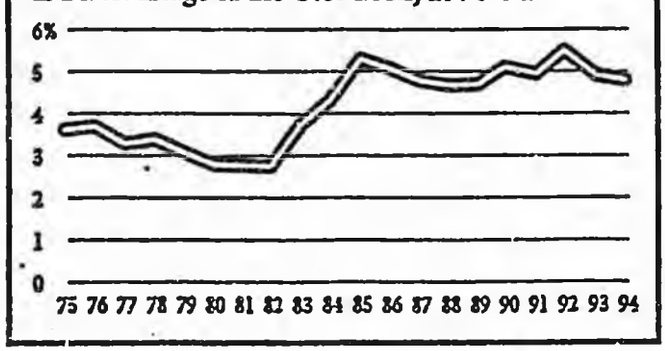


FIGURE 2

Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



ruling that overturned the cap. [See Figure 2.]

Such a cap should be established on a per-medical-injury basis at a level low enough to have an impact—at $250,000, for example. In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple indemnification cannot be collected through multiple suits. Under this rule, a jury or judge would have to consider compensation paid from other sources.

Above all, the Academy report warns against piecemeal or faulty changes. Loss experience in New York shows that the individual tort reform measures adopted in that state over the past two decades did not improve costs relative to the U.S. total. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs," says Hurley.

Above all, the Academy report warns against piecemeal or faulty changes. "Poorly crafted malpractice reform—either individual measures that are too limited or broad transformations that are too far-reaching—can have unintended consequences that drive up costs."

The Academy's suggested approach involves what medical malpractice experts call "takeaway" reforms—preserving the current reliance on the tort system, but eliminating some of the costliest and most abused features.

Other voices in the debate, including representatives of the medical community, call for a back-to-the-drawing-board approach. Unfortunately, the design that comes back often relies on a no-fault model. While no-fault medical malpractice insurance would largely untangle the process from the legal system, no-fault often rewards individuals whose claims would otherwise be denied. Says Hurley, "No-fault would drive frequency of claims through the roof—some ue by a factor of at least two and perhaps by a factor of eight or more. It's scary how many things can be compensated under the typical no-fault system."

Frequency of claims, according to Hurley, is the key driver of costs. "Over the past two decades, the plateaus and surges of claims frequency have been difficult to anticipate and measure, but the long-term trend has been up," says Hurley. Size of claims also is an important cost factor, but dollar amounts in settlements have been increasing in a more predictable fashion over time.

No-fault also would take most cases out of court and make malpractice a transaction between insurer and claimant. Advocates claim that this would cut legal costs—which are enormous. For example, according to the Insurance Services Office, legal defense costs for insurers alone accounted for 14 percent of total tort costs in 1992.

However, experience in Florida and Virginia, where n fault for obstetric cases is already in place, does not show substantially reduced costs or less need for legal counsel. Says Boyberg, "*Everyone* who uses the no-fault system in Florida and Virginia consults a lawyer."

Other options exist. A proposal by Jeffrey O'Connell, professor at the University of Virginia School of Law, seeks a middle way between no-fault and status quo. He would shorten the process and lower costs through an early offer of payment of noneconomic damages.

O'Connell is blunt about his disgust with the current state of affairs. "Medical malpractice is a nightmare of useless circularity," he says. However, according to O'Connell, the system is not consistently biased against defendants. Most proposed changes, on the other hand, invariably favor the defendant. Justice—as well as political reality—requires benefits for the plaintiff as well.

"Reform requires a quid pro quo," says O'Connell. "While the Academy has described quite lucidly the options for takeaway reform, such measures could not get through Congress without being so watered down as to be meaningless," says O'Connell. "True reform should involve a fair trade: making it easier for claimants to be paid, but paying them less, as under workers compensation laws."

An Offer You Can't Refuse

O'Connell's ideas have found sponsorship on Capitol Hill. A bill introduced in the 104th Congress by Sen. Mitch Mc-

Connell (R-Ky.) would create an early-offer plan for all tort claims, including medical malpractice. Under the proposal, a defendant in a personal injury claim is given the option of offering payment to the injured party within 180 days of the claim. The defendant purchases for the claimant a comprehensive major medical insurance policy that covers medical expenses, rehabilitation, and lost wages beyond monies received from collateral sources. In addition, reasonable hourly fees for the claimant's attorney would be paid.

Claimants who are offered such a settlement within 180 days of the claim would be obliged to accept. This won't get egregious medical offenders off the hook, however. A normal tort claim could be pursued for noneconomic damages, but with a higher-than-current standard of evidence.

> Medical malpractice is a nightmare of useless circularity.

The plaintiff must prove that the medical provider's misconduct was wanton or intentional.

Because the defendant would not be forced to offer a settlement, physicians and their insurers could take their chances in court in the case of bogus claims. However, the risk might be too great. O'Connell cites a prominent medical malpractice defense lawyer who estimates that he'd make an early offer in 200 of the his firm's 250 current cases. So the balance is tipped toward the defendant, but not without providing a substantial benefit to the plaintiff: Timely resolution and quick settlement.

The limit on legal fees would discourage what O'Connell calls "the unconscionable abuse of the system by some members of my profession." Among other criticisms, the Virginia professor points out that contingent fees are often not truly contingent on risk. Attorneys take the same settlement percentage from open-and-shut cases as from complex cases, a practice that subsidizes work on failed litigation and which O'Connell denounces as an illegal tax on deserving claimants.

Hurley gives O'Connell's proposal a mixed review. "To its credit, the early-offer plan is not mandatory for defendants, which leaves the tort system in place to challenge claims perceived as nonmeritorious," says Hurley. He also notes that periodic insurance payment to claimants allows compensation to be made as costs are incurred, eliminating the burden of large lump-sum payouts. Also, O'Connell's plan emphasizes two fundamentals that the Academy report identified: mandatory recognition of collateral benefits and controlling noneconomic damage costs. In fact, the O'Connell plan eliminates consideration of noneconomic damages altogether unless the case goes to court.

However, Hurley notes, the periodic payment plan theoretically would have to remain in force for decades. Will claimants be out in the cold after the disability policy limits are reached, or will the insurer face unlimited exposure? Another concern: Like no-fault, the early-offer plan could give incentives for unmerited claims. Insurers may pay a doubtful claim rather than incur expensive litigation costs and risk a large judgment award. In addition to increased costs, Hurley worries about a basic question: "Is it the right message to send to individuals who think doctors and insurers have deep pockets? The system may have practical advantages, but in terms of equity, it is hardly fair."

No matter which remedy is tried, no action will slash premium costs immediately, Hurley cautions. "Tying tort reform to premium reductions, as has been done in some states, is unrealistic," he says. "There is little evidence that the cost savings can be translated directly into lower costs for health care providers. More likely, reform will slow the rate of premium cost increases."

The course of reform will be determined by elected officials at the state and federal levels. The debate will be long, no matter which option—if any—is approved. In the meantime, the cost of inaction continues to be passed on to the public in the form of increased medical fees and reduced services.

By working together in recent years, insurers and healthcare providers have begun to bring medical spending under control. Effective medical malpractice reform is one way to keep the momentum going. □

Answer to Brain Drain, page 13: The house number is 76.

Fall
1996

ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

Medical Malpractice Tort Reform: Lessons from the States

The cost of insuring physicians against medical malpractice claims has increased dramatically in recent years. Skyrocketing premium costs and a string of highly publicized lawsuits have led many physicians to curtail certain high-risk procedures. By reducing the availability of important medical services, this practice of defensive medicine could have serious public-health consequences. In addition, increased malpractice insurance expenses are passed on to patients and health plans, thus fueling medical inflation.

To combat these ill effects, several states have adopted reforms designed to reduce the cost of medical malpractice insurance. More recently, Congress has attempted to follow the initiative of the states but has been unable to enact comprehensive medical malpractice tort reforms into law.

To date, state efforts have enjoyed varying degrees of success in reducing medical malpractice insurance rates. What can be learned from the experience of the states? How can these conclusions be applied at the federal level? The American Academy of Actuaries Work Group on Medical Malpractice Reform has studied the impact of state reforms and offers its comments to state and federal officials who are considering national tort reform.

Findings

Any federal medical malpractice tort reform effort should be based on a *package* of measures that have exhibited some success in stabilizing medical malpractice costs. The most effective elements of such a package are a cap on noneconomic damages and an offset for collateral payments from other sources. These reforms would limit the financial exposure of health-care providers to lawsuits and would ensure that damages could not be collected through multiple suits. While there are significant limitations on data used to study specific tort reforms, persuasive results can be observed by looking at medical malpractice costs in certain states over time and relating that experience to the timing of particular tort reform measures.

In the following comparison of cost levels in three states that have enacted tort reform measures, paid losses of the individual states as a percentage of the U.S. total are used as the measure of costs. The percentage of physicians in each state as a total of U.S. physicians is used as a reasonable benchmark. The degree to which the percentage of paid losses differs from the percentage of physicians measures the effectiveness of the reforms. All else being equal, the relative cost percentages of paid medical malpractice claims should remain constant over time. Any observed changes in a state's relative cost levels provide an indication of the effectiveness of tort reform. The three states studied are California, New York, and Ohio.

The American Academy of Actuaries is the public policy organization for the actuarial profession, providing unbiased actuarial information to elected officials and regulators.

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Reform Act (MICRA) package of reforms was enacted in 1975, medical malpractice costs have fallen substantially as a percentage of the U.S. total.

• New York. Individual reform measures were adopted in 1975, 1981, 1985, and 1986. No observable improvement in the state's relative costs has resulted. The New York reforms did not include a cap on damages.

• Ohio. Reforms enacted in 1975 included a cap on damages. The cap was overturned in 1985, after which costs rose dramatically and have remained high.

