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

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

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

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

7. Texas

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

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

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

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

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

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

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

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

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

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

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

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

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

8. West Virginia

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

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

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

9. Anecdotes from other crisis states

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

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

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

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

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

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

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

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

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

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

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

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

II. Solutions

A. State Legislative Reforms Demonstrate Lower Costs

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

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

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

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

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

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

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

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

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

states.)[55]

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

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

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

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

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

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

[56] MO. REV. STAT. § 538.210 (2002).

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

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

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

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

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

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

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

1. Equal Protection Clause

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

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

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

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

3. Right to Trial by Jury

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

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

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

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

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

as was done with the caps.

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

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

C. California's Solution: MICRA

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

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

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

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

   b. Establishes periodic payments of future damages;

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

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

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

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

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[64] CAL. CIV. CODE § 3333.2 (2003).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. National Legislation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[85] *See infra*, note 82.

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

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

III. Responding to Other Arguments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[95] *Id.* at 18.

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

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

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

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

[100] *Id.* at 2.

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

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

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

B. Trial Bar Explanations

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

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

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

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

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

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[101] *Id.* at 3.

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

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

[104] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Additional Reflections of the Insurance Industry

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

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

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

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

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

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

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

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

D. GAO Reports

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

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

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

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

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

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

access among other vulnerable populations, such as Medicaid patients.

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

E. The Current Liability Crisis and Patient Safety

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

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

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

   a. Encouraging defensive medicine.

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

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

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

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

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

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

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

[120] *Id.* at 1965.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAL MALPRACTICE INSURANCE

A STUDY OF MARKET CONDITIONS

DRAFT REPORT

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

ERIC NORDMAN

DAVIN CERMAK

December 3, 2003

MEDICAL MALPRACTICE INSURANCE

A STUDY OF MARKET CONDITIONS

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INTRODUCTION

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

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

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

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

MEDICAL PROFESSIONAL LIABILITY

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

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

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

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

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

The Medical Professional Liability Insurance Market

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

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

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

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

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

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

State Regulatory Systems

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

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

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

Non-Standard Market Mechanisms

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

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

Self-Insurance

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

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

Ratemaking for Medical Liability Insurance

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

Insurance Department Activity to Prevent Inadequate Rates

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

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

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

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

The Role of Reserving and Possible Reserve Deficiencies

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

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

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

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

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

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

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

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

THE PUBLIC HEARING ON MEDICAL MALPRACTICE

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

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

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

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

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

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

MARKET ANALYSES FROM OTHER STUDIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REVIEW OF MEDICAL MALPRACTICE INSURANCE MARKET, 1992-2002

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

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

needed.

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

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

Premium, Losses and Profitability

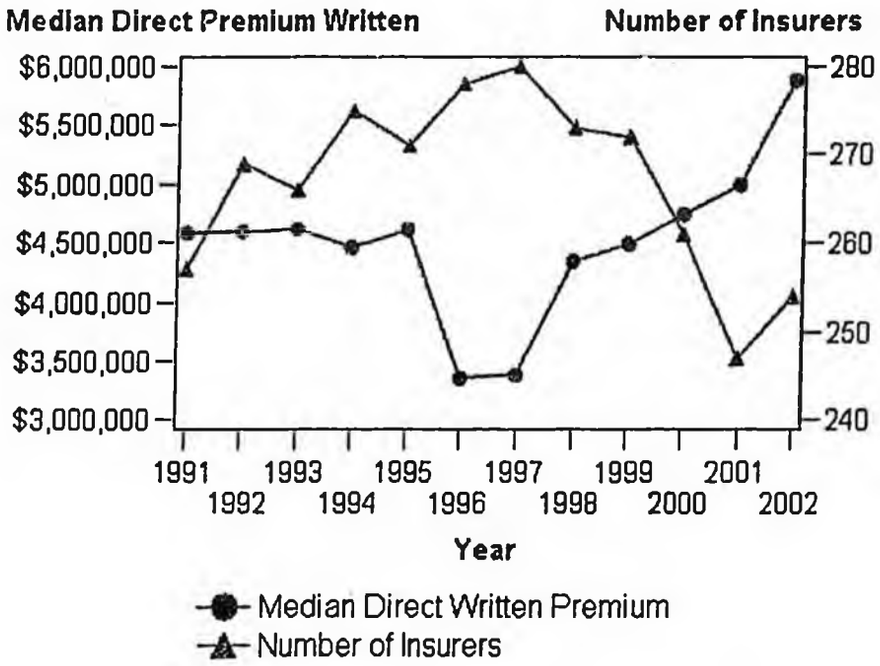
[36] The term 'insurer' refers to a legal entity writing medical liability insurance premium. This figure is based on insurers filing annual financial statements with the NAIC.

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

Premium

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

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



Source: National Association of Insurance Commissioners.

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

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

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

Losses

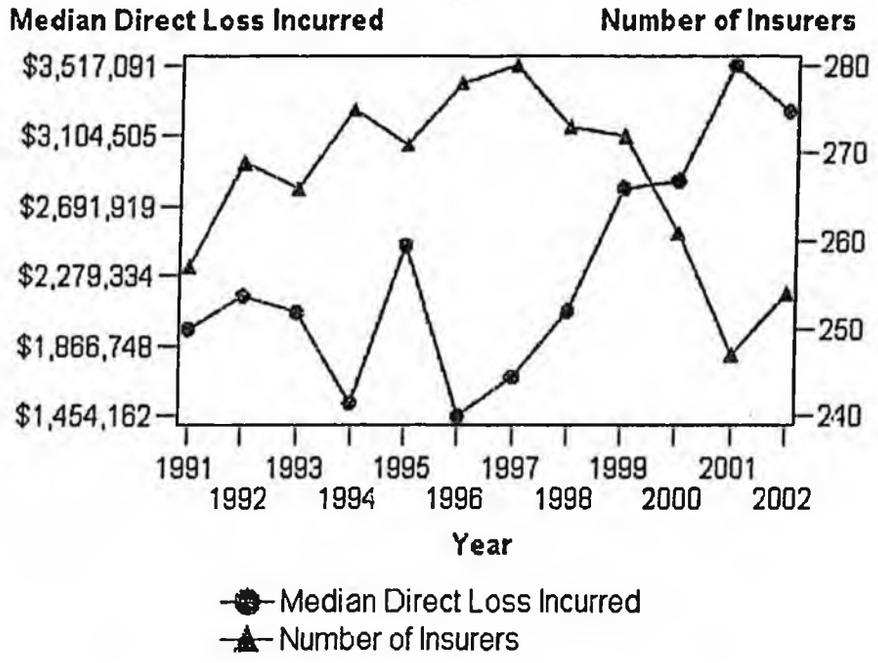
Losses are the major contributing factor in determining medical liability rates. Insurers consider historical patterns in both incurred loss and paid loss for ratemaking purposes. Incurred losses are the insurer's estimate of the total value of all its insurance claims received during the annual statement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

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

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

Figure 2 – Countrywide Direct Losses Incurred

(In 2002 $USD)



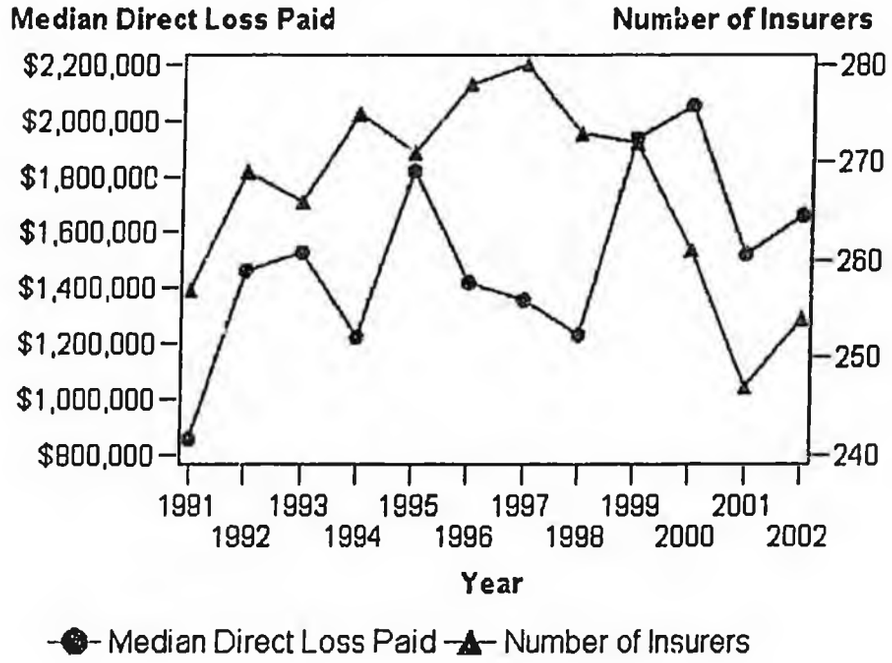
Source: National Association of Insurance Commissioners

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

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

Figure 3 - Countrywide Direct Losses Paid

(In 2002 $USD)