California

The California loss data (Exhibit 1) illustrate that while the state's proportion of the U.S. physician population has remained relatively stable, its per-

Exhibit 1
Malpractice Loss Payments in California as a Percentage of the U.S. Total, 1975–94

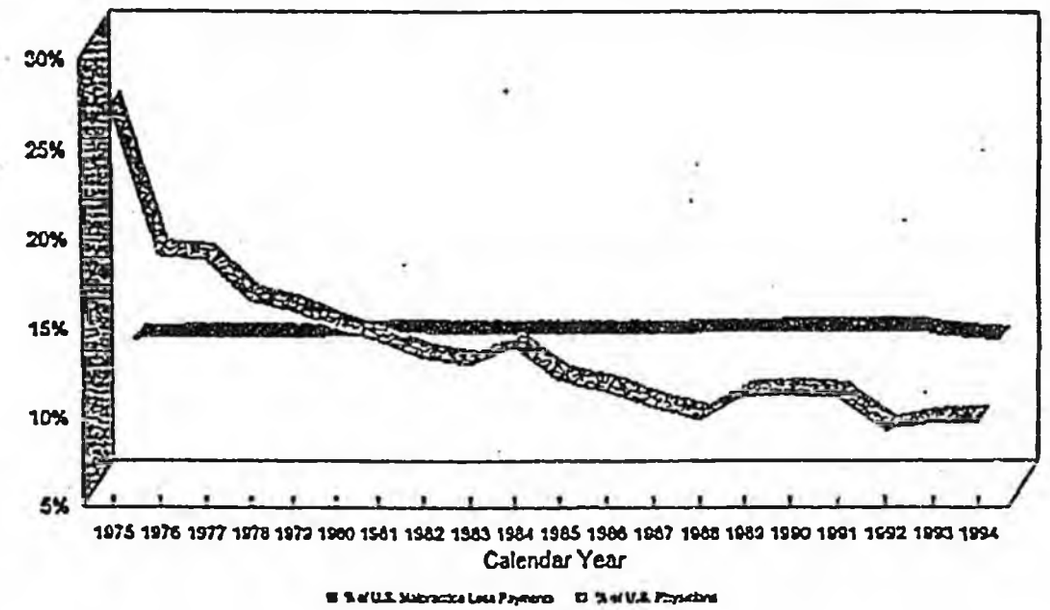
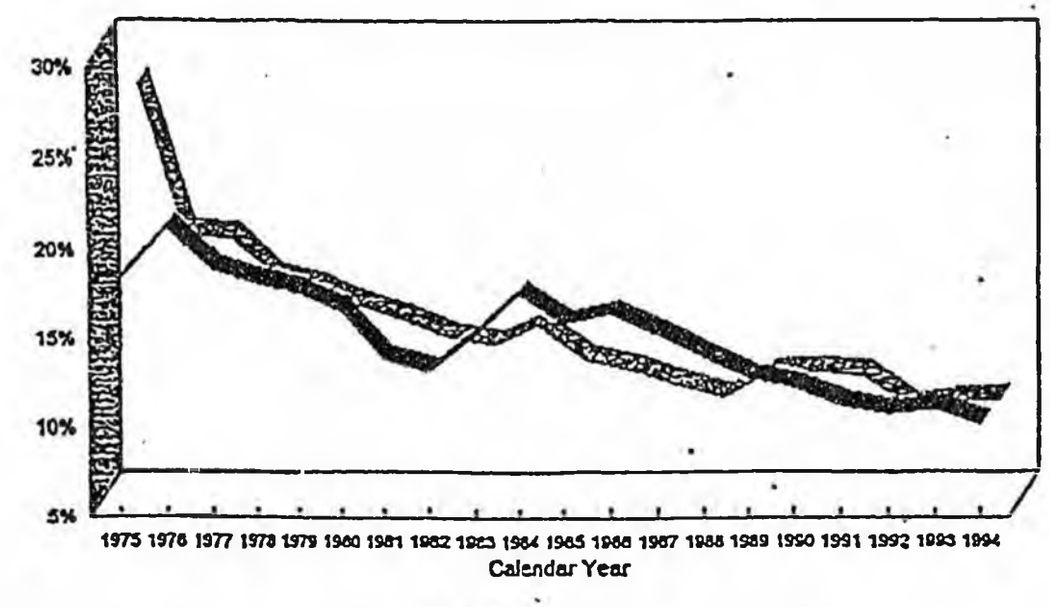


Exhibit 2
Malpractice Premiums and Malpractice Loss Payments in California as a Percentage of the U.S. Total,



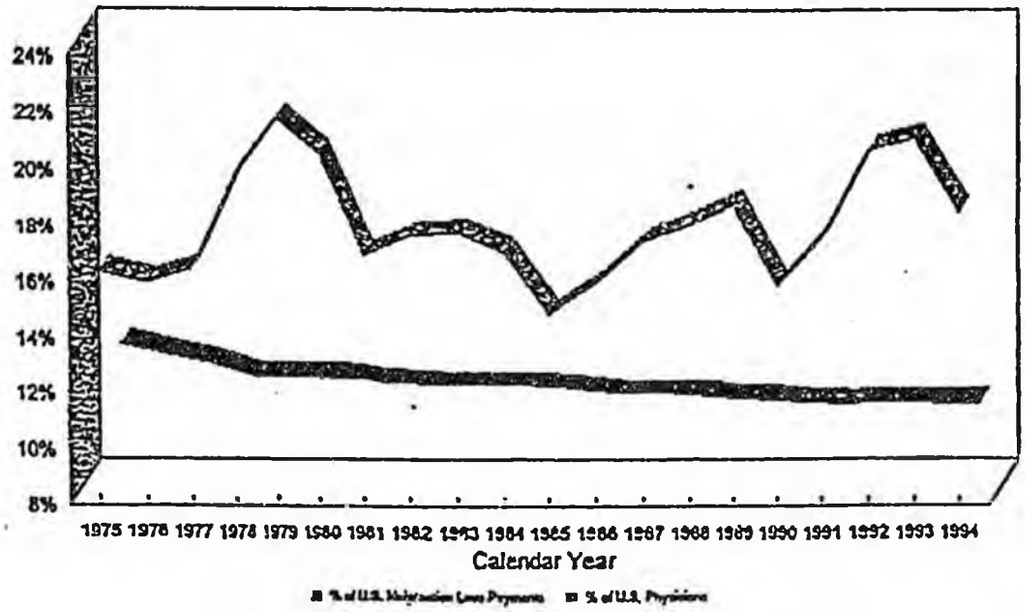
centage of loss payments has dropped dramatically since enactment of the MICRA package of tort reforms. Before MICRA's adoption in 1975, California's percentage of loss payments was significantly higher than its proportion of physicians. By 1981, California's loss payments had dropped and were about even with its percentage of physicians. Since that date, California has continued to benefit from MICRA: Costs continue to drop as a percentage of the U.S. total, even as the percentage of physicians remains stable. Although other factors affect these data, the relationship of decreased relative costs to the timing of reform provides strong evidence for the effectiveness of the MICRA package.

Many opponents of tort reform argue that insurance premiums do not drop after medical malpractice reform. Indeed, costs and premiums normally rise with inflation, and tort reform may only slow the increases. However, the California data show that premiums declined as losses declined. Exhibit 2 compares the paid loss data from Exhibit 1 with California premiums as a percentage of the total U.S. medical malpractice premiums. Although year-to-year fluctuations do occur, premiums have fallen in proportion to the decline in losses. Competition tends to keep companies at an appropriate profit margin, and any extra profits are normally short-lived.

New York

The New York loss experience is shown in Exhibit 3. It shows that the individual tort reform measures implemented in New York did not improve New York's experience relative to that of other states. New York's loss payment percentage does not show any observable pattern of decline or improvement over the 19-year period, despite the various tort reform measures adopted. The New York reforms did not include a cap on damages and were enacted in piecemeal fashion. Therefore, this result supports the merits of a cap on damages and the concept of a package of reforms.

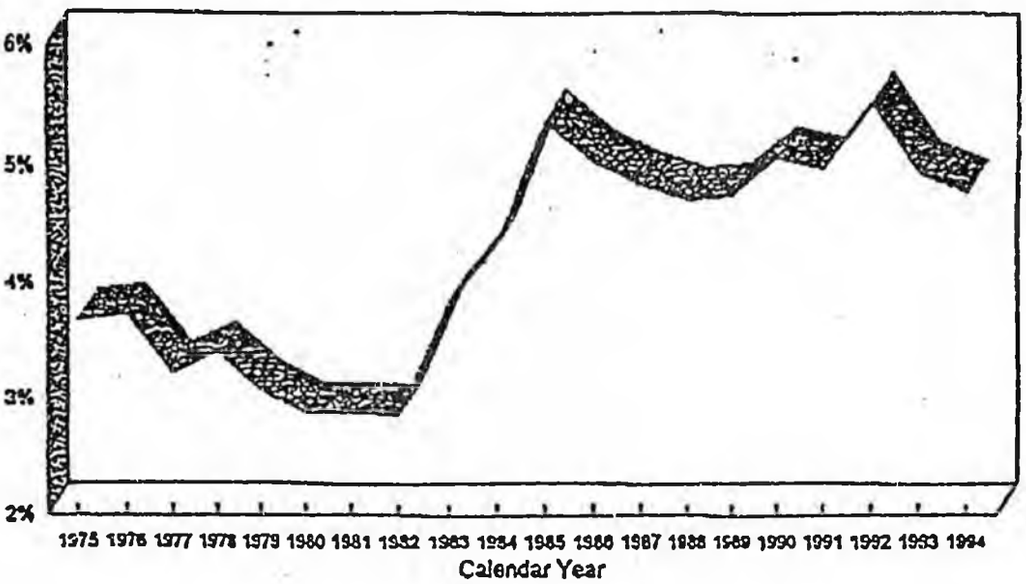
Exhibit 3
Malpractice Loss Payments in New York as a Percentage of the U.S. Total, 1975–94



Ohio

The final example is Ohio, with data presented in Exhibit 4. The data show a gradual decline in costs following tort reform in 1975. The Ohio cap on damages came under court challenge in 1982, resulting in sharp increases that reached a peak in 1985 when the cap was finally overturned. Since 1985, costs in Ohio have remained high, with no signs of decreasing. Again, the data appear to support a tort reform package and the specific benefit of a cap on noneconomic damages.

Exhibit 4
Malpractice Loss Payments in Ohio as a Percentage of the U.S. Total, 1975–94



Conclusions

California's experience indicates that properly implemented medical malpractice tort reform can reduce the cost of medical malpractice insurance. After reviewing several states' experience with medical malpractice tort reform and examining studies on the issue, the Academy work group has concluded the following:

- a package of reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums, and
- key among the reforms in the package are a cap on noneconomic awards and a mandatory collateral-source offset rule.

For reform to be effective in reducing costs, the cap on noneconomic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000). In addition, a mandatory collateral-source offset rule is needed to ensure that double and triple damages cannot be collected through multiple suits. Under this rule, each suit would have to consider damages already paid from other sources.

Although these reforms have been successful in reducing the cost of medical malpractice insurance, elected officials and regulators must still consider the effects of medical malpractice reform on physicians, consumers, health plans, and other interested parties. When considering medical malpractice reform, state and federal officials should weigh the impact on society as a whole and strive for a balanced, comprehensive solution.

AMERICAN ACADEMY *of* ACTUARIES

Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

Hearing on
"Assessing the Need to Enact Medical Liability Reform"

Statement of James Hurley, ACAS, MAAA
Chairperson, Medical Malpractice Subcommittee
American Academy of Actuaries

February 27, 2003

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INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to patient access to health care and, in particular, the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as Congress considers related proposals.

This testimony discusses what has happened to medical malpractice financial results and its likely effect on rates, tort reform, and some discussion of frequent misconceptions.

MEDICAL MALPRACTICE – WHAT HAS HAPPENED?

The medical malpractice insurance marketplace is in serious turmoil after an extended period of reported of high profitability and competitiveness during the 1990s. This turmoil began with serious deterioration in financial results, continued with some consequences of these results and, at least at this point, gives rise to an uncertain future. Industry-wide financial results reflect a 2001 combined ratio (the measure of how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year) that reached 153 percent and an operating ratio (reducing the combined ratio for investment income) of about 135 percent; the worst results since separate tracking of this line of business began in 1976. Projections for 2002 are for a lower combined ratio of approximately 140 percent and probable lesser improvement in the operating ratio. This follows 1999 and 2000 operating ratios of 106 percent.

The consequences of these poor financial results are several. Insurers have voluntarily withdrawn from medical malpractice insurance (e.g., St. Paul, writer of approximately nine percent of total medical malpractice insurance premium in 2000) or have selectively withdrawn from certain marketplaces or segments of medical malpractice insurance. In addition, several insurers have entirely withdrawn due to poor financial results (e.g., Phico, MIIX, Frontier, Reciprocal of America, some of which are under regulatory supervision). Overall, premium capacity has been reduced by more than 15 percent. These withdrawals fall unevenly across the states and generally affect those identified as jurisdictions with serious problems more severely than others.

Capacity to write business would have decreased even more if not for the fact that much medical malpractice coverage is written by companies specializing in this coverage, some of whom were formed for this specific purpose.

The future outlook is not positive, at least in the short term. Claim costs are increasing more rapidly now than they were previously. Further, the lower interest rate environment would require higher premium rates, even if losses were not increasing. The combined effect is that there are likely to be more poor financial results and additional rate increases.

Background

Today's premium increases are hard to understand without considering the experiences of the last decade. Rates during this time period often stayed the same or decreased relative to the beginning of the period due to several of the following factors:

- Favorable Reserve Development--Ultimate losses for coverage years in the late 1980s and early 1990s have developed more favorably than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years were reduced, income was contributed to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s for 30 provider-owned medical malpractice insurers whose results are shown in Chart A. What is evident from that chart is that favorable reserve development (shown as a percentage of premium) was no longer a significant factor in 2001 for these insurers as the effect approached zero. In contrast to the experience of these provider-owned insurers, the prior-year reserves for the total medical malpractice line of business actually deteriorated in 2000 and in 2001.

- Low Level of Loss Trend--The annual change in the cost of claims (frequency and severity) through most of the 1990s was lower than expected by insurers, varying from state to state and by provider type. This coincided with historically low medical inflation and may have benefited from the effect of tort reforms of the 1980s. Rates established earlier anticipated higher loss trends and were able to cover these lower loss trends to a point. As a result, rate increases were uncommon and there were reductions in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.

Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.

- High Investment Yields--During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Counter to what some may believe, medical malpractice investment results are based on a portfolio that is dominated by bonds with stock investments representing a minority of the portfolio. Although medical malpractice insurers had only a modest holding of stocks, capital gains on stocks also helped improve overall financial results. These gains improved both the investment income ratio and the operating ratio.

- Reinsurers Helped--Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. The additional capacity provided by reinsurers allows for greater availability of medical malpractice. Similar to what was happening in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.

- Insurers Expanded Into New Markets--Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (often with limited information to develop rates). They also became more competitive in existing markets, offering more generous premium discounts. Both actions tended to push rates down.

What Has Changed?

Although these factors contributed to the profitability of medical malpractice insurance in the 1990s, they also paved the way for the changes that began at the end of the decade.

- Loss Trend Began to Worsen--Loss cost trends, particularly claim severity, started to increase toward the latter part of the 1990s. The number of large claims increased, but even losses adjusted to eliminate the distortions of very large claims began to deteriorate. This contributed to indicated rate increases in many states.

- Loss Reserves Became Suspect--As of year-end 2001, aggregate loss reserve levels for the industry are considered suspect. Reserve reductions seem to have run their course. As mentioned earlier, the total medical malpractice insurance industry increased reserves for prior coverage year losses in 2000 and 2001, although results vary on a company-by-company basis. Some observers suggest that aggregate reserves will require further increases, particularly if severity trends continue or intensify.

- Investment Results Have Worsened--Bond yields have declined and stock values are down from 1990s highs. The lower bond yields reduce the amount of expected investment earnings on a future policy that can be used to reduce prospective rates. A one percent drop in interest rates can be translated to a premium rate increase of two to four percent (assuming no changes in other rate components) due to the several year delay in paying losses on average. A 2.5 percent drop in interest rates, which has occurred since 2000, can translate into rate increases of between 5 percent and 10 percent. Note that this factor may discourage an insurer from maintaining market presence and also may discourage new entrants.

- The Reinsurance Market Has hardened--Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of losses, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after Sept. 11, has caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

The bottom line is that these changes require insurers to increase rates if they are to preserve their financial health and honor future claim payments.

The Results

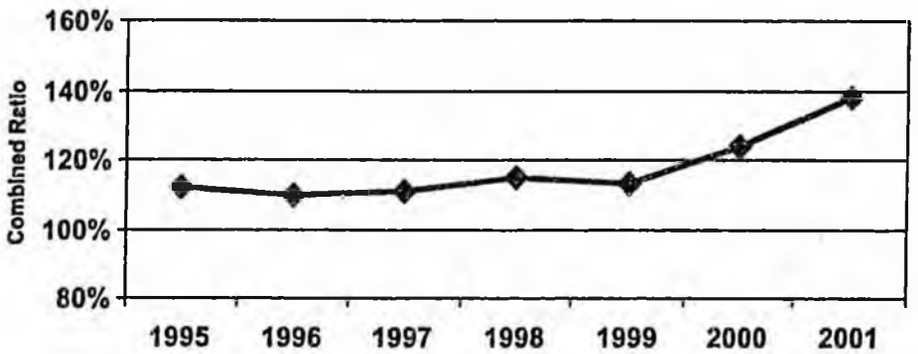
To obtain a better understanding of the effect of these changing conditions, we focus on the results of 30 specialty insurers that are primarily physician owned or operated and that write primarily medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the United States.

These insurers, achieving more favorable financial results than that of the total industry, showed a slight operating profit (four percent of premiums) in 2000. This deteriorated to a 10-percent operating loss in 2001 (see Chart B).

There are two key drivers of these financial results:

- Insurance Underwriting--For these companies, a simplified combined ratio was calculated by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124 percent and 138 percent in 2000 and 2001, respectively. That means in 2001, these insurers incurred $1.38 in losses and expenses for each $1.00 of premium. The preceding five years were fairly stable, from 110 percent to 115 percent. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively constant (see Chart C).

CHART C: COMBINED RATIO



- Investment Income--Pre-tax investment income (including realized capital gains and losses) derives from policyholder-supplied funds invested until losses are paid as well as from the company capital ('surplus'). The ability of investment income to offset some of the underwriting loss is measured as a percentage of earned premiums. This statistic declined during the measurement period from the mid-40 percent to the mid-30 percent level and, in 2001, to 31 percent (see Chart D).

  This offset will continue to decline because (i) most insurer-invested assets are bonds, many of which were purchased before recent lower yields, and interest earnings do not yet fully reflect these lower yields; and (ii) the premium base is growing due to increased rates and growth in exposure. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

The effect of these results on surplus is reflected in Chart E, which shows the percent change in surplus from one year to the next. Surplus defines an insurer's capacity to write business prospectively and to absorb potential adverse loss development on business written in prior years (see Chart E).

TORT REFORM

Some states enacted tort reform legislation after previous crises as a compromise between affordable health care and an individual's right to seek recompense. The best known is the Medical Injury Compensation Reform Act or MICRA, California's tort reform package. Since MICRA's implementation in 1975, California has experienced a more stable marketplace and lower premium increases than have most other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. The Academy, which takes no position for or against tort reforms, has previously reviewed and commented on this subject. Based on research underlying the issue, we observe the following:

- A coordinated package of tort reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums.
- Key among the reforms in the package are a cap on non-economic awards (on a per-event basis and at some level low enough to have an effect; such as MICRA's $250,000) and a mandatory collateral source offset rule.
- Such reforms may not assure immediate rate reductions, particularly given the size of some increases being implemented currently, as the actual effect, including whether or not the reforms are confirmed by the courts, will not be immediately known.
- These reforms are unlikely to eliminate claim severity (or frequency) changes but they may mitigate them. The economic portion of claims is not affected if a non-economic cap is enacted. Thus rate increases still will be needed.
- These reforms should reduce insurer concerns regarding dollar awards containing large, subjective non-economic damage components and make the loss environment more predictable.
- Poorly crafted tort reforms could actually increase losses and, therefore, rates.

FREQUENT MISCONCEPTIONS

In closing, it might be helpful to address some frequent misconceptions about the insurance industry and medical malpractice insurance coverage.

Misconception 1: "Insurers are increasing rates because of investment losses, particularly their losses in the stock market."

As we have pointed out, investment income plays an important role in the overall financial results of insurers, particularly for insurers of medical professional liability, because of the long delay between payment of premium and payment of losses. The vast majority of invested assets are fixed-income instruments. Generally, these are purchased in maturities that are reasonably consistent with the anticipated future payment of claims. Losses from this portion of the invested asset base have been minimal, although the rate of return available has declined.

Stocks are a much smaller portion of the portfolio for this Group, representing about 15 percent of

invested assets. After favorable performance up through the latter 1990s, there has been a decline in the last few years, contributing to less favorable investment results and overall operating results. Investment returns are still positive, but the rates of return have been adversely affected by stock declines and more so by lower fixed income investment yields.

In establishing rates, insurers do not recoup investment losses. Rather, the general practice is to choose an expected prospective investment yield and calculate a discount factor based on historical payout patterns. In many cases, the insurer expects to have an underwriting loss that will be offset by investment income. Since interest yields drive this process, when interest yields decrease, rates must increase.

Misconception 2: "Companies operated irresponsibly and caused the current problems."

Financial results for medical liability insurers have deteriorated. Some portion of these adverse results might be attributed to inadequate knowledge about rates in newly entered markets and to being very competitive in offering premium discounts on existing business. However, decisions related to these actions were based on expectations that recent loss and investment markets would follow the same relatively stable patterns reflected in the mid-1990s. As noted earlier, these results also benefited from favorable reserve development from prior coverage years. Unfortunately, the environment changed on several fronts — loss cost levels increased, in several states significantly; the favorable reserve development ceased; investment yields declined; and reinsurance costs jumped.

While one can debate whether companies were prudent in their actions, today's rate increases reflect a reconciliation of rates and current loss levels, given available interest yields. There is no added cost for past mispricing. Thus, although there was some delay in reconciling rates and loss levels, the current problem reflects current data.

Misconception 3: "Companies are reporting losses to justify increasing rates."

This is a false observation. Companies are reporting losses primarily because claim experience is worse than anticipated when prices were set. Several companies have suffered serious adverse consequences given these financial results, including liquidation or near liquidation. Phico, MIIX, Frontier and, most recently, the Reciprocal of America, are all companies forced out of the business and in run-off due to underwriting losses. Further, the St. Paul Cos., formerly the largest writer of medical malpractice insurance, is now in the process of withdrawing from this market. One reason for

this decision is an expressed belief that the losses are too unpredictable to continue to write the business.

The Academy appreciates the opportunity to provide an actuarial perspective on these important issues and would be glad to provide the subcommittee with any additional information that might be helpful.