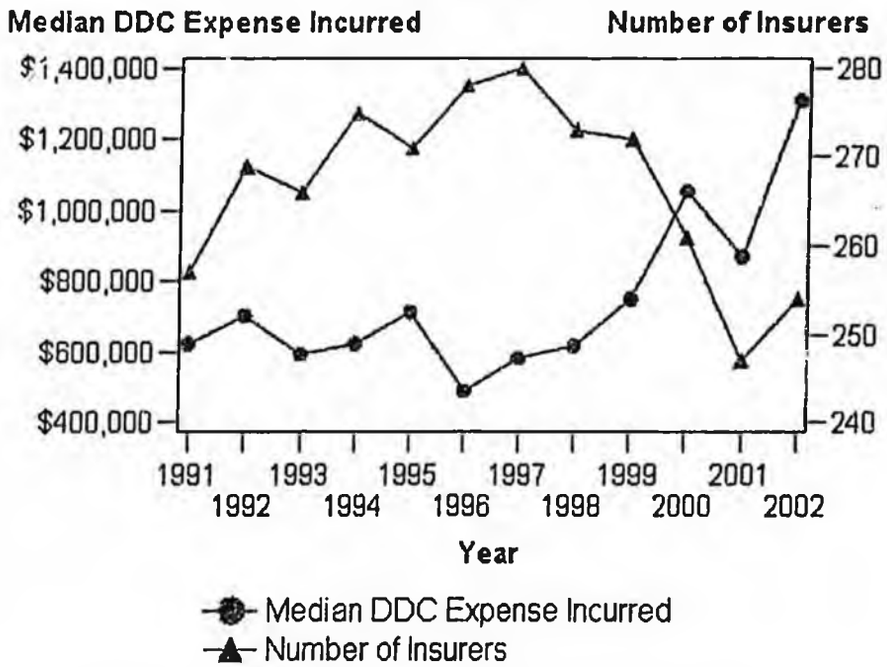
Source: National Association of Insurance Commissioners

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

Loss and Other Expenses

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

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



Source: National Association of Insurance Commissioners

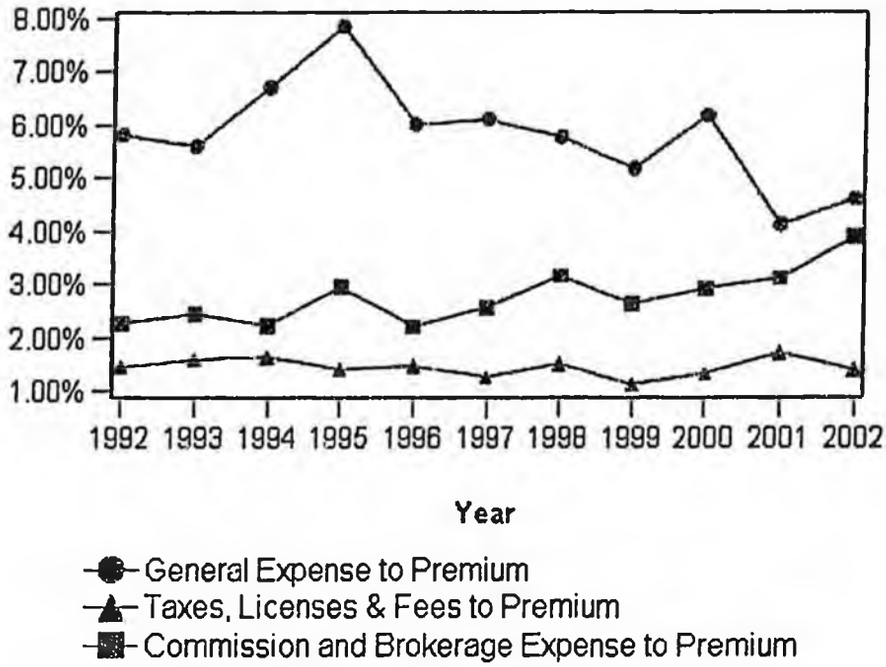
Table 9 shows that the inflation-adjusted median insurer DDC expenses were $857,547 and $1,660,748 in 1991 and 2002 respectively. The large standard deviations relative to