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STATEMENT

OF THE

PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Presented by
Richard E. Anderson, M.D., Chairman
The Doctors' Company

Before the

Subcommittee on Health
Committee on Energy and Commerce
U.S. HOUSE OF REPRESENTATIVES

Regarding:
"Harming Patient Access to Care:
Implications of Excessive Litigation"

Wednesday, July 17, 2002

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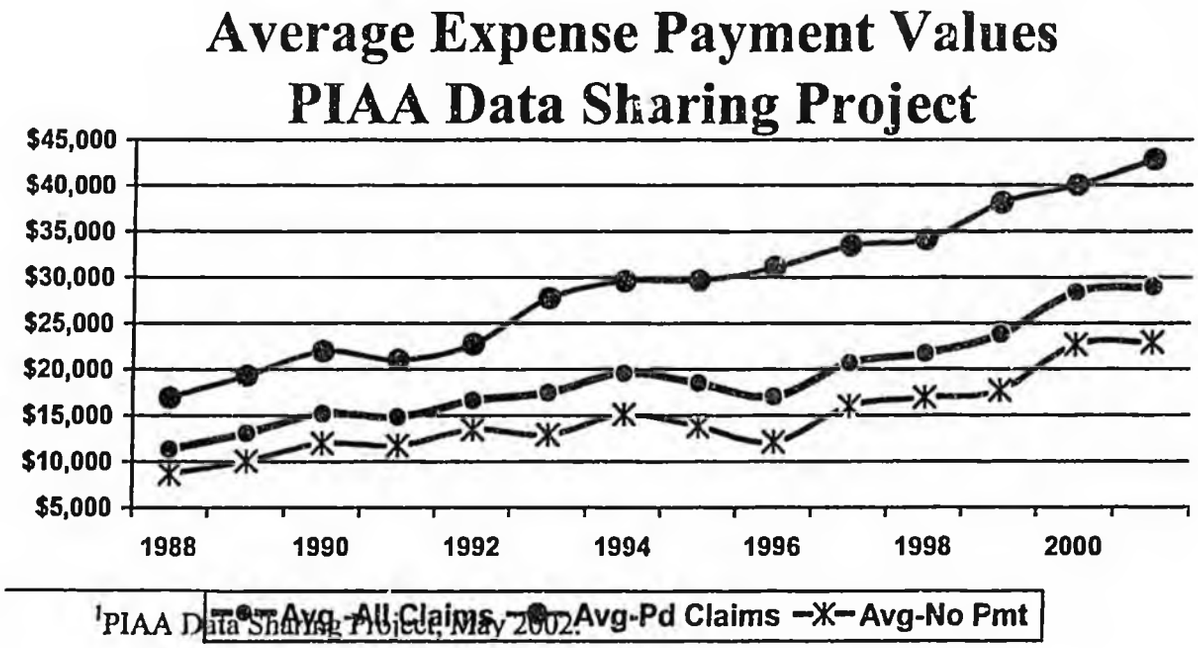
Chairman Bilirakis, Representative Brown and members of the subcommittee, thank you for this opportunity to present to you today our views on the implications of excessive litigation and the need for Federal health care litigation reform. My name is Richard Anderson and I am an oncologist with more than 25 years experience practicing cancer medicine in California. I am also Chairman of The Doctors' Company one of the 45 doctor-owned and/or operated medical liability insurers that comprise the Physician Insurers Association of America (PIAA). Collectively, the PIAA companies insure over 60% of the Nation's practicing physicians. At last count, PIAA companies insured more than 277,000 doctors and 1,100 hospitals. On behalf of our member companies and their insureds, the PIAA has always supported health care liability reform that will more equitably and rapidly compensate patients who have received substandard care, but which at the same time will also limit frivolous lawsuits and increase access to health

care.

BACKGROUND

Despite stunning advances in scientific knowledge, medicine remains more of an art than science because human beings are not machines. Sadly, the tide of litigation against America's doctors has risen even faster. Approximately one of every six practicing physicians faces a malpractice claim every year. In high-risk specialties such as obstetrics, orthopedics, trauma surgery and neurosurgery, there is one claim for each doctor every 2 ½ years. However, fully 70% of these tens of thousands of cases are found to be without merit. Nonetheless, every single case requires a costly legal defense. Nationally, as the chart below shows, these loss adjustment expenses average $22,967 per defendant. Those cases that go all the way through trial before a vindicating defense verdict average $85,718 per defendant.[1] [See chart below] The Doctors' Company itself, for example, has spent more than $400 million defending claims that ultimately were shown to be without merit.



[1]PIAA Data Sharing Project, May 2002.

ROOTS OF THE CURRENT ENVIRONMENT

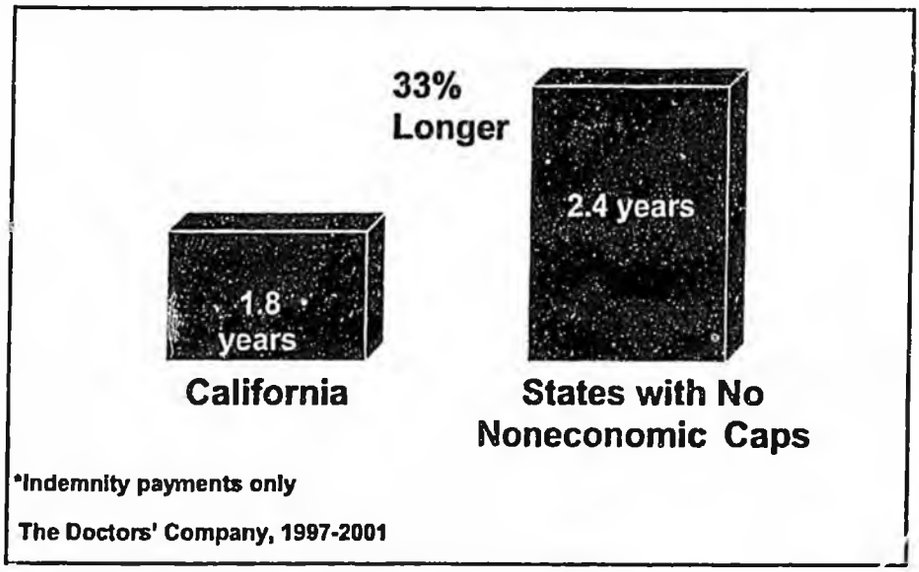
Medical liability claims were fairly uncommon until the 1970s. In the 40 year period between 1935 and 1975, 80% of all medical malpractice lawsuits were filed in the last five years of that period.[2] Massive losses between 1970 and 1975 forced many commercial insurers to conclude that the practice of medicine was an uninsurable risk, and they simply refused to provide malpractice insurance at any price. This resulted in a "crisis of availability" to which providers responded emergently. Doctors contributed their own funds as capital to support the efforts of their state medical and hospital associations, among others, to start as many as 100 provider owned specialty carriers across the country. Dubbed "bed pan mutuals" by their commercial competitors (many of whom had fled the market), these upstarts were not expected to succeed where the giant commercials could not find success. Because their primary mission is to provide a service, and because they were entirely committed to remaining present even in the most difficult markets, these companies have succeeded and are the basis of the PIAA. As one example, The Doctors' Company was formed by doctors, for doctors in 1976, and today insures more than 25,000 doctors throughout the nation.

A LITIGIOUS SOCIETY GROWS

A second crisis emerged in the early 1980's, known as a "crisis of affordability." Insurers faced ever-mounting losses, with rampant increases in paid claim frequency (number of paid claims) and severity (amount of indemnity payment). PIAA data shows that on average it takes 5 ½ years for an insurer to

close a malpractice claim after the date of the incident.[3] There is often a long lag before the claim is reported. The majority of the delay, however, comes because of the inefficiencies of the tort system. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of malpractice litigation in that state. The Doctors' Company data reveals that claims are settled in one-third less time than the national average. [See chart below] This result not only decreases the cost of litigation, but it means injured patients are indemnified much faster in California.

MICRA Reduces Average Time to Settlement



During much of the 1990s, PIAA companies exercised their fiduciary responsibility to wisely invest the premium deposits of their policyholders, who benefited from the rising bond markets. These returns were used not to line the pockets of the companies, but to subsidize the premium rates being charged to

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[2]Professional Liability in the '80s, Report 1, American Medical Association, 10, 84, p4.

policyholders so that they could remain affordable. It was the policy holders (health care providers) who reaped the financial benefits.

It must be noted that insurance is a highly regulated industry. Every state department of insurance, as well as the national rating agencies, closely monitors both the kinds and qualities of investments. Virtually no medical liability insurance company has experienced net investment losses. In fact, 80% of investments by PIAA companies are in high-grade bonds. What has happened is that investment yields have declined due to falling interest rates and are no longer available to subsidize premium rates to the extent they once did. In other words, premium rates must now more closely match the actual cost of losses. The combination of these factors created "the perfect storm" for medical liability insurers.

THE PERFECT STORM

During this same time period, claim frequency and severity continued to increase. In addition, reinsurance costs rose significantly in relation to the increase in loss costs. The insurance system was able to accommodate even this inexcusable volume of litigation as long as the size of the few valid claims was predictable. Unfortunately, in the past few years there has been an explosion in the cost of individual claims. Texas has seen a $268,000,000 verdict. A number of states have witnessed verdicts in excess of $100,000,000. The city of Philadelphia alone has recorded multiple verdicts in excess of $50,000,000 in just the past two years. Four claims in Arkansas totaled $98,000,000 in just the past year. According to PIAA data [shown on next chart], during the period 1991 to 2001, the percentage