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

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

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

Figure 5 - Countrywide Medical Malpractice Expenses to Premium



Source: National Association of Insurance Commissioners

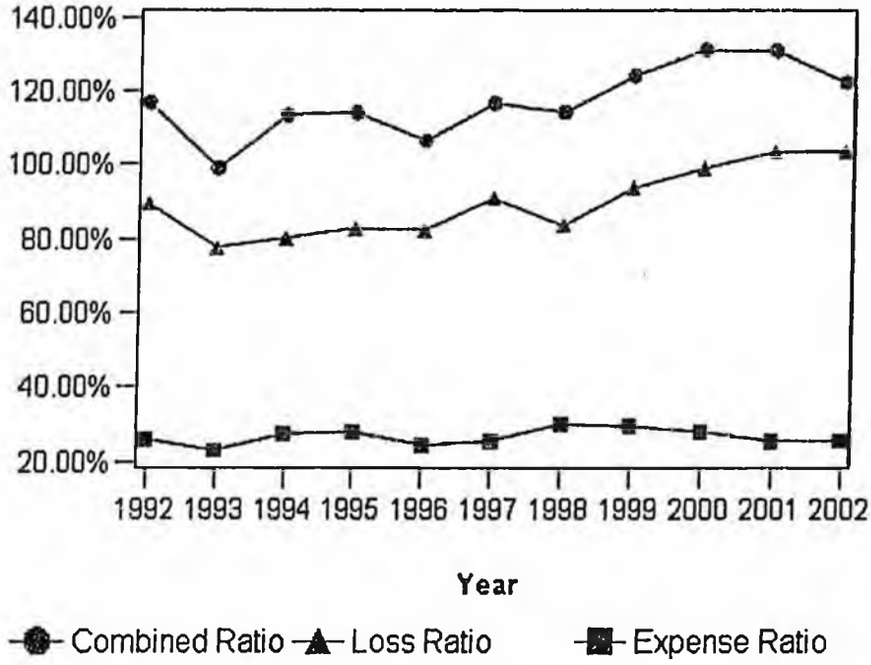
Profitability

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

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

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

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



Source: National Association of Insurance Commissioners

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

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

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

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

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

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

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

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

Industry Investments

Assets

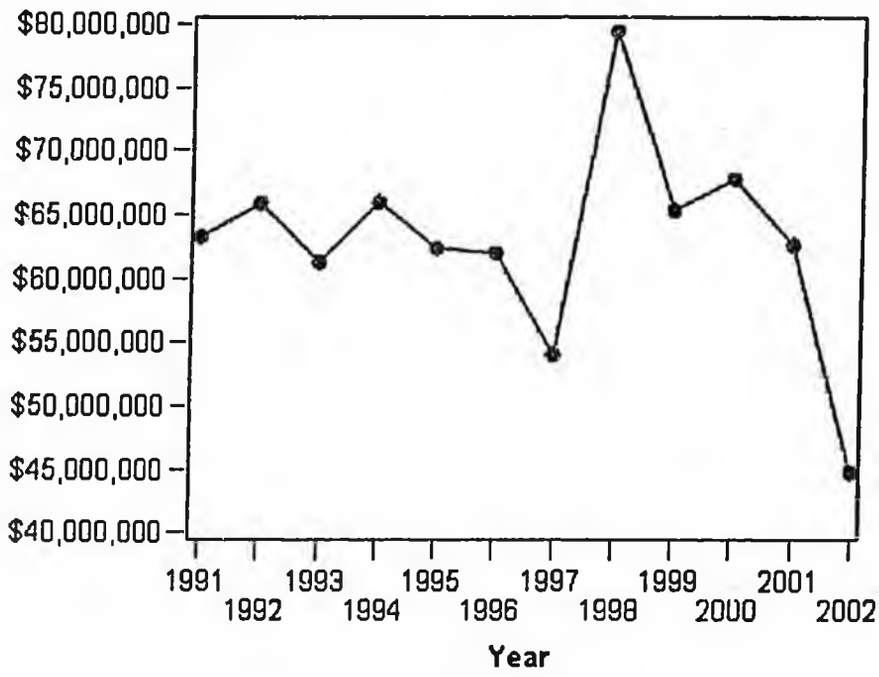
The values of assets an insurer reports are an important part of its market capacity. Capacity, or the ability to insure risk, is determined by the amount of insurer surplus, which is the difference between its assets and liabilities. Capacity defines whether an

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

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

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

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



Source: National Association of Insurance Commissioners.

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

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

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

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

Capital Gains (Losses)

[TO BE ADDED.]

Investment Income

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

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

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

Total Income = $1.00 + $.08

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

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

Impact = -.04 / 1.08 = -3.70%

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

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

Surplus Analysis

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

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

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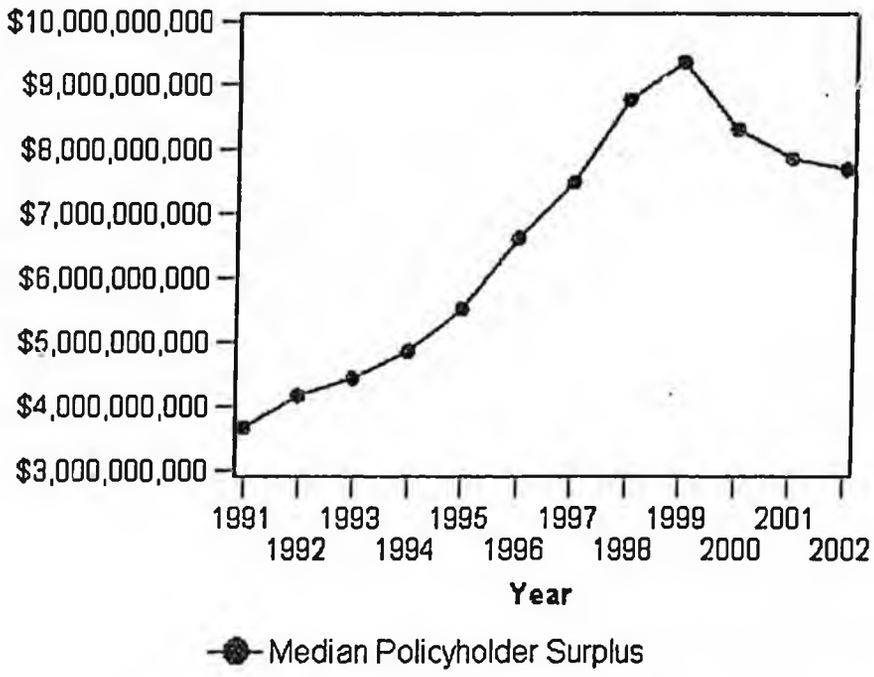
[39] United States. General Accounting Office. Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. Washington, DC: GPO, 2002