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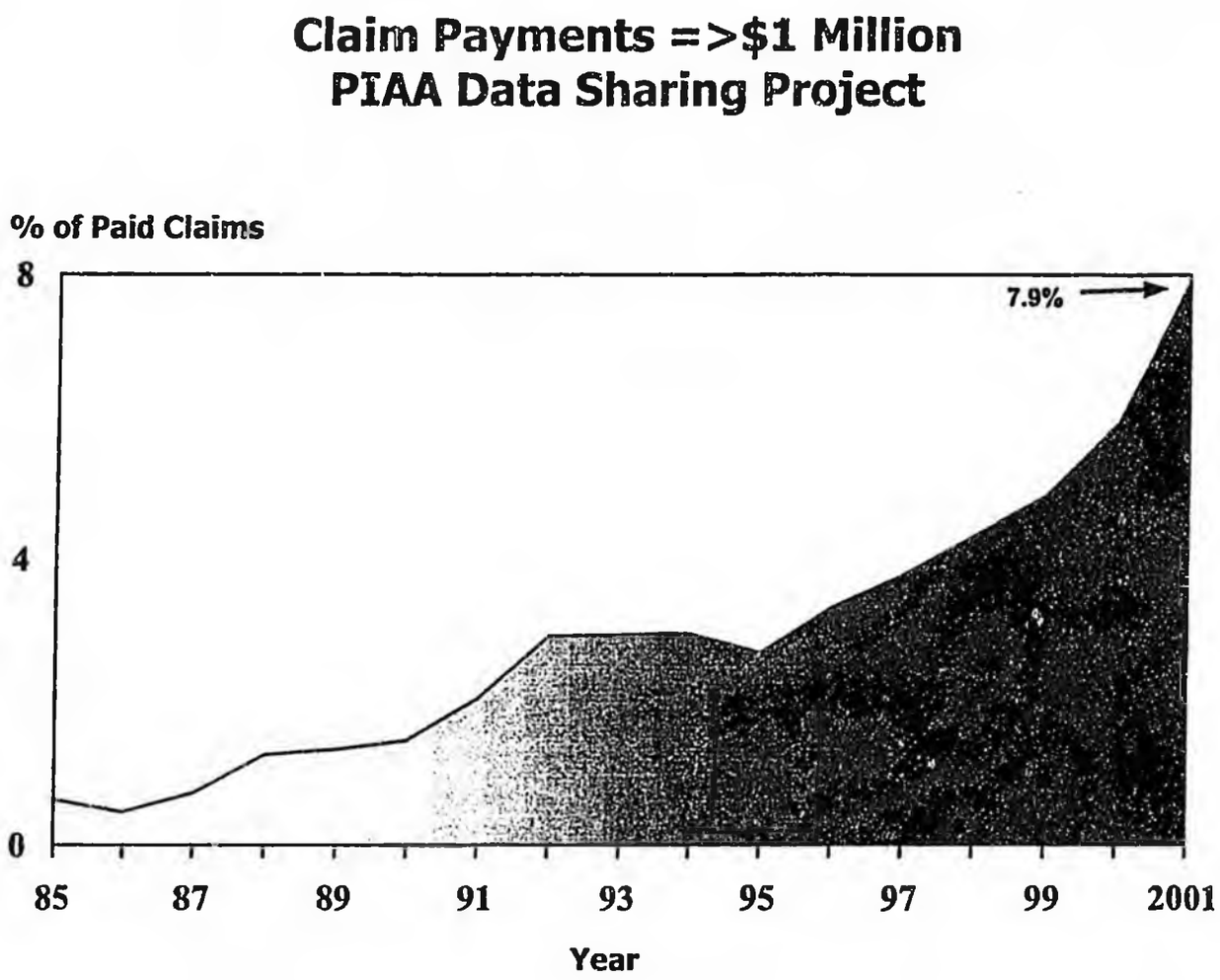
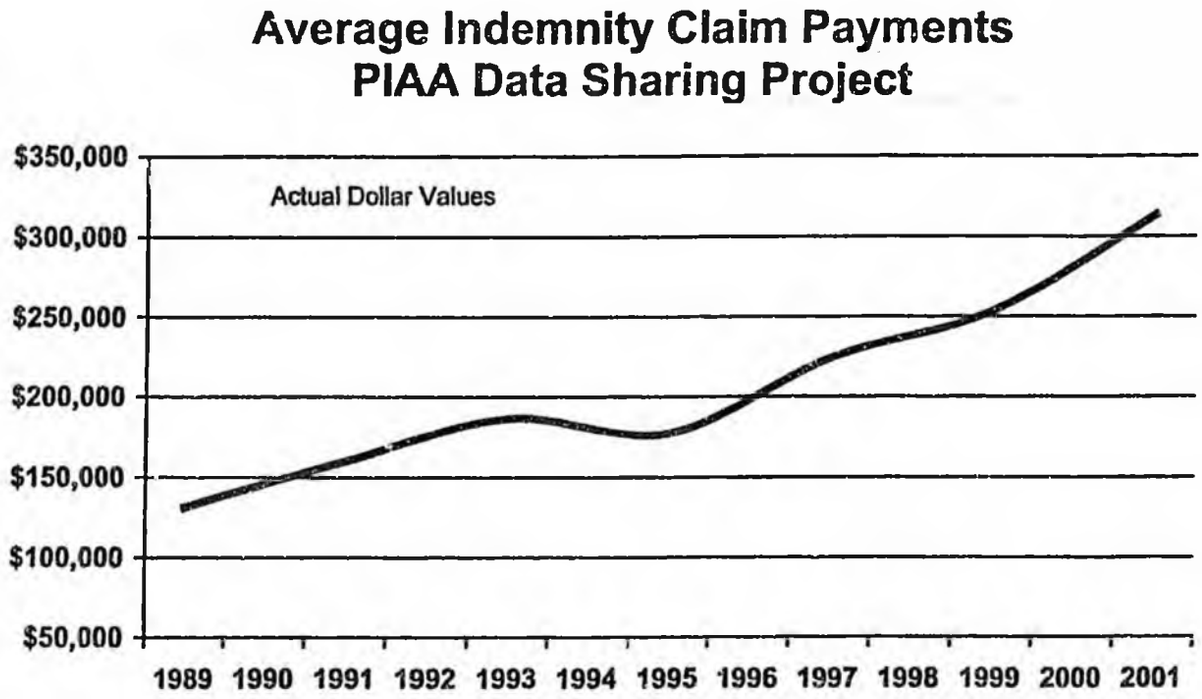
[3]PIAA Data Sharing Project, December, 2001.

of claims costing in excess of $1 million dollars increased nearly four-fold. Insurance is not magic. If society expects insurers to pay unlimited awards, it should expect those who are insured to pay corresponding premiums. As premiums rise so must the cost of health care. Since health care today is a zero sum game, these costs increases mean corresponding decreases in ***access*** to health care.



Those are the largest claims. What about the size of the average claim? PIAA data shows that the average indemnity payment in 2001 was more than $310,000, a 60% increase in the last five years. As the next chart shows, the average malpractice payment is rising precipitously. With it, the sum of the

malpractice claims paid rises. In New York and Pennsylvania alone nearly $1 billion was paid in 2000.



*Per defendant - many claims have more than one defendant

**Data reported for year 2000 incomplete at time of analysis.

THE CURRENT SITUATION

As the new millennium began, insurers who were not able to weather the storm began to experience poor financial results. Expressed differently, a number of companies that felt that they could provide insurance for less than its cost learned the inevitable lesson. Several, such as PHICO, PIE and Reliance, have ceased

all underwriting operations. In December of last year, long-time industry leader St. Paul announced that due to unsustainable losses and the "unfavorable tort environment" the company would no longer write new medical liability coverage and it would not renew the policies of its 42,000 physicians, 750 hospitals and 73,000 other health care providers. Though St. Paul is a commercial carrier and not a member of PIAA, it is telling that the largest company in the industry for the better part of two decades feels that it can no longer afford the risk of insuring the practice of medicine. Companies remaining in the market have had no choice but to take the rate increases necessary to insure survival.

Conning & Co. estimates that malpractice insurers will pay out approximately $1.40 for every premium dollar collected in 2001 and 2002. Even with the projected rate increases, Conning & Co. still projects insurers will pay out $1.35 for each dollar collected in 2003 (Conning Report on Medical Malpractice Insurance, April 2002). PIAA data reveals that since 1990, claims costs have risen annually by 6.9%, nearly three times the rate of inflation.

IN CONCLUSION

The average claim payment has increased by 60% over the past five years. The cost of the most expensive claims has exploded in a manner that is absolutely unprecedented. If judgments are to be unlimited, than the premiums need to increase accordingly to pay for those judgments. With absolute certainty, this money will be taken out of our healthcare system and compound the severe access to care issues that we all face today.

Several spurious arguments have been put forth by those with an interest in continuing the tsunami of medical malpractice litigation. First, it has been deceptively argued that stock market losses are the real driver of price increases. In fact, investments by insurance companies are highly regulated and controlled by each state department of insurance and closely monitored by the rating agencies. Insurance companies continue to gain funds from their investments and use those funds to offset even higher malpractice premium rates. As income from investments decreases, however, premiums must more closely match losses.

Second, it is argued that insurance companies should have raised rates sooner. There may be some truth to this. However, *it is difficult to understand how having today's sky-high rates earlier would make them more palatable.*

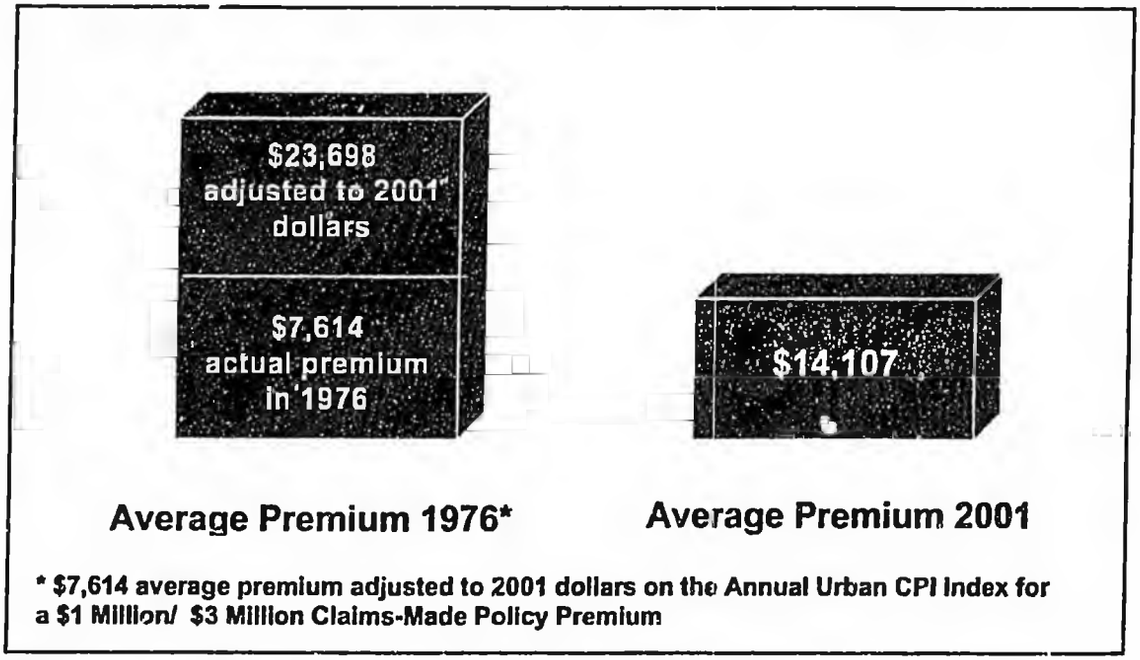
Third, it is argued that insurance companies fail to settle claims when they should, and are therefore, exposed to astronomic jury verdicts. Again, reality is quite different. In most cases, it is the physician, not the company, who must make any settlement decision. Remember that doctors are found to be without fault in approximately 8 out of 10 malpractice trials. Should these cases have been settled?

Finally, there are those who argue for a state run medical liability system. Allow me to point out that the majority of state run malpractice programs have gone bankrupt, or charge premiums that are much higher than those charged by PIAA companies. In New York, premiums are actually set by the Department of Insurance, not by individual companies, and New York rates are among the highest in the nation.

THERE IS A "TRIED AND TRUE" SOLUTION

California has 27 years of experience with the MICRA statutes. We know, we do not have to speculate, that tort reform works. Since 1975, The Doctors Company malpractice premium rates in California have decreased by 40% in constant dollars. [See chart below] This is true despite the fact that there has not been and is not today any limit on actual damages awarded.

MICRA Helps Reduce California Medical Liability Premium Rates by 40%



We know, we do not speculate, that claims settle about 33% faster in California than the rest of the nation because the lottery aspect of non-economic damages has been controlled.

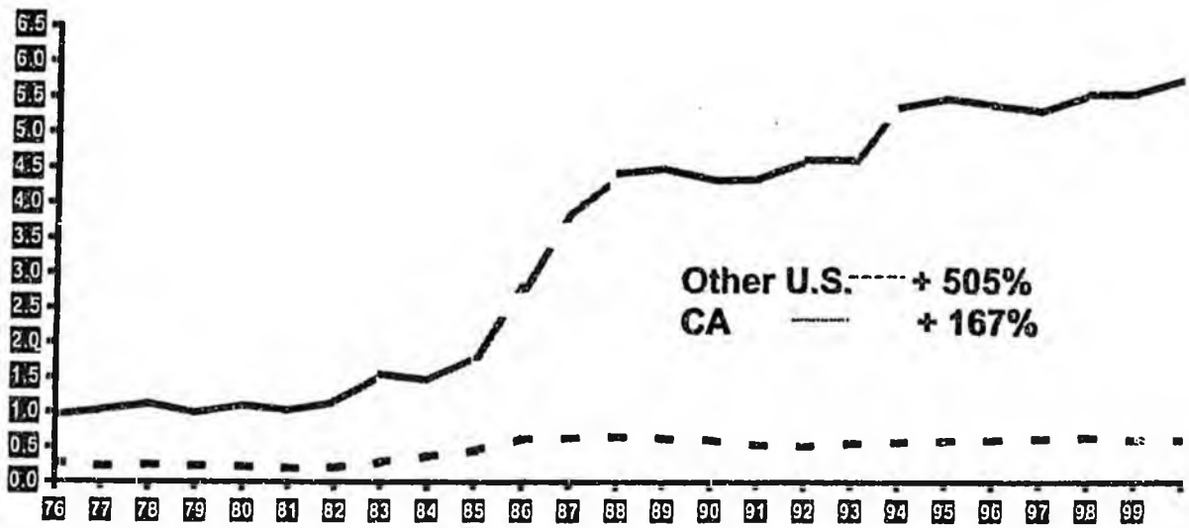
We know, we do not speculate, that even very large judgments can be accommodated by the insurance system because they can be paid on an annual basis over the intended period of compensation, not as a single jackpot.

We know, we do not speculate, that injured patients actually take home a significantly higher percentage of awards in California because there is an upper limit on attorney contingency fees. In many areas, more than 40% of a malpractice award goes directly into the pocket of the plaintiff's attorney. In California, MICRA contains a limitation on this fee. An attorney winning a $1 million claim must be satisfied with a legal fee of $221,000.

We know, we do not speculate, that MICRA has not limited access to attorneys. California remains a litigious state and according to The Doctors Company data the frequency of malpractice cases in the state is 50% higher than the national average.

California passed effective tort reforms and its providers have been able to weather this liability crisis well. These same reforms are found in H.R. 4600, the Help Efficient, Accessible, Low-cost, and Timely Healthcare Act of 2002 (the HEALTH Act). The PIAA and The Doctors Company fully support the provisions of this act, which when signed into law, will provide the same protections to patients across the United States as found in California for over a quarter century. The next chart, which was compiled from data reported to the National Association of Insurance Commissioners, speaks volumes about MICRA's effectiveness:

Savings from MICRA Reforms
California vs. U.S. Premiums 1976 - 2000



We thank members of the Committee and their staff for holding this important hearing and inviting us to testify. We look forward to working with you to make the health care liability system fairer for everyone. I will be happy to answer any questions you might have.

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

Medical Professional Liability - *Not for the Faint of Heart*

Medical Professional Liability **is one of the most dangerous lines of insurance, second only to earthquake (property) coverage**

by Deborah Ropelewski, CPCU, ARM, ARe, Division Sr. VP, Gallagher Healthcare Insurance Services, Inc.

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

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

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

Gallagher Healthcare Insurance Services

A SUBSIDIARY OF ARTHUR J. GALLAGHER & CO

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

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

1. A sustained escalation of underwriting losses-

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

- A study done for the U.S. Department of Health & Human Services (HHS) dated July, 2002 [3], indicates that the **average** award rose 76% in the period from 1996 to 1999. The **median** award increased 6.7% from 1998 to 1999, and another 43% in 1999-2000, or from roughly $750,000 to $1,140,000 in the two-year period from 1998-2000.
- The HHS study [3] notes that Jury Verdict Research data [3] reflects that the **average** jury award went from $1,140,000 in 1994 to $3,480,000 in 2000- a whopping 305% increase!

- The PIAA Data Sharing Project [4] illustrates that in 1985 less than 10% of all paid claims were over $250,000; by 2001 the number had jumped to over 40%. Likewise, less than 5% of all paid claims in 1985 were over $500,000, but this had increased to over 25% by 2001.

2. A decline in investment income-

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

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

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

3. An epidemic of national proportions-

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

The states "in crisis" share several key characteristics-

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

4. Emerging marketplace issues-

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

The companies that remain simply do not have the capacity to write all the business that is made available to them. Many that had enjoyed low Written Premium-to-Surplus ratios in the recent past now find their surplus stretched to an extent that they would have never thought possible, and much of that is just due to rating actions in the past few years that have significantly increased the written premiums on their existing books of business. This has been exacerbated by deteriorating results due to development on prior years, and the companies have had difficulty in finding ways to increase surplus to finance additional premium growth. Primary insurers have returned to underwriting discipline and find themselves having to carefully and consciously allocate what surplus they do have available, if any.

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

So what is the Reinsurers' response?

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

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

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

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

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

In conclusion, the key reinsurers that are dedicated to the Medical Professional Liability industry have made a renewed commitment to underwriting and pricing integrity and discipline over the past few years. One of their primary responsibilities going forward will be to monitor and evaluate the ongoing financial viability of their reinsureds, as reflected in responsive rate actions, their loss projections based on prior years' losses, and investment income assumptions, among other measures. Given the current climate and experience in our industry it is unlikely that the MPL reinsurance market will become significantly less restrictive in the near future.

Footnotes:

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

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PROFESSIONAL ISSUES

Liability insurance crisis: Bigger awards just one factor

Lower interest rates and a highly competitive insurance market also contributed to today's medical malpractice mess.

By Tanya Albert, *AMNews* staff. April 15, 2002.

The latest statistics confirm what many physicians already suspect: Jury verdicts in medical malpractice cases continue to soar.

Plaintiffs lose the majority of cases that go before a jury. But when they win, an increasing number win big.

With this article
- Jury awards kept going up...
- Going to trial

The median medical malpractice awards were up nearly 43% between 1999 and 2000, according to Jury Verdict Research data released in late March. The Pennsylvania-based company gathers information on verdicts and awards from cases involving physicians, hospitals and other health care entities nationwide.

The fourth straight annual jump means that the median award -- the middle award value when the awards are listed in ascending order -- hit the $1 million mark in 2000. That's nearly double what it was in 1996, when the median award was $503,000, according to the statistics.

"There are jurisdictions where it is manifesting itself as a crisis," said Jim Hurley, an actuary with Tillinghast-Towers Perrin who looks at medical malpractice issues. "But it is not a crisis nationwide yet."

Physicians in Pennsylvania, West Virginia, Mississippi and Nevada have been the hardest hit by medical malpractice woes. The large jury awards coincide with other volatile factors that have some calling the situation "the perfect storm."

And it's unlikely physicians will see any relief this year.

Medical liability insurers continue to pull out of some markets or set narrow guidelines defining the physicians they are willing to insure. Interest rates remain low. And jury awards show no sign of coming under control. In March, a Florida jury said a physician, a physician's assistant and nursing staff were negligent in caring for a patient who ended up with a brain injury and awarded her $78.5 million.

"I fear it's not heading in a great direction for doctors," said James Saxton, a lawyer and chair of the health litigation group for Stevens & Lee in Pennsylvania.

For doctors, that translates into higher liability insurance rates and, for some, difficulty finding insurance at all.

How costs got here

Increasing jury verdicts shoulder only some of the blame for rising liability insurance rates. But other factors that influence insurance cost are also going haywire.

Insurance experts say those factors include low interest rates, which translate into a lower return on investments insurers make to cover claims and rate increases to compensate for realities in the market throughout the 1990s. Rates were underpriced and held in a highly competitive market. In the haste to expand into new states, some insurers initially priced their products incorrectly because they did not completely understand the market.

The 2000 median malpractice award was $1 million; the 1996 median award was $503,000.

"It's a perfect storm," Hurley said.

Some of the storm damage to date: PHICO Insurance Co. is in liquidation. Princeton Insurance Co. announced it would leave the Pennsylvania market. The St. Paul Companies pulled out of the medical liability market nationwide.

"And that's just a sampling of what's going on," said Tim Saunders, vice president of claims for the Illinois State Medical Inter-Insurance Exchange. "This is a unique cycle."

While jury verdicts are just one piece of the puzzle, they are an area with room for improvement in most states, insurance companies and physicians say.

It's difficult to pinpoint exactly why jury awards are going up. Some say jurors are desensitized to what constitutes a significant sum of money thanks to lottery and game show winnings in the tens of millions of dollars. Specific to the medical profession, jurors may be acting out of an anger toward managed care or a desire to send a message about their dismay with health care in general.

And despite Jury Verdict Research data showing that settlements went down 16% between 1999 and 2000, many companies say the amount they settle cases for continues to rise.

"We win the vast majority of cases we take to verdict," said Walt Davis, Mutual Insurance Co. of Arizona's vice president of claims. "Of the verdicts that go to the plaintiff, many of them come in under our last offer. However, each year we get hit with one higher award than expected. Based on our verdicts and the verdicts and settlements of others, it is costing a lot more to settle cases."

Damage caps could offer relief

One way to curb the unpredictable verdicts and the rising settlements that inevitably follow are limits on the amount of noneconomic damages juries can award. The AMA and other physician organizations are encouraging states to pass laws that would limit damages.

Proponents of these laws point to California's $250,000 cap on noneconomic awards as one of the main reasons the state hasn't seen jury verdicts spiral out of control.

"You don't have the emotion-laden blockbuster verdicts," said Ron Neupauer, vice president of underwriting for Medical Insurance Exchange of California. "There have been large awards, but they aren't those unpredictable, out-of-the-blue-sky awards."

MIEC insures physicians in California, Idaho, Alaska, Nevada and Hawaii. Neupauer said the company had been forced to raise rates outside California, but that rates had remained stable in that state.

"Overall, the California experience is better than it is next door in Nevada," he said. "You can't say medicine here is better or the attorneys in other states are better."

"The sky's the limit in most states," said Robert Hartwig, chief economist for the Insurance Information Institute.

"The jury is allowed to come up with any amount, and, unfortunately, the theory of deep pockets often prevails."