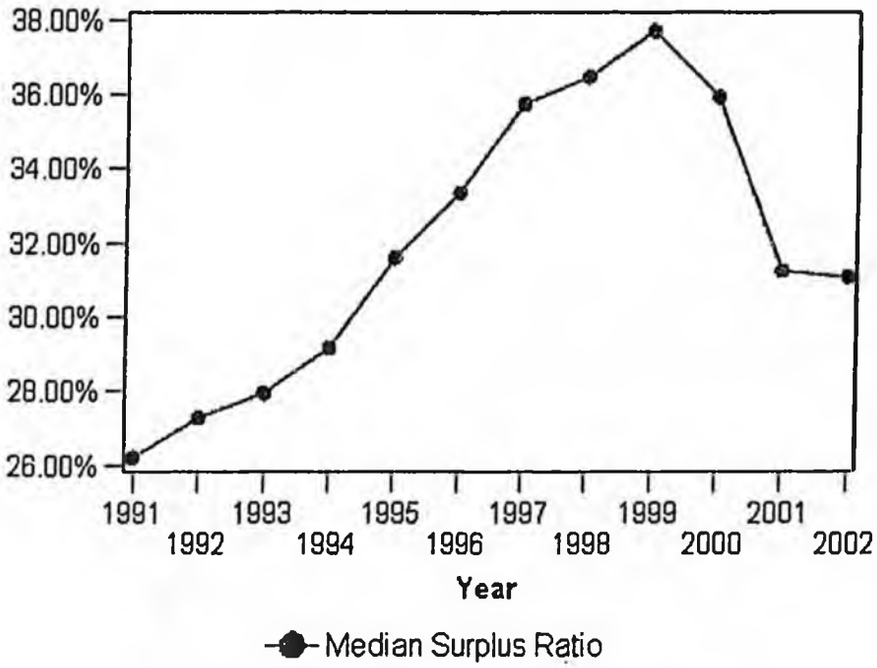
Figure 8 – Countrywide Median Insurer Policyholder Surplus



Source: National Association of Insurance Commissioners.

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

Figure 9 - Policyholder Surplus to Total Assets, Countrywide



Source: National Association of Insurance Commissioners.

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

Reserve Analysis

[TO BE ADDED]

Reinsurance Analysis

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

[ANALYSIS TO BE ADDED]

Competition

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

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

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

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

While neither economic theory nor experience establishes a critical level of concentration for the existence of oligopoly in a particular industry, the U.S. Justice Department has established merger guidelines for certain industries using the HHI (DOJ, 1984). Under these guidelines, a post-merger market with an HHI in excess of 1,800 is considered

highly concentrated. A proposed horizontal merger between two firms that would result in such a market is likely to provoke a challenge from the Justice Department, depending on other circumstances. A post-merger market with an HHI between 1,000 and 1,800 is considered moderately concentrated. A post-merger market with an HHI of less than 1,000 is not considered concentrated. A horizontal merger resulting in such a market is unlikely to encounter opposition.

The Justice Department looks at a number of additional factors in determining its position on a particular merger. It also should be pointed out that these criteria have been developed to evaluate mergers in national industries, broadly defined. The purpose here is to evaluate the structural competitiveness of medical liability insurance by state, which is more narrowly defined. There are a number of industries with HHI values in excess of 2,000 at the national level that are considered competitive. While Justice Department guidelines provide some perspective, they should not be used as absolute standards to determine the competitiveness of a market or to determine whether additional market regulation is warranted.

Table 27 shows concentration ratios and HHI values for the medical liability market countrywide for 1991-2002. Market concentration in the medical liability market increased slightly countrywide in the mid-1990s and began decreasing by the late-1990s, continuing through 2002. The number of insurers peaked in 1997 and then declined 10.6% between 1997 and 2001 and recovered slightly in 2002. While the number of insurers declined, it appears the largest insurers gained some market share during this

time.

While examining countrywide data over a period of years gives a general idea of how the competitive nature of the medical liability market has changed, examining statewide data tells more about whether a particular market may lack competition. This is particularly true in medical liability since companies tend to be geographical in nature. However, a word of caution is necessary when looking at statewide data insurers provide to the NAIC. The data contains many insurers, often captive insurers that do not actively write insurance in the market. Captive insurers may write insurance for a specific group of hospitals, nursing homes or medical specialties and hence do not directly compete for market share.[41] The data also includes insurers that may write insurance exclusively in certain markets, such as hospitals or certain medical specialties. Theoretically, a state may have many insurers indicating strong competition, but each insurer could have a monopoly in its niche market, thereby creating the appearance of competition. Additionally, some insurers may not write new business, for a variety of reasons, including surplus limitations that prevent them from market activity. These aspects should be taken into consideration when assessing the competitive nature of a market.