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ADDITIONAL INFORMATION:

Jury awards kept going up...

The median jury award -- the middle value among awards listed in ascending order -- increased nearly 43% between 1999 and 2000. It's up 100% since 1995.
1995: $500,000
1996: $474,536
1997: $503,000
1998: $733,900
1999: $700,000
2000: $1,000,000

... But settlements went down

The median settlement in 2000 was nearly 16% below 1999's level.
1995: $350,000
1996: $375,000
1997: $400,000
1998: $500,000
1999: $592,074
2000: $500,000

Note: Statistics for years prior to 2000 may not match numbers previously reported for that year. Statistics for previous years are updated with new information that may come after a report is published.

Source: Jury Verdict Research report "Medical Malpractice: Verdicts, Settlements and Statistical Analysis"

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Going to trial

Compensatory award medians for most commonly claimed liability situations between 1994 and 2000 are significantly higher than the settlement medians for the same time period.

	Compensatory award median	Settlement median
Childbirth	$2,050,000	$750,000
Cancer diagnosis	$1,000,000	$500,000
Delayed treatment	$1,000,000	$665,000
Diagnosis	$750,000	$462,500
Medication	$668,000	$235,000
Lack of informed consent	$500,000	n/a*
Nonsurgical treatment	$400,688	$250,000
Negligent surgery	$355,000	$325,000
Negligent supervision	$147,750	$200,000

* Settlement median unavailable.

Source: Jury Verdict Research report "Medical Malpractice: Verdicts, Settlements and Statistical Analysis"

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ATRA Tort Reform Record

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December 31, 2003

The Tort Reform Record is published each June and December to record the accomplishments of the latest legislative year. It includes a two-page, state-by-state summary of the ATRA-supported reforms enacted by the states since 1986.

Please note: The Record lists tort reforms enacted since 1986; it does not list legislative reforms enacted prior to 1986, the year of ATRA's founding.

For each issue included in the Record, ATRA provides issue papers and model legislation.

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Tort Reform Record

At-A-Glance

	Punitive Damages	Joint & Several Liability	Prejudgment Interest	Collateral Source Rule	Noneconomic Damages	Product Liability	Class Action Reform	Attorney Retention Sunshine	Appeal Bond Reform	Jury Service Reform
Alabama	X			X	◈		X			
Alaska	X	X	X	X	X					
Arizona	X	X		X						X
Arkansas	X	X							X	
California	X	X				X			X	
Colorado	X	X	X	X	X	X	X	X	X	
Connecticut		X		X						
Delaware										
District of Columbia										
Florida	X	X		X	X	X			X	
Georgia	X	X	X	◈		X	X		X	
Hawaii		X		X	X					
Idaho	X	X		X	X				X	
Illinois	◈	X		X	◈	◈				
Indiana	X			X		X			X	
Iowa	X	X	X	X		X				
Kansas	X			◈	X			X	X	
Kentucky	X	X		X					X	
Louisiana	X	X	X			X	X		X	X
Maine			X	X		X				
Maryland					X					
Massachusetts		X								
Michigan		X	X	X	X	X			X	
Minnesota	X	X	X	X	X				X	
Mississippi	X	X			X	X			X	
Missouri	X	X	X	X					X	
Montana	X	X		X	X	X				

◈ Denotes state where reform was struck down as unconstitutional and no additional reforms are in place.

Tort Reform Record
At-A-Glance

	Punitive Damage	Joint & Several Liability	Prejudgment Interest	Collateral Source Rule	Noneconomic Damage	Product Liability	Class Action Reform	Attorney Retention Sunshine	Appeal Bond Reform	Jury Service Reform
Nebraska		X	X							
Nevada	X	X			X				X	
New Hampshire	X	X	X		◈	X				
New Jersey	X	X		X		X			X	
New Mexico		X								
New York	X	X		X						
North Carolina	X					X			X	
North Dakota	X	X		X	X	◈		X		
Ohio	X	X		X	X	X	X		X	
Oklahoma	X		X	X	X				X	
Oregon	X	X		X	◈					
Pennsylvania		X								
Rhode Island			X							
South Carolina	X									
South Dakota	X	X								
Tennessee*									X	
Texas	X	X	X		X	X	X	X	X	
Utah	X	X								X
Vermont		X								
Virginia	X							X	X	
Washington		X			◈					
West Virginia		X			X				X	
Wisconsin	X	X			X				X	
Wyoming		X								

*Tennessee abolished joint and several liability by judicial decision

◈ Denotes state where reform was struck down as unconstitutional and no additional reforms are in place.

THE RULE OF JOINT AND SEVERAL LIABILITY

Joint and several liability is a theory of recovery that permits the plaintiff to recover damages from multiple defendants collectively, or from each defendant individually. In a state that follows the rule of joint and several liability, if a plaintiff sues three defendants, two of whom are 95 percent responsible for the defendant's injuries, but are also bankrupt, the plaintiff may recover 100 percent of her damages from the solvent defendant that is 5 percent responsible for her injuries.

The rule of joint and several liability is neither fair, nor rational, because it fails to equitably distribute liability. The rule allows a defendant only minimally liable for a given harm to be forced to pay the entire judgment, where the co-defendants are unable to pay their share. The personal injury bar's argument in support of joint and several liability—that the rule protects the right of their clients to be fully compensated—fails to address the hardship imposed by the rule on co-defendants that are required to pay damages beyond their proportion of fault.

ATRA supports replacing the rule of joint and several liability with the rule of proportionate liability. In a proportionate liability system, each co-defendant is proportionally liable for the plaintiff's harm. For example, a co-defendant that is found by a jury to be 20% responsible for a plaintiff's injury would be required to pay no more than 20% of the entire settlement. More moderate reforms that ATRA supports include: (1) barring the application of joint and several liability to recover non-economic damages; and (2) barring the application of joint and several liability to recover from co-defendants found to be responsible for less than a certain percentage (such as 25%) of the plaintiff's harm.

Thirty-eight states have modified the rule of joint and several liability.

ALASKA

1988—Proposition Two

Barred application of the rule of joint and several liability in the recovery of all damages through a ballot initiative on November 8, 1988.

ARIZONA

1987—SB 1036

Barred application of the rule of joint and several liability in the recovery of all damages, except in cases of intentional torts and hazardous waste.

The Arizona Court of Appeals upheld the constitutionality of this statute in Church v. Rawson Drug & Sundry Co., No. 1 CA-CV 90-0357, October 1, 1992.

ARKANSAS

2003—HB 1038

Modified repeal of joint and several liability instead of complete repeal, whereby defendants who are found to be 1 percent to 10 percent at fault will only be responsible for the percentage of damage caused, defendants who are 11 percent to 50 percent at fault could have their share of a judgment increased up to an additional 10% if a co-defendant is unable to pay its share of a judgment, and defendants who are 51% to 99% at fault could have their share of a judgment increased up to an additional 20% if a co-defendant is unable to pay its share of the judgment. The reform applies to all

GEORGIA

1987—HB 1

Barred application of the rule of joint and several liability in the recovery of all damages when a plaintiff is assessed a portion of the fault.

HAWAII

1994—HB 1088

Barred application of the rule of joint and several liability in the recovery of all damages from all governmental entities.

1986—SB S1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be 25% or less at fault. The reform does not apply to auto, product, or environmental cases.

IDAHO

1990—HB 744

Defined the term "acting in concert," as used in SB 1223 (below), as pursuing a common plan or design that results in the commission of an intentional or reckless tortious act.

1987—SB 1223

Barred application of the rule of joint and several liability in the recovery of all damages, except in cases of intentional torts, hazardous waste, and medical and pharmaceutical products.

ILLINOIS

1995—HB 20

Barred application of the rule of joint and several liability in the recovery of all damages.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

1986—SB 1200

Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be 25% or less at fault. The reform does not apply to auto, product, or environmental cases.

IOWA

1997—HF 693

Provided that defendants found to be 50% or more at fault are jointly liable for economic damages only.

1985

Barred application of the rule of joint and several liability in the recovery of all damages from defendants who are found to be less than 50% at fault.

1989—HB 1171

Provided that the rule of joint and several liability only applies to the extent necessary for the injured party to receive 50% of his or her recoverable damages.

MISSOURI

1987—HB 700

Barred application of the rule of joint and several liability in the recovery of all damages when a plaintiff is assessed a portion of the fault.

MONTANA

1997—HB 571

Retained the current system of modified joint and several liability, where joint liability does not apply to defendants found to be less than 50% at fault. Revised the comparative negligence statute to permit the allocation of a percentage of liability to defendants who settle or are released from liability by the plaintiff. Allowed those defendants to intervene in the action to defend against claims affirmatively asserted.

1997—HB 572

Barred application of the rule of joint and several liability in the recovery of all damages.

Takes effect only if HB 571 is held unconstitutional.

1995—SB 212

Restored the joint and several liability reforms of 1987, which had been weakened by the Montana Supreme Court. Provided procedural safeguards to allow joint liability to apply only when a defendant is found to be more than 50% at fault.

1987—SB 51

Barred application of the rule of joint and several liability in the recovery of all damages from defendants found to be 50% or less at fault.

NEBRASKA

1991—LB 88

Modified the rule of joint and several liability by replacing the slight-gross negligence rule with a 50/50 rule, in which the plaintiff wins if the plaintiff's responsibility is less than the responsibility of all the defendants; Barred application of the rule of joint and several liability in the recovery of noneconomic damages.

NEVADA

2002—AB 1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages for medical liability claims.

OHIO

1996—HB 350

Barred application of the rule of joint and several liability in the recovery of all damages from defendants found to be less than 50% at fault. Barred application of the rule of joint and several liability in the recovery of noneconomic damages from defendants found to be more than 50% at fault.

Held unconstitutional in *Ohio Academy of Trial Lawyers v. Sheward*, August 1999.

1987—HB 1

Barred application of the rule of joint and several liability in the recovery of noneconomic damages when the plaintiff is also assessed a portion of the fault.

OREGON

1995—SB 601

Barred application of the rule of joint and several liability in the recovery of all damages, except where the defendants is determined to be insolvent within one year of the final judgment. In those cases, a defendant less than 20% at fault would be liable for no more than two times her original exposure and a defendant more than 20% liable would be liable for the full amount of damages.

1987—SB 323

Barred application of the rule of joint and several liability in the recovery of noneconomic damages. Barred application of the rule of joint and several liability in the recovery of all damages, where the defendant is found to be less than 15% at fault.

PENNSYLVANIA

2002—SB 1089

Barred application of the rule of joint and several liability in the recovery of all damages, except when a defendant has not: (1) been found liable for intentional fraud or tort; (2) been held more than 60% liable; (3) been held liable for environmental hazards, or; (4) been held civilly liable as a result of drunk driving.

SOUTH DAKOTA

1987—SB 263

Provided that "any party who is allocated less than 50% of the total fault allocated to all parties may not be jointly liable for more than twice the percentage of fault allocated to that party."

TEXAS

2003—HB 4

Defendant pays only assessed percentage of fault unless defendant is 50% or more responsible.

Defendants can designate (as opposed to join) other responsible third parties whose fault contributed to causing plaintiff's harm

In toxic tort cases, the threshold for joint and several liability raised from 15% to 50%.

1994—SF 35

Amended the joint and several liability reform passed in 1986. Defined when an individual is at fault. Specified the amount of damages recoverable in cases where more than one party is at fault. Clarified the relationship between fault and negligence.

1986—SB 17

Barred application of the rule of joint and several liability in the recovery of all damages.

□□□

THE COLLATERAL SOURCE RULE

The collateral source rule of the common law says that evidence may not be admitted at trial to show that plaintiffs' losses have been compensated from other sources, such as plaintiffs' insurance, or worker compensation. As a result, for example, 35% of total payments to medical malpractice claimants are for expenses already paid from other sources.

Twenty-three states have modified or abolished the collateral source rule. Two states have had reforms struck down as unconstitutional and have not enacted additional reforms.

ALABAMA

1987

Permitted the admissibility of evidence of collateral source payments.

ALASKA

1986—SB 337

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

ARIZONA

1993—SB 1055

Extended the existing collateral source legislation from medical malpractice issues to other forms of liability litigation. Under this legislative approach, a jury would not be bound to deduct the amounts paid under a collateral source provision, but would be free to consider it in determining fair compensation for the injured party.

COLORADO

1986—SB 67

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

CONNECTICUT

1986—HB 6134

Permitted the admissibility of evidence of collateral source payments. Provided for awards to be offset with broad exclusions.

FLORIDA

1986—SB 465

Provided for awards to be offset with broad exclusions.

The Florida Supreme Court upheld the collateral source provision as constitutional in Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987).

The $150,000 threshold for the admissibility of collateral sources into evidence was held unconstitutional by the Kansas Supreme Court in Thompson v. KFB Insurance Company, Case No. 68452 (1993).

KENTUCKY

1988—HB 551

Mandated that juries be advised of collateral source payments and subrogation of rights of collateral payers.

MAINE

1990

Provided for awards to be offset by collateral source payments, where the collateral sources have not exercised subrogation rights within 10 days after a verdict for the plaintiff.

MICHIGAN

1986—HB 5154

Permitted the admissibility of evidence of collateral source payments after the verdict and before judgment is entered. Permitted courts to offset awards, as long as a plaintiff's damages are not reduced by more than the amount awarded for economic damages.

MINNESOTA

1986—SB 2078

Permitted the admissibility of evidence of collateral source payments only for the court's review. Provided for awards to be offset by collateral source payments, unless the source of reimbursement has a subrogation right.

MISSOURI

1987—HB 700

Permitted the admissibility of evidence of collateral source payments, but provided that a defendant who presents collateral source payments as evidence waives his right to a credit against the judgment for that amount.

MONTANA

1987—HB 567

Permitted the admissibility of evidence of collateral source payments, unless the source of reimbursement has a subrogation right under state or federal law. Required a court to offset damages over $50,000.

NEW JERSEY

1987—SB 2703, SB 2708

Provided for awards to be offset by collateral source payments other than workers' compensation and life insurance benefits.

PUNITIVE DAMAGES

Punitive damages are awarded not to compensate a plaintiff, but to punish a defendant for intentional or malicious misconduct and to deter similar future misconduct. While punitive damages awards are infrequent, their frequency and size have grown greatly in recent years. More importantly, they are routinely asked for today in civil lawsuits. The difficulty of predicting whether punitive damages will be awarded by a jury in any particular case, and the marked trend toward astronomically large amounts when they are awarded, have seriously distorted settlement and litigation processes and have led to wildly inconsistent outcomes in similar cases. ATRA recommends four reforms:

- Establishing a liability "trigger" that reflects the intentional tort origins and quasi-criminal nature of punitive damages awards - "actual malice."
- Requiring "clear and convincing evidence" to establish punitive damages liability.
- Requiring proportionality in punitive damages so that the punishment fits the offense.
- Enacting federal legislation to address the special problem of multiple punitive damages awards; This would protect against unfair overkill, guard against possible due process violations, and help preserve the ability of future claimants to recover basic out-of-pocket expenses and damages for their pain and suffering.

Thirty-three states have reformed punitive damages laws. One state had reforms struck down as unconstitutional and has not enacted additional reforms.

ALABAMA

1999—SB 137

In non-physical injury cases:

1) General rule: Limited the award of punitive damages to the greater of three times the award of compensatory damages or $500,000.

2) For businesses with a net worth of less than $2 million: Limited the award of punitive damages to $50,000 or 10% of net worth up to $200,000, whichever is greater.

In physical injury cases: Limited the award of punitive damages to the greater of three times the award of compensatory damages or $1.5 million.

Prohibited application of the rule of joint and several liability in actions for punitive damages, except for wrongful death actions, actions for intentional infliction of physical injury, and class actions.

Provided that the limit on punitive damages will be adjusted on January 1, 2003 and increased at three-year intervals in accordance with the Consumer Price Index.

1987

Required a plaintiff to show by "clear and convincing" evidence that a defendant acted with "wanton" conduct.

Limited punitive damages to the greater of $250,000 or three times compensatory damages, not to exceed $1,000,000.

Provided for bifurcated proceedings for punitive damages.

CALIFORNIA

1987—SB 241

Required a plaintiff to show by "clear and convincing" evidence that a defendant acted with oppression, fraud, or malice.

Required the determination of awards for punitive damages to be made in a separate proceeding, allowing evidence of defendants' financial conditions only after a finding of liability.

COLORADO

2003—HB 1186

Prohibited a plaintiff from filing a claim for punitive damages unless the claim can show evidence of willful or wanton action that would justify such a claim.

1991—HB 1093

Expanded the 1990's prohibition against seeking punitive damages in cases in which FDA-approved drugs are administered by a physician to include medically prescribed drugs or products used on an experimental basis (when such experimental use has not received specific FDA approval) and when the patient has given informed consent.

1990—HB 1069

Provided that punitive damages may not be alleged in a professional negligence suit until discovery is substantially completed.

Provided that discovery cannot be reopened without an amended pleading.

Provided that physicians cannot be liable for punitive damages because of the bad outcome of a prescription medication, as long as it was administered in compliance with current FDA protocols.

Prohibited punitive damages from being assessed against a physician because of the act of another unless she directed the act or ratified it.

1986—HB 1197

Provided that an award for punitive damages may not exceed an award for compensatory damages. Permitted a court to reduce a punitive damages award if deterrence can be achieved without the award. Permitted a court to increase a punitive damages award to three times an award for compensatory damages if misbehavior continues during trial.

Required one-third of punitive damages awards to be paid to the state fund.

The Colorado Supreme Court held the state fund portion of this statute unconstitutional in Kirk v. The Denver Publishing Company, 15 Brief Times Reporter, No. 88SA405, September 23, 1991.

IDAHO

2003—HB 92

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $250,000.

Raised the standard for the imposition of punitive damages to "clear and convincing evidence"

1987—SB 1223

Required a plaintiff to show by a preponderance of evidence that a defendant's conduct was "oppressive, fraudulent, wanton, malicious or outrageous."

ILLINOIS

1995—HB 20

Limited the award of punitive damages to three times the award of economic damages.

Prohibited the award of punitive damages absent a showing that conduct was engaged in "with an evil motive or with a reckless indifference to the rights of others."

Required the determination of awards for punitive damages to be made in a separate proceeding.

Held unconstitutional by the Illinois Supreme Court in Best v. Taylor Machine Works, Inc., December 1997.

1986—SB 1200

Prohibited plaintiffs from pleading punitive damages in an original complaint.

Required a subsequent motion for punitive damages to show at a hearing a reasonable chance that the plaintiff will recover an award for punitive damages at trial.

Required a plaintiff to show that the defendant acted "willfully and wantonly."

Provided discretion to the court to award punitive damages among the plaintiff, the plaintiff's attorney, and the State Department of Rehabilitation Services.

INDIANA

1995—HB 1741

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $50,000.

Required 75% of punitive damage awards to be paid to the state fund.

The Kentucky Supreme Court held the "clear and convincing" evidence standard that conduct constituted oppression, fraud or malice unconstitutional in Terri C. Williams v. Patricia Lynn Herald Wilson, No. 96-SC-1122-DG, April 16, 1998.

LOUISIANA

1996—HB 20

Repealed the statute that authorized punitive damages to be awarded for the wrongful handling of hazardous substances. (The Louisiana courts had established precedents substantially expanding liability based upon the repealed statute.)

MINNESOTA

1990—Minn. Stat. Sec. 549.20

Required a plaintiff to show that a defendant acted with "deliberate disregard." (The former standard required only a showing of "willful indifference.")

Required the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant.

Granted trial and appellate judges the power to review all punitive damages awards.

1986—SB 2078

Prohibited plaintiffs from pleading punitive damages in an original complaint. Required a plaintiff to make a *prima facie* showing of liability before an amendment of pleadings is permitted by the court.

MISSISSIPPI

1993—HB 1270

Required a plaintiff to prove punitive damages by "clear and convincing" evidence.

Required the determination of awards for punitive damages to be made in a separate proceeding.

Prohibited the award of punitive damages in the absence of compensatory awards.

Prohibited the award of punitive damages against an innocent seller.

Established factors for the jury to consider when determining the amount of a punitive damages award.

MISSOURI

1987—HB 700

Required the determination of awards for punitive damages to be made in a separate proceeding. Permitted the jury to set the amount for punitive damages if, in the first stage, the jury finds a defendant liable for punitive damages. Permitted the admissibility of evidence of a defendant's net worth only during the proceeding for the determination of punitive damages.

NEW HAMPSHIRE

1986—HB 513

Prohibited the award of punitive damages.

NEW JERSEY

1995—SB 1496

Limited the award of punitive damages to the greater of five times the award of compensatory damages or $350,000.

The reform does not apply to cases involving bias crimes, discrimination, AIDS testing disclosure, sexual abuse, and injuries caused by drunk drivers.

1987—SB 2805

Required a plaintiff to show that a defendant acted with "actual malice" or "wanton and willful disregard" for the rights of others.

Required the determination of awards for punitive damages to be made in a separate proceeding.

Provided for an FDA government standards defense to punitive damages.

The reform does not apply to cases involving environmental torts.

NEW YORK

1992—SB 7589

Required that 20% of all punitive damages awards be paid to the New York State General Fund.

NORTH CAROLINA

1995—HB 729

Limited the award of punitive damages to the greater of three times the award of compensatory damages or $250,000. The reform does not apply to cases where the defendant caused the injury by driving while impaired.

Required a plaintiff to show by "clear and convincing" evidence that a defendant was liable for compensatory damages and acted with fraud, malice, willful or wanton conduct.

Required the determination of awards for punitive damages to be made in a separate proceeding at the request of the defendant.

NORTH DAKOTA

1997—HB 1297

Required a plaintiff to show by a preponderance of the evidence that a defendant acted with oppression, fraud, or actual malice before a moving party may amend pleadings and claim punitive damages.