Table 28 compares market share for three different ranges and the HHI by state. The mean and median number of insurers reporting medical liability insurance premium was 65 and 61 respectively. Illinois had the most insurers with 102 and Alaska the fewest with 39. The mean and median market concentration of the four largest insurers was 65.9%

[41] Such insures may be indirectly competitive in some markets. For example, physicians may choose to leave a private practice for a facility that provides coverage through a captive or group policy because the physician feels coverage in the private practice has become prohibitively expensive.

and 67.1% respectively.[42] The range of market concentration ratios for the four largest insurers was 30.8% to 86.4%. The mean and median market concentration of the eight largest insurers was 80.4% and 81.0% respectively with a range of 55.1% to 93.6%. The mean and median market concentration of the 20 largest insurers was 94.4% and 95.3% respectively ranging between 85.0% and 99.2%. As would be expected from economic theory, there is an approximately inverse correlation between the numbers of insurers writing premium in a market with the concentration of business they write. In other words, states with a larger number of insurers writing business appear to have less market concentration among the largest insurers. It also appears that, from the data, states with smaller populations have more concentrated markets than states with larger populations.

The mean and median HHI was 1,877.61 and 1,617.38 respectively, ranging from 498.91 to 4338.19. Twenty-one states had a HHI greater than 1,800, which would be considered highly concentrated by the DOJ's guidelines for review of merging markets. Twenty-one states have a HHI between 1,000 and 1,800, which are considered moderately concentrated by the DOJ's guidelines. As discussed above, these numbers may be misleading because many of the insurers included in the HHI may not be writing new business, or are not directly competitive. If these insurers could be identified and removed from the HHI calculations, the indices would likely increase significantly. However, since captive insurers may indirectly compete in the market, it is reasonable to assume that the DOJ's guidelines for competitive markets would be at least indicative of the competitiveness of a particular market.

[42] Market concentration is calculated as the percent of market share of the four largest insurers to the rest of the market in terms of direct written premium.

Entries and Exits

The initial investment in physical facilities needed to start an insurance company is relatively small compared to more capital-intensive industries such as manufacturing. The minimum capital and surplus requirement to become licensed to write medical malpractice insurance in most states is $2 million or less, which is not a significant sum by itself in relation to most insurers' premium volume. However, there must be at least a dollar of surplus for every dollar of premium volume a new insurer intends to write. This raises the financial requirement considerably for a new insurer intending to acquire a significant market share in a large state. **Table 29** lists minimum capital and surplus requirements by state for medical liability insurers.

In addition, there are non-monetary barriers to entering the medical malpractice market. Some can be readily overcome, but others present more difficulty.

1. Regulatory constraint. A medical malpractice insurer may not sell across state lines without filing for license or eligibility. Rates and forms must be adjusted to local requirements.
2. Insured resistance. Insurers operating on a mutual or reciprocal exchange basis may face difficulty convincing member insureds to support moving to new markets, whether a new state or a different provider line. Insureds of provider-owned or operated insurers (60% of national medical malpractice market) may be averse to risking capital gathered over years in a home market.
3. Lack of specialty market experience. Underwriting, pricing, and defending claims

in a new market, whether new state or specialty, requires specialized and local knowledge.

4. Lack of locally knowledgeable staff. Staffing a start-up insurer or an expansion office means selecting from a small pool of experts. Employees skilled in the facets of operating a medical malpractice insurer are scarce on the national level and scarcer still in local markets.
5. Exit costs. The known cost of exiting a line of medical malpractice may be daunting to a start-up insurer or an existing insurer considering entry into a new market.
6. Pricing difficulty. Third party liability insurance is subject to socio-legal developments that can rapidly render assumptions on future losses obsolete. Medical malpractice is very volatile.
7. Adverse financial history. There have been three major medical malpractice crises since 1975, each with adverse financial effects on insurers of the time. The provider-owned or operated insurers mentioned above came into existence beginning with the 1975 crisis when traditional stock commercial insurers did not return in number to the medical malpractice market place.

There are other costs involved with exit. Unique to medical malpractice markets is the long tail associated with malpractice claims. It can take up to twenty years to run off all claims incurred during active participation in a medical malpractice market. This keeps insurers committed to claims expenditure long after premium income has ceased. Regulators further require that withdrawing insurers offer coverage for this run off to

non-renewed claims-made insureds, now a majority of medical malpractice policyholders. Insurers will also lose the value of any sunk investments they have made in establishing operations in the market from which they are withdrawing.

The prospect of such costs can sometimes serve as a deterrent to entry altogether. They also may induce insurers to sustain inadequate profits for a period while assessing the need to withdraw. **Table 30** and **Table 31** show the number of insurers entering and exiting the medical liability line countrywide and median by state, respectively, for 1992-2002.

Regulatory exit restrictions pose a different issue. A number of states impose some limitations on insurers' ability to withdraw from the market for liability lines. These restrictions take various forms including requirements to give policyholders advance notice, delayed withdrawal requirements, residual market assessment obligations and 'lock-in' provisions, i.e., prohibitions against selectively withdrawing from some lines of business while continuing to write others.

Standard vs. Non-standard Markets

Table 32 and **Table 33** provides 2002 medical liability direct premium written by state by type of company. Countrywide, stock insurers wrote 35.05 percent of all direct medical liability premiums. Mutual insurers and reciprocals wrote 19.28% and 14.81% respectively of the countrywide direct premium. Non-standard markets made up 30.45% of the direct premium written in 2002, with surplus lines insurers writing 24.60% of all

premiums countrywide. It should be noted that states do not require all insurers to report data to the NAIC. This is particularly true for medical professional liability.

Caution should also be taken when looking at data for risk retention groups. The NAIC does receive filings for such entities, but it is not known how many of these groups file annual statement data. This is likely a particular problem when analyzing state markets as opposed to countrywide analyses. Bear in mind also that surplus and excess lines insurers typically price products significantly higher than standard markets, so their relative premium volume likely does not equate to their percentage of exposures in the marketplace. The NAIC currently does not have data to examine this facet of the market, so such a statement remains hypothetical.

Availability

Availability is a very important aspect of insurance market performance. It is a general term that can be interpreted in various ways. In crisis periods, medical liability insurance coverage is often available through non-standard market mechanisms. However, this market presents a number of disadvantages and is generally not a desirable source of coverage. Availability in non-standard markets is not an indicator of medical malpractice market health.

A more meaningful indicator is the availability of medical liability coverage in the admitted market. Yet, even this variable is not easily quantifiable from readily available data. The number of insurance carriers willing to offer coverage and the terms they would

offer can vary dramatically among different medical specialties and states. A commonly used proxy for availability is the proportion of total premiums written through the residual market, which are shown in **Table 32** and **Table 33**. This is a less than perfect proxy for availability. Some risks may actually choose to obtain coverage through the residual markets when they could purchase coverage in the voluntary market.

Insurers contend that residual market growth and operating losses can be caused by inadequate voluntary market rates. If these insurers are unable to charge a premium to an insured sufficient to provide a fair return on investment, they may be disinclined to offer coverage. The greater the degree of rate inadequacy, in this view, the greater the number of insureds thrust into the residual market.

If premiums in the residual market are insufficient to cover losses and servicing carrier fees, then an operating deficit results. This deficit, in turn, may in some states be recovered through assessments on voluntary market insurers. To the extent that insurers are able to recover the assessments through higher voluntary market rates, the burden of the residual market is borne by purchasers of medical liability insurance from voluntary market insurers. This may increase purchaser incentives to self-insure, if that is a viable option. Alternatively, to the degree that insurers are not allowed to recover assessments through higher rates, insurers may be influenced to decrease their voluntary market business. This can lead to a situation in which growing residual market losses cause further shrinkage of the voluntary market, which in turn increases residual market losses. Regulators do not deny the potential for this cycle, but they also raise other issues about

performance of the residual market. There are concerns about the quality of service that residual market risks receive and the incentives servicing carriers have to properly administer policies and control costs.

Solvency

Solvency is critical to the integrity of the insurance contract. State insurance regulators' primary responsibility is to protect policyholders and claimants against insurer insolvencies. This responsibility is met through financial regulation and state guaranty funds.

State regulators seek to reduce, but not necessarily eliminate the incidence and cost of insolvencies. There is a presumed need to balance insolvency risk with the cost and availability of insurance. Some possibility of failure is inherent in a competitive market. State guaranty funds ensure that insurance claims are paid according to statutory benefit provisions. These insolvency costs are passed back to solvent insurers through assessments on premiums. Some states allow insurers to recoup guaranty fund assessments through higher rates while others allow premium tax offsets. Claimants may suffer inconvenience if forced to recover through a state guaranty fund, but insureds are insulated from most adverse effects unless a catastrophic claim has occurred. For former claims-made insureds, including retired providers, the risk is that they may lose run-off coverage and become exposed to uncovered suits.

Beginning in 1994, property and casualty insurers began submitting risk-based capital

filings annually to the NAIC. The risk-based capital system, established under the Risk-Based Capital for Insurers Model Act, uses a formula establishing a minimum capital (RBC) requirement for insurers based on the insurer's size and risk. Comparing the insurer's RBC requirement to its own statutory capital indicates whether an insurer is at risk of becoming insolvent. The model law allows regulators to intervene when capital requirements are not met.

Under the model act, the first level of regulatory intervention is the Company Action Level triggered when the total adjusted capital (TAC) to authorized control level (ACL) RBC falls below 200 percent. At this action level, insurers are required to submit an RBC Plan to the domiciliary regulator identifying both problems and corrective actions the insurer intends to take to bring its RBC level above 200 percent. The second level of regulatory intervention is the Regulatory Action Level triggered by a TAC to ACL RBC fall below 150 percent. The insurer is required to revise its RBC Plan and submit to the domiciliary regulator's request to perform examinations or analyses of its assets, liabilities and operations. The third action level, the Authorized Control Level, is triggered when the TAC to ACL RBC falls below 100 percent. At this level, the insurer must comply with the requirements of the first two levels. It also gives the domiciliary (home state) regulator the discretionary authority to place the insurer under regulatory control through its rehabilitation or liquidation act. The fourth and most severe level, Mandatory Control Level, is triggered when the TAC to ACL RBC falls below 70 percent. At this level, the company is placed under the control of the domiciliary regulator in accordance with the state's rehabilitation and liquidation act.

Table 34 shows the number of medical liability insurers that have reached RBC triggers since 1994, when the NAIC first began RBC filings. The number of insurers in each of the action levels remained consistent between 1994 and 2000. However, coinciding with the hardening insurance markets and recession in 2001, more insurers triggered the Mandatory Control Level than in past years. Surviving medical liability insurers may have been financially stronger during this period than in past crises. However, some hospitals report having to ease credentialing requirements as insurer rating services downgrade many insurers below A or excellent ratings.

Other Market Performance Dimensions

Prices, profit, availability and solvency are not the only dimensions of market performance that are of concern. Quality of service, efficiency and innovation are also important parameters in terms of how well markets are served. Unfortunately, it is difficult to obtain data or measure performance in these areas.

Quality of service encompasses a number of different variables including the accuracy/timeliness of policy issuance and rating adjustments, loss prevention and safety engineering and claims adjustment. In a competitive market, insurers should be spurred to provide the highest level of services commensurate with what insureds are willing to pay for these services. Insureds may differ in their demand or preference for different services. Consequently, insurers may differentiate themselves in terms of the level of service they provide based on insureds' preferences and adjust their rates accordingly.

Economists describe this type of market structure as monopolistic competition (Scherer, 1980, pp. 15-16).

Similarly, efficiency and innovation are important parameters, but are difficult to measure. Some analysts have used expense ratios (i.e. expenses divided by premiums) to measure efficiency, but expense ratios can be misleading for a number of reasons. Because statutory accounting requires insurers to book expenses when they are paid, as opposed to when related income is earned, expense ratios can be misleading when insurers are either growing or contracting. Lower expenses could also reflect diminished quality of service, rather than greater efficiency.

Innovation can be targeted at improving efficiency and lowering loss costs and expenses, developing new products and services or improving the insurers ability to more accurately manage estimates of future loss costs. Medical liability insurers face certain statutory and regulatory constraints in their ability to develop new products and services. Market pressures on prices may further induce some carriers to become more innovative.

SURVEY OF MARKET INTERVENTIONS

Tort Reform

Claims paid by medical liability insurers are based on the civil justice system of each state where they operate. Tort reform initiatives, particularly medical malpractice reform, generally refer to the variety of solutions states have introduced to change the legal environment for compensating claimants. The goal of these reforms is generally to limit

the frequency of lawsuits and/or the amount paid per claim. Reductions in these subsequently reduce costs to insurers, which in turn restrain premium increase over time.

In this section, we discuss several of the more common types of tort reform states have tried. It is also important to note that the U.S. Congress has considered legislation to enact specific tort reforms that would affect states in dramatically different ways. In fact, the House of Representatives passed the Help Efficient, Accessible Low-Cost, Timely Healthcare (HEALTH) Act of 2003. A similar bill was introduced in the Senate; however, no action has been taken on it. These bills contain damage limitations that would limit recovery of non-economic damages.

The US Department of Health and Human Services produced a report on the medical malpractice crisis in 2002.[43] The report argued that patient access to care and safety had been impacted by the most recent medical liability crisis.[44] The report also argued that health care costs had increased as a result of the crisis and the litigation system was responsible for the crisis.[45] The report also concluded that the crisis was less acute in states that had tort reforms in place.[46] The report recommends federal reforms that: improve the ability of patients to receive unlimited compensation for economic losses; cap recoveries for non-economic damages by a reasonable amount ($250,000); reserve punitive damages for cases that justify them; provide for payment of judgments over

[43] United States. Department of Health and Human Services. Confronting the New Health Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System. Washington, DC: GPO, 2002.
[44] Ibid. p. 2
[45] Ibid. p. 7
[46] Ibid. p. 14

time; provide that a case may not be brought more than three years following the date or injury or one year after the claimant discovers or, with reasonable diligence, should have discovered the injury; inform the jury if a plaintiff has another source of payment for the injury, such as health insurance; and provides that defendants pay any judgment in proportion to their fault, not on the basis of how deep their pockets are.[47]

There has been a significant amount of literature written on tort reform in general. The authors take very different approaches in their analysis. Much of the research focused on the impact of tort reform measures on claim costs to insurers and subsequently premium to consumers. Viscusi, et al (Journal of Risk and Uncertainty: 1993, p181-3) found that "tort reforms intended to constrain costs and enhance profitability did neither. Yet, these results suggest that premiums were dampened by the introduction of a reform measure." The authors offer two explanations for this observation. First, "if liability reforms stabilized insurance companies' expectations about the losses that would be experienced for policies currently being written, this could restrain premiums even though current losses are unaffected." Second, "the reform measures were correlated with states in crisis; there is the possibility that insurance was being rationed in those states." In contrast, Viscusi and Born (Journal of Legal Studies: 1995, p 496) found that "liability reforms increased insurer profitability (that is, decreased the loss ratios), where the main mechanism of influence was through decreasing losses. The quantile regression estimates imply that the greatest effects of liability reform are on the most unprofitable firms and that the effect is not uniform across the entire market." The authors also find that "the

[47] Ibid. p. 